| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 495255 | A. BUILDING _____ B. WING _____ | C 12/29/2021 |

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| SKYVIEW SPRINGS REHAB AND NURSING CENTER | 30 MONTVUE DRIVE LURAY, VA 22835 |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid abbreviated standard and FIC survey was conducted 12/28/21 through 12/30/2021. Three complaints (VA00053999- substantiated with deficiencies, VA00053760- unsubstantiated with unrelated deficiencies, and VA00052295- unsubstantiated with no deficiencies) were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements.<br><br>The census in this 120 certified bed facility was 107 at the time of the survey. There were no COVID-19 positive residents at the time of the survey. The survey sample consisted of twenty current resident reviews (Resident #3 through Resident #22) and two closed record reviews (Resident #1 and Resident #2). | F 000 | This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. | |
| F 655 SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders. | F 655 | F655 Baseline Care Plan<br><br>1. The facility staff failed to develop a baseline care plan to address Resident #4's and Resident #1's assessed risks for developing a pressure injury. Resident #4's and Resident #1's care plans were immediately updated.<br>2. All other residents may have potentially been affected. Nursing staff will be educated on baseline care plans and importance of timely updates on admission/readmission. | 1/21/22 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 1/12/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 655 | Continued From page 1<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to develop a baseline care plan for two of 22 residents in the survey sample, Residents #4 and #1.<br><br>The facility staff failed to develop a baseline care plan to address Resident #4's and Resident #1's assessed risks for developing a pressure injury. | F 655 | 3. The Director of Nursing/Designee will educate nursing staff on policy "Care Planning – Comprehensive Person-Centered", including but not limited to importance of timely update on admission/readmission to facility to include risk assessment identifications.<br>4. The Director of Nursing/designee will review medical records of newly admitted residents weekly for 4 weeks to ensure that risk assessment identifications are identified and baseline care plan updated appropriately. When variances are identified in the weekly audits, the variance will be investigated, and the responsible nurse will be educated/counseled on the incident. The Director of Nursing/Designee will track the weekly audits for trends and a summary will be provided to the QAPI Committee for additional oversight/recommendation monthly x3. | |

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| F 655 | Continued From page 2<br>The findings include:<br><br>1. Resident #4 was admitted to the facility on 10/11/21 with diagnoses including arthritis and chronic pain. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/20/21, Resident #4 was coded as being moderately impaired for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). She was coded as having no pressure injuries, and as being at risk for developing a pressure injury. She was coded as always being incontinent of both bladder and bowel.<br><br>A review of Resident #4's admission "Braden Scale for Predicting Pressure Ulcer Risk" revealed that the resident was "at risk" for developing a pressure injury, having scored a 16 on the assessment.<br><br>A review of Resident #4's baseline care plan, dated 10/11/21, revealed, in part: "H. Safety Risks...Skin Risk ...Current skin integrity issues (box not checked...History of skin integrity issues (box not checked)." Further review failed to reveal any indications of or interventions for Resident #4's assessed risk for developing a pressure injury. (1)<br><br>On 12/30/21 at 8:28 a.m., LPN (licensed practical nurse) #5, the assistant director of nursing, was interviewed. She stated she was responsible for developing Resident #4's baseline care plan. She stated she normally obtains information for the care plan from the resident's hospital records, the resident, the family, and any other relevant sources. LPN #5 stated the baseline is developed | F 655 | | |

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| F 655 | Continued From page 3<br>on admission, and is in effect until the admission MDS assessment can be completed, and the comprehensive care plan developed. She stated the floor nurses usually start the initial care plan, but she goes behind them to make sure everything is complete. LPN #5 stated the admitting nurse performs the initial skin assessment and the initial pressure injury risk assessment (Braden Assessment). She stated the Braden Assessment information should be included in the baseline care plan. She stated that the Braden Assessment information that Resident #4 was at risk of developing a pressure injury was not included in the resident's baseline care plan, and should have been included. LPN #5 stated, "We should have had something in place."<br><br>On 12/30/21 at 9:43 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations, and ASM #4, the regional nurse consultant, were informed of these concerns.<br><br>A review of the facility policy, "'Care Planning - Comprehensive Person-Centered," revealed, in part: "1.To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within 48 hours of the resident's admission.<br>a. The Interdisciplinary Team will review the following to assist in developing the baseline care plan:<br>i. Orders obtained at the time of admission<br>ii. IDT initial evaluation and assessment...<br>d. The baseline care plan will include at a minimum:<br>i. The resident's initial goals for care;<br>ii. The instructions needed to provide effective and person-centered care that meets | F 655 | | |

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| F 655 | Continued From page 4<br>professional standards of quality care;<br>iii. The resident's immediate health and safety needs;<br>iv. Physician and dietary orders...<br>c. The baseline care plan will be used while the comprehensive admission MDS assessment and CAA review is being conducted.<br>d. The baseline care plan will form the foundation of the comprehensive care plan and be incorporated as the comprehensive care plan is developed."<br><br>No further information was provided prior to exit.<br><br>(1) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue." This information is taken from the website Https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf .<br><br>2. Resident #1 was admitted to the facility on 9/22/21 with diagnoses including chronic inflammatory demyelinating polyneuritis (1), lung disease, and bipolar disorder (2). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/28/21, the resident was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the | F 655 | | |

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| F 655 | Continued From page 5<br>BIMS (brief interview for mental status). She was coded as being at risk for developing a pressure injury, and as having no current unhealed pressure injuries.<br><br>A review of Resident #1's admission "Braden Scale for Predicting Pressure Ulcer Risk" revealed that the resident was "at high risk" for developing a pressure injury, having scored a 12 on the assessment.<br><br>A review of Resident #1's baseline care plan, dated 9/22/21, revealed, in part: "H. Safety Risks...Skin Risk ...Current skin integrity issues (box not checked...History of skin integrity issues (box not checked)." Further review failed to reveal any indications of or interventions for Resident #1's assessed risk for developing a pressure injury.<br><br>On 12/30/21 at 8:28 a.m., LPN (licensed practical nurse) #5, the assistant director of nursing, was interviewed. She stated she was responsible for developing Resident #4's baseline care plan. She stated she normally obtains information for the care plan from the resident's hospital records, the resident, the family, and any other relevant sources. LPN #5 stated the baseline is developed on admission, and is in effect until the admission MDS assessment can be completed, and the comprehensive care plan developed. She stated the floor nurses usually start the initial care plan, but she goes behind them to make sure everything is complete. LPN #5 stated the admitting nurse performs the initial skin assessment and the initial pressure injury risk assessment (Braden Assessment). She stated the Braden Assessment information should be included in the baseline care plan. She stated that | F 655 | | |

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| F 655 | Continued From page 6<br>the Braden Assessment information that Resident 1 was at risk of developing a pressure injury was not included in the resident's baseline care plan, and should have been included. LPN #5 stated, "We should have had something in place."<br><br>On 12/30/21 at 9:43 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations, and ASM #4, the regional nurse consultant, were informed of these concerns.<br><br>COMPLAINT DEFICIENCY<br><br>REFERENCES<br>(1) "Chronic inflammatory demyelinating polyneuropathy (CIDP) is a neurological disorder characterized by progressive weakness and impaired sensory function in the legs and arms." This information is taken from the website https://www.ninds.nih.gov/Disorders/All-Disorders/Chronic-Inflammatory-Demyelinating-Polyneuropathy-CIDP-Information-Page.<br><br>(2) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. | F 655 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered | F 656 | | |

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| F 656 | Continued From page 7<br>care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by: | F 656 | F656 Develop/Implement Comprehensive Care Plan<br><br>1. Resident #4 was observed to be without a dressing on her pressure injury. The resident's comprehensive care plan documented the resident's pressure injury should be treated as ordered. Resident #4's wound was immediately assessed and treated as ordered with no adverse outcome noted.<br>2. All other residents may have potentially been affected. The Director of Nursing/Designee will educate nursing staff on policy "Care Planning – Comprehensive Person-Centered", including but not limited to importance of ensuring all care plans have interventions implemented. Nursing staff will be educated on importance of alerting nurse timely when dressing is not intact as ordered. Nursing staff will be educated on timely treatment and monitoring of pressure injuries per orders and comprehensive care plan. | : 1/21/22 |

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| F 656 | Continued From page 8<br>Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to implement the comprehensive care plan for one of 22 residents in the survey sample, Resident #4. On 12/29/21 at 9:59 a.m., Resident #4 was observed to be without a dressing on her pressure injury. The resident's comprehensive care plan documented the resident's pressure injury should be treated as ordered.<br><br>The findings include:<br><br>Resident #4 was admitted to the facility on 10/11/21 with diagnoses including arthritis and chronic pain. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/20/21, Resident #4 was coded as being moderately impaired for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). She was coded as having no pressure injuries, and as being at risk for developing a pressure injury. Resident #4 was coded as always being incontinent of both bladder and bowel.<br><br>On 12/29/21 at 9:59 a.m., observation was made of LPN (licensed practical nurse) #3 as she provided a dressing change for Resident #4's sacral pressure injury. Resident #4 was lying on her right side, and observation revealed her mattress was a pressure-relieving mattress. In preparation for changing the dressing, LPN #3 removed Resident #4's incontinence brief. When she removed the brief, there was no dressing covering Resident #4's pressure injury. LPN #3 stated she was surprised to see the uncovered | F 656 | 3. The Director of Nursing/Designee will educate nursing staff on policy "Care Planning – Comprehensive Person-Centered", including but not limited to importance of ensuring all care plans have interventions implemented. Nursing staff will be educated on importance of alerting nurse timely when dressing is not intact as ordered. Nursing staff will be educated on timely treatment and monitoring of pressure injuries per orders and comprehensive care plan.<br>4. The Director of Nursing/designee will review medical records of 5 residents weekly for 4 weeks to ensure that ordered treatments are in place per comprehensive care plan and order. When variances are identified in the weekly audits, the variance will be investigated, and the responsible nurse will be educated/counseled on the incident. The Director of Nursing/Designee will track the weekly audits for trends and a summary will be provided to the | |

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| F 656 | Continued From page 9<br>pressure injury. She stated there should have been a dressing covering the pressure injury at all times, especially because the resident was incontinent of bowel and bladder. LPN #3 stated the resident's brief contained urine at that moment. She stated if someone had accidentally removed the dressing at some point, the pressure injury should have been re-dressed and covered, and never left open to the possibility of having urine or feces come into contact with the wound. LPN #3 completed the dressing of Resident #4's pressure injury using Dakins solution (a wound cleanser) and Medihoney (a wound healing agent). She covered the wound with a foam dressing.<br><br>A review of Resident #4's comprehensive care plan dated 10/22/21 and updated 11/18/21, revealed, in part: "The resident has pressure ulcer to the sacrum...Administer treatments as ordered and monitor for effectiveness...Pressure reducing mattress to bed."<br><br>A review of Resident #4's physician's orders revealed the following: "11/16/21 Cleanse...coccyx with wound cleanser and apply medihoney with a foam dressing daily and prn (as needed.)"<br><br>A review of Resident #4's TARs (treatment administration records) revealed the wound care had been provided as ordered.<br><br>On 12/29/21 at 11:51 a.m., CNA (certified nursing assistant) #3 was interviewed. She stated she provided incontinence care that morning to Resident #4. She stated at approximately 8:45 a.m., she changed Resident #4 incontinence brief. She stated the brief contained a "medium" | F 656 | QAPI Committee for additional oversight/recommendation monthly x3. | |

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| F 656 | Continued From page 10<br>amount of urine. She stated there was no dressing on Resident #4's pressure injury, and that the brief contained some evidence of wound drainage. She stated she knew Resident #4's wound was supposed to have a dressing. She stated she could not remember whom she had informed about the lack of a dressing, but believed she had informed the wound nurse. CNA #3 stated she did not know what time the resident's brief had been last changed prior to her providing incontinence care. When asked if she was aware of what Resident #4's comprehensive care plan stated about pressure injuries, CNA #3 stated she was an agency staff member, and she was not fully aware of Resident #4's care plan.<br><br>On 12/29/21 at 2:53 p.m., LPN #2 was interviewed. When asked the purpose of a comprehensive care plan, she stated the care plan directs the individual interventions for caring for a Resident. When asked if Resident #4's care plan was being followed when the resident's pressure injury was left without a dressing, she stated it was not.<br><br>On 12/29/21 at 4:45 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations, and ASM #4, the regional nurse consultant, were informed of these concerns.<br><br>A review of the facility policy, "Care Planning - Comprehensive Person-Centered," revealed, in part: "A person-centered comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs shall be developed for each resident...The facility will develop and implement a comprehensive | F 656 | | |

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| | 495255 | A. BUILDING _____ B. WING _____ | C 12/29/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SKYVIEW SPRINGS REHAB AND NURSING CENTER | 30 MONTVUE DRIVE LURAY, VA 22835 |

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| F 656 | Continued From page 11<br>person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process."<br><br>No further information was provided prior to exit.<br><br>REFERENCES<br><br>(1) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue." This information is taken from the website Https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf . | F 656 | | |
| F 657 SS=E | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident. | F 657 | | |

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| F 657 | Continued From page 12<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and facility document review and during the course of a complaint investigation, it was determined that the facility staff failed to review and revise the comprehensive care plan for four of 22 residents in the survey sample, Resident #12, Resident #14, Resident #19 and Resident #21.<br><br>The facility staff failed to review and revise Residents #12, #14, #19, and #2's comprehensive care plans to reflect the residents' positive RSV (1) status and care related to the respiratory infection.<br><br>The findings include:<br><br>The facility staff failed to review and revise Residents #12, #14, #19, and #2's comprehensive care plans to address the residents' positive RSV (1) status and care. | F 657 | F657 Care Plan Timing and Revision<br><br>1. The facility staff failed to review and revise Residents #12, #14, #19, and #2's comprehensive care plans to address the residents' positive RSV (1) status and care. These care plans were immediately updated.<br>2. All residents with RSV diagnoses may have potentially been impacted. All residents with current RSV diagnoses care plans were reviewed and updated if necessary.<br>3. The Director of Nursing/Designee will educate interdisciplinary team with access to care plans as appropriate on policy titled "Care Plans, Comprehensive Person-Centered". The education will include but not be limited to revising care plans annually, quarterly, and with significant changes, including but not limited to: new orders, new diagnoses, new preferences. | |

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| F 657 | Continued From page 13<br><br>Resident #12 was admitted to the facility on 11/22/21 with diagnoses including a urinary tract infection, malnutrition, and failure to thrive. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/9/21, the resident was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status).<br><br>A review of Resident #12's clinical record revealed laboratory results dated 12/18/21 documenting that the resident was positive for RSV.<br><br>A review of the resident's care plan dated 11/23/21 revealed no information related to RSV or isolation precautions.<br><br>Resident #14 was admitted to the facility on 10/20/21 with diagnoses including angina, cellulitis, and diabetes. On the most recent MDS, an admission assessment dated 10/27/21, the resident was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status).<br><br>A review of Resident #14's clinical record revealed laboratory results dated 12/21/21 documenting that the resident was positive for RSV.<br><br>A review of Resident #14's comprehensive care plan dated 10/22/21 and updated 11/4/21 revealed no information related to RSV or isolation precautions. | F 657 | 4. The Director of Nursing/Designee will perform an audit of 5 resident care plans weekly for 4 weeks to ensure care plans are updated appropriately after any significant changes. The QA Coordinator/Designee will track the weekly audits for trends and a summary will be provided to the QAPI Committee for additional oversight/recommendation monthly x3. | 1/21/22 |

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|---|---|---|---|
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|---|---|
| SKYVIEW SPRINGS REHAB AND NURSING CENTER | 30 MONTVUE DRIVE LURAY, VA 22835 |

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| F 657 | Continued From page 14<br>Resident #19 was admitted to the facility on 12/10/20 with diagnoses including chronic lung disease and dementia. On the most recent MDS, a quarterly assessment with an ARD of 11/8/21, the resident was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS.<br><br>A review of Resident #19's clinical record revealed laboratory results dated 12/19/21 documenting that the resident was positive for RSV.<br><br>A review of Resident #19's comprehensive care plan dated 5/26/21 and updated 11/1/21 revealed no information related to RSV or isolation precautions.<br><br>Resident #21 was admitted to the facility on 9/8/20 with diagnoses including dementia and schizoaffective disorder. On the most recent MDS, a quarterly assessment with an ARD of 12/15/21, the resident was coded as being severely cognitively impaired for making daily decisions, having scored five out of 15 on the BIMS.<br><br>A review of Resident #21's clinical record revealed laboratory results dated 12/19/21 documenting that the resident was positive for RSV.<br><br>A review of Resident #21's comprehensive care plan dated 5/25/21 and updated 7/27/21 revealed no information related to RSV or isolation precautions.<br><br>On 12/29/21 at 4:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the | F 657 | | |

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| F 657 | Continued From page 15<br>director of nursing, ASM #3, the regional director of operations, and ASM #4, the regional nurse consultant, were informed of these concerns. ASM #2 stated that updating care plans is the responsibility of "everyone," including all the members of the IDT (interdisciplinary team) who attend the daily morning meetings. She stated any nurse or IDT member is able to update the care plans. She stated that all four residents' care plan should have been updated to include RSV-positive status and the droplet isolation precautions (2).<br><br>No further information was provided prior to exit.<br><br>(1) "Respiratory syncytial virus, or RSV, is a respiratory virus that infects the lungs and breathing passages. Healthy people typically experience mild, cold-like symptoms and recover in a week or two. However, RSV can be serious, particularly for infants and the elderly." This information is taken from the website https://www.niaid.nih.gov/diseases-conditions/respiratory-syncytial-virus-rsv.<br><br>(2) "Droplet Precautions are used to prevent the spread of pathogens that are passed through respiratory secretions and do not survive for long in transit. These droplets are relatively large particles that cannot travel through the air very far. They are transmitted through coughing, sneezing, and talking." This information is taken from the website https://www.cdc.gov/infectioncontrol/pdf/strive/PPE102-508.pdf. | F 657 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) | F 658 | | |

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| F 658 | Continued From page 16<br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to follow professional standards for nursing documentation for one of 22 residents in the survey sample, Resident #4. The facility staff failed to document clinical assessments of Resident #4's pressure injury (1) on a date prior to 11/5/21 and on 11/5/21.<br><br>The findings include:<br><br>Resident #4 was admitted to the facility on 10/11/21 with diagnoses including arthritis and chronic pain. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/20/21, Resident #4 was coded as being moderately impaired for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). She was coded as having no pressure injuries, and as being at risk for developing a pressure injury. She was coded as always being incontinent of both bladder and bowel.<br><br>On 12/29/21 at 9:59 a.m., observation was made of LPN (licensed practical nurse) #3 as she provided a dressing change for Resident #4's sacral pressure injury. Resident #4 was lying on her right side, and observation revealed her | F 658 | F658 Services Provided Meet Professional Standards<br><br>1. The facility staff failed to document clinical assessments of Resident #4's pressure injury (1) on a date prior to 11/5/21 and on 11/5/21. Resident #4's pressure injury (1) was assessed and any appropriate documentation completed in skin and wound module.<br>2. All other residents may have potentially been affected.<br><br>Nursing staff will be educated on proper clinical documentation in medical record of pressure injuries.<br>3. The Director of Nursing/Designee will educate nursing staff on skin and wound module, which includes but not limited to proper clinical documentation in medical record of pressure injuries. | |

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| F 658 | Continued From page 17<br>mattress was a pressure-relieving mattress. LPN #3 completed the dressing of Resident #4's pressure injury using Dakins solution (a wound cleanser) and Medihoney (a wound healing agent). The wound measured 2.2 cm (centimeters) by 5 centimeters. The depth of the wound could not be determined because the wound contained approximately 20% slough (2). She covered the wound with a foam dressing.<br><br>A review of Resident #4's physician's orders revealed the following:<br><br>- "11/5/21...Cleanse areas to coccyx and right buttock with wound cleanser, apply calcium alginate and cover with foam dressing PRN (as needed)."<br><br>- "11/8/21...Cleanse areas to coccyx and right buttock with wound cleanser and apply calcium alginate and cover with foam dressing q day (every day) on Monday-Wednesday-Friday."<br><br>- "11/16/21 Cleanse...coccyx with wound cleanser and apply medihoney with a foam dressing daily and prn."<br><br>A review of Resident #4's TARs (treatment administration records) for November and December 2021 revealed she had received pressure injury treatments as ordered.<br><br>Further review of Resident #4's clinical record failed to reveal evidence of a pressure injury assessment prior to on or before 11/5/21.<br><br>A review of Resident #4's comprehensive care plan dated 10/22/21 and updated 11/18/21, revealed, in part: "The resident has pressure | F 658 | 4. The Director of Nursing/designee will review medical records of 5 residents weekly for 4 weeks to ensure that pressure injuries have appropriate documentation in appropriate time frame in medical record. When variances are identified in the weekly audits, the variance will be investigated, and the responsible nurse will be educated/counseled on the incident. The Director of Nursing/Designee will track the weekly audits for trends and a summary will be provided to the QAPI Committee for additional oversight/recommendation monthly x3. | 1/21/22 |

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| F 658 | Continued From page 18<br>ulcer to the sacrum...Administer treatments as ordered and monitor for effectiveness...Pressure reducing mattress to bed." The care plan failed to reveal evidence of the presence of a pressure injury prior to 11/16/21.<br><br>On 12/29/21 at 4:02 p.m., ASM (administrative staff member) #4, regional nurse consultant) and ASM #2 (director of nursing) were asked to provide evidence that Resident #4's pressure injury had been assessed prior to 11/16/21. At 4:40 p.m., ASM #4 stated she could not locate any assessments of Resident #4's pressure injury prior to 11/16/21. She stated the facility follows its policies as its professional standard of practice.<br><br>On 12/29/21 at 4:45 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations, and ASM #4, the regional nurse consultant, were informed of these concerns.<br><br>On 12/30/21, LPN (licensed practical nurse) #4 was interviewed. She presented copies of two licensed nurse weekly skin assessments for Resident #4. The first assessment was not dated. The second assessment was dated 11/5/21. LPN #4 stated she had completed both of these assessments, and she had neglected to date the first assessment. However, she was certain the first assessment was completed prior to 11/5/21, probably around 10/31/21 or 11/1/21. The undated skin assessment documented a "red and blanchable" area on Resident #4's sacrum. The assessment dated 11/5/21 documented a 2 by 2 cm area on Resident #4's sacrum, which was described as "100% slough and drainage." When asked where she obtained these assessments, LPN #4 stated she was Resident #4's admitting | F 658 | | |

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| F 658 | Continued From page 19<br>nurse on 10/11/21. There were no skin issues visible on that date. She stated she had completed the undated and 11/5/21 skin assessment sheets, but had put them in her locker at the facility. She stated she always keeps paper copies of assessments, and usually includes the originals in the clinical record. She stated, however, that she realized she had failed to include these two assessments as part of the clinical record. LPN #4 stated she contacted the nurse practitioner on 11/5/21, and that is how the order was generated on 11/5/21 for the original treatment of Resident #4's pressure injury. She stated she is aware she should have included the assessments in the resident's clinical record, and that she should have written a progress note about her findings and about her conversation with the nurse practitioner. She stated she did not have any excuses for why she did neither of these things. LPN #4 added that Resident #4 is not compliant with the turning and repositioning required to offload pressure from her sacrum.<br><br>A review of the facility policy, "Pressure Injury Prevention and Management," revealed, in part: "Treatments will be ordered by the physician/practitioner...Weekly skin observations will be conducted by a licensed nurse and findings will be documented in the resident's medical record.<br>3. Observations of new pressure ulcer/injury will be:<br>a. Reported to the physician / practitioner for further evaluation and treatment.<br>b. Referred to the designated wound nurse as appropriate."<br><br>No further information was provided prior to exit. | F 658 | | |

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| F 658 | Continued From page 20<br>REFERENCES<br>(1) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue." This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf .<br><br>(2) 'The wound bed may be covered with necrotic tissue (non-viable tissue due to reduced blood supply), slough (dead tissue, usually cream or yellow in color), or eschar (dry, black, hard necrotic tissue). Such tissue impedes healing." This information is taken from the website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360405/. | F 658 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent | F 686 | | |

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| F 686 | Continued From page 21<br>with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide care and services to treat a pressure injury (1) for one of 22 residents in the survey sample, Resident #4. On 12/29/21 at 9:59 a.m., Resident #4 was observed to be without a dressing on her pressure injury.<br><br>The findings include:<br><br>Resident #4 was admitted to the facility on 10/11/21 with diagnoses including arthritis and chronic pain. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/20/21, Resident #4 was coded as being moderately impaired for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). She was coded as having no pressure injuries, and as being at risk for developing a pressure injury. Resident #4 was coded as always being incontinent of both bladder and bowel.<br><br>On 12/29/21 at 9:59 a.m., observation was made of LPN (licensed practical nurse) #3 as she provided a dressing change for Resident #4's sacral pressure injury. Resident #4 was lying on her right side, and observation revealed her mattress was a pressure-relieving mattress. In preparation for changing the dressing, LPN #3 removed Resident #4's incontinence brief. When | F 686 | F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer<br><br>1. On 12/29/21 at 9:59 a.m., Resident #4 was observed to be without a dressing on her pressure injury. Resident #4's wound was immediately assessed and treated as ordered with no adverse outcome noted.<br>2. All other residents may have potentially been affected. Nursing staff will be educated on importance of alerting nurse timely when dressing is not intact as ordered. Nursing staff will be educated on timely treatment and monitoring of pressure injuries per orders.<br>3. The Director of Nursing/Designee will educate nursing staff on protocols for alerting staff of non-intact dressings, pressure injury care and prevention. | |

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| F 686 | Continued From page 22<br>she removed the brief, there was no dressing covering Resident #4's pressure injury. LPN #3 stated she was surprised to see the uncovered pressure injury. She stated there should have been a dressing covering the pressure injury at all times, especially because the resident was incontinent of bowel and bladder. LPN #3 stated the resident's brief contained urine at that moment. She stated if someone had accidentally removed the dressing at some point, the pressure injury should have been re-dressed and covered, and never left open to the possibility of having urine or feces come into contact with the wound. LPN #3 completed the dressing of Resident #4's pressure injury using Dakins solution (a wound cleanser) and Medihoney (a wound healing agent). The wound measured 2.2 cm (centimeters) by 5 centimeters. The depth of the wound could not be determined because the wound contained approximately 20% slough (2). She covered the wound with a foam dressing.<br><br>A review of Resident #4's physician's orders revealed the following: "11/16/21 Cleanse...coccyx with wound cleanser and apply medihoney with a foam dressing daily and prn (as needed.)"<br><br>A review of Resident #4's TARs (treatment administration records) revealed the wound care had been provided as ordered.<br><br>A review of Resident #4's comprehensive care plan dated 10/22/21 and updated 11/18/21, revealed, in part: "The resident has pressure ulcer to the sacrum...Administer treatments as ordered and monitor for effectiveness...Pressure reducing mattress to bed." | F 686 | 4. The Director of Nursing/designee will review medical records of 5 residents weekly for 4 weeks to ensure that ordered treatments are in place per comprehensive care plan and order. When variances are identified in the weekly audits, the variance will be investigated, and the responsible nurse will be educated/counseled on the incident. The Director of Nursing/Designee will track the weekly audits for trends and a summary will be provided to the QAPI Committee for additional oversight/recommendation monthly x3. | 1/21/22 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495255 | A. BUILDING _____ B. WING _____ | C 12/29/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SKYVIEW SPRINGS REHAB AND NURSING CENTER | 30 MONTVUE DRIVE LURAY, VA 22835 |

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|---|---|---|---|---|
| F 686 | Continued From page 23<br>A review of the most recent pressure injury assessment for Resident #4, dated 12/22/21, revealed the wound measured approximately 2 by 5 centimeters, and contained approximately 20% slough.<br><br>On 12/29/21 at 11:51 a.m., CNA (certified nursing assistant) #3 was interviewed. She stated she provided incontinence care that morning to Resident #4. She stated at approximately 8:45 a.m., she changed Resident #4 incontinence brief. She stated the brief contained a "medium" amount of urine. She stated there was no dressing on Resident #4's pressure injury, and that the brief contained some evidence of wound drainage. She stated she knew Resident #4's wound was supposed to have a dressing. CNA #3 stated she could not remember whom she had informed about the lack of a dressing, but believed she had informed the wound nurse. She stated she did not know what time the resident's brief had been last changed prior to her providing incontinence care.<br><br>On 12/29/21 at 12:30 p.m., ASM (administrative staff member) #6, the wound physician, was interviewed. He stated Resident #4's wound should have been protected from contact with urine and feces at all times. He stated the wound was at risk of worsening with contact with either urine or feces. He stated even if the facility staff was not 100% sure about which dressing to apply, the wound should at least have been covered with a piece of gauze, or with some sort of other protective dressing until the proper supplies could be obtained.<br><br>On 12/29/21 at 4:45 p.m., ASM #1, the administrator, ASM #2, the director of nursing, | F 686 | | |

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|---|---|---|---|---|
| F 686 | Continued From page 24<br>ASM #3, the regional director of operations, and ASM #4, the regional nurse consultant, were informed of these concerns.<br><br>A review of the facility policy, "Pressure Injury Prevention and Management," revealed, in part: "Treatments will be ordered by the physician/practitioner...orders for pressure ulcer/injury treatment will be specific for each resident."<br><br>No further information was provided prior to exit.<br><br>REFERENCES<br><br>(1) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue." This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf .<br><br>(2) 'The wound bed may be covered with necrotic tissue (non-viable tissue due to reduced blood supply), slough (dead tissue, usually cream or yellow in color), or eschar (dry, black, hard necrotic tissue). Such tissue impedes healing." This information is taken from the website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360405/. | F 686 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|
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| F 842 | Continued From page 25 | F 842 | | |
| F 842 SS=D | Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, | F 842 | F842 Resident Records - Identifiable Information<br><br>1. The facility staff failed to document feeding Resident #2, 29 meals from 10/24/21 to 11/8/21, failed to ensure two skin assessments were included in Resident #4's clinical record. Resident #2 was assessed for weight loss, no adverse outcome noted. Resident #4 had a skin assessment completed with no new areas noted.<br>2. All other residents may have potentially been affected. Department heads and nursing staff will be educated on importance of accurate and timely documentation in the medical record.<br>3. The Director of Nursing/Designee will educate nursing staff on policy titled, "Charting and Documentation". This education will include but not be limited to importance of accurate and timely documentation in the medical record. | |

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| | 495255 | A. BUILDING _____ B. WING _____ | C 12/29/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 842 | Continued From page 26<br>medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, observations and facility document review, it was determined the facility staff failed to maintain a complete and accurate medical record for two of 22 residents in the survey sample, Resident #2 and Resident #4.<br><br>The facility staff failed to document feeding Resident #2, 29 meals from 10/24/21 to 11/8/21, | F 842 | 4. The Director of Nursing/designee will review medical records of 10 residents weekly for 4 weeks to ensure that meals are documented timely. The Director of Nursing/Designee will review 6 residents weekly for 4 weeks to ensure that skin assessments are documented weekly. When variances are identified in the weekly audits, the variance will be investigated, and the responsible nurse will be educated/counseled on the incident. The Director of Nursing/Designee will track the weekly audits for trends and a summary will be provided to the QAPI Committee for additional oversight/recommendation monthly x3. | 1/21/22 |

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|---|---|---|---|
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| F 842 | Continued From page 27<br>failed to ensure two skin assessments were included in Resident #4's clinical record.<br><br>The findings include:<br><br>1. Resident #2 was admitted to the facility on 6/6/19 with diagnosis that included but were not limited to:<br>diabetes mellitus (inability of insulin to function normally in the body) (1), Alzheimer's (progressive loss of mental ability and function often accompanied by personality changes and emotional instability) (2), PTSD [post-traumatic stress disorder] (mood disorder occurring after a traumatic event) (3) and psychoses (mental disorder with detachment from reality and impaired perceptions, thinking and responses) (4).<br>,<br>The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/8/21, coded Resident #2 as scoring a 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as totally dependant of assistance for bed mobility, transfer, dressing, hygiene and bathing; extensive assistance for eating and supervision for locomotion. A review of MDS Section H- Bowel and Bladder coded the resident as always incontinent for bowel and for bladder.<br><br>A review of the ADL (activities of daily living) for 10/24/21-11/8/21 for Resident #2 evidenced 29 meals that had no documentation of the resident being fed. The meals not documented included | F 842 | | |

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|---|---|---|---|---|
| F 842 | Continued From page 28<br>10/24- supper, 10/25- breakfast lunch/supper, 10/26-supper, 10/27- breakfast lunch/supper, 10/29-supper, 10/30-lunch/supper, 10/31- breakfast lunch/ supper, 11/1- breakfast lunch/supper, 11/2-supper, 11/3- breakfast lunch/supper, 11/4-supper, 11/5-lunch/supper, 11/6-lunch/supper, 11/7- breakfast lunch/supper and 11/8-lunch/supper. The remaining meal documentation evidenced the resident was a complete feed, one person assist.<br><br>A review of the comprehensive care plan dated 6/15/21, documented in part, "FOCUS-Resident has the potential for further ADL self-care performance deficit related to Alzheimer's, Dementia. INTERVENTIONS-Staff is to feed resident all meals."<br><br>An interview was conducted on 12/30/21 at 8:30 am with CNA (certified nursing assistant) #4. When asked what the blanks on the ADL form documenting eating for Resident #2 meant, "CNA #4 stated, "It just means that we did not get to document it on the form, not that it was not done."<br><br>An interview was conducted on 12/30/21 at 8:55 am with CNA #5. When asked what the blanks on the ADL form documenting eating for Resident #2 meant, "CNA #5 stated, "It would mean we did not take the time to document what we had done for the resident."<br><br>On 12/30/21 at 9:00 AM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the concern.<br><br>According to the facility's "Charting and Documentation" revised 5/21, which documents | F 842 | | |

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| | 495255 | A. BUILDING _____ B. WING _____ | C 12/29/2021 |

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|---|---|
| SKYVIEW SPRINGS REHAB AND NURSING CENTER | 30 MONTVUE DRIVE LURAY, VA 22835 |

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|---|---|---|---|---|
| F 842 | Continued From page 29<br>in part, "All services provided to the resident, progress toward the care plan goals or any changes in the resident's medical, physical, functional or psychosocial condition, will be documented in the resident's medical record. The following information is to be documented in the resident medical record: treatments or services performed. Documentation of procedures and treatments will include care-specific details."<br><br>No further information was provided prior to exit.<br><br>References:<br>(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 160.<br>(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 25.<br>(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 467.<br>(4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 480.<br><br>2. Resident #4 was admitted to the facility on 10/11/21 with diagnoses including arthritis and chronic pain. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/20/21, Resident #4 was coded as being moderately impaired for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). She was coded as having no pressure injuries, and as being at risk for developing a pressure injury. She was coded as | F 842 | | |

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|---|---|---|---|
| | 495255 | A. BUILDING _____ B. WING _____ | C 12/29/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SKYVIEW SPRINGS REHAB AND NURSING CENTER | 30 MONTVUE DRIVE LURAY, VA 22835 |

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| F 842 | Continued From page 30<br>always being incontinent of both bladder and bowel.<br><br>On 12/29/21 at 9:59 a.m., observation was made of LPN (licensed practical nurse) #3 as she provided a dressing change for Resident #4's sacral pressure injury. Resident #4 was lying on her right side, and observation revealed her mattress was a pressure-relieving mattress. LPN #3 completed the dressing of Resident #4's pressure injury using Dakins solution (a wound cleanser) and Medihoney (a wound healing agent). The wound measured 2.2 cm (centimeters) by 5 centimeters. The depth of the wound could not be determined because the wound contained approximately 20% slough (2). She covered the wound with a foam dressing.<br><br>A review of Resident #4's physician's orders revealed the following:<br><br>"11/5/21...Cleanse areas to coccyx and right buttock with wound cleanser, apply calcium alginate and cover with foam dressing PRN (as needed)."<br><br>"11/8/21...Cleanse areas to coccyx and right buttock with wound cleanser and apply calcium alginate and cover with foam dressing qday (every day) on Monday-Wednesday-Friday."<br><br>"11/16/21 Cleanse...coccyx with wound cleanser and apply medihoney with a foam dressing daily and prn."<br><br>A review of Resident #4's TARs (treatment administration records for November and December 2021 revealed she had received pressure injury treatments as ordered. | F 842 | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SKYVIEW SPRINGS REHAB AND NURSING CENTER | 30 MONTVUE DRIVE LURAY, VA 22835 |

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| F 842 | Continued From page 31<br><br>Further review of Resident #4's clinical record failed to reveal evidence of a pressure injury assessment prior on or before 11/5/21.<br><br>A review of Resident #4's comprehensive care plan dated 10/22/21 and updated 11/18/21, revealed, in part: "The resident has pressure ulcer to the sacrum...Administer treatments as ordered and monitor for effectiveness...Pressure reducing mattress to bed." The care plan failed to reveal evidence of the presence of a pressure injury prior to 11/16/21.<br><br>On 12/29/21 at 4:02 p.m., ASM (administrative staff member) #4, regional nurse consultant) and ASM #2 (director of nursing) were asked to provide evidence that Resident #4's pressure injury had been assessed prior to 11/16/21. At 4:40 p.m., ASM #4 stated she could not locate any assessments of Resident #4's pressure injury prior to 11/16/21.<br><br>On 12/29/21 at 4:45 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations, and ASM #4, the regional nurse consultant, were informed of these concerns.<br><br>On 12/30/21, LPN #4 was interviewed. She presented copies of two licensed nurse weekly skin assessments for Resident #4. The first was not dated. The second assessment was dated 11/5/21. She stated she had completed both of these assessments, and she had neglected to date the first assessment. However, she was certain the first assessment was completed prior to 11/5/21, probably around 10/31/21 or 11/1/21. The undated skin assessment documented a "red | F 842 | | |

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|---|---|---|---|
| | 495255 | A. BUILDING _____ B. WING _____ | C 12/29/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SKYVIEW SPRINGS REHAB AND NURSING CENTER | 30 MONTVUE DRIVE LURAY, VA 22835 |

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| F 842 | Continued From page 32<br>and blanchable" area on Resident #4's sacrum. The assessment dated 11/5/21 documented a 2 by 2 cm area on Resident #4's sacrum, which was described as "100% slough and drainage." When asked where she obtained these assessments, LPN #4 stated she was Resident #4's admitting nurse on 10/11/21. There were no skin issues visible on that date. She stated she had completed the undated and 11/5/21 skin assessment sheets, but had put them in her locker at the facility. She stated she always keeps paper copies of assessments, and usually includes the originals in the clinical record. She stated, however, that she realized she had failed to include these two assessments as part of the clinical record. LPN #4 stated she contacted the nurse practitioner on 11/5/21, and that is how the order was generated on 11/5/21 for the original treatment of Resident #4's pressure injury. She stated she is aware she should have included the assessments in the resident's clinical record, and that she should have written a progress note about her findings and about her conversation with the nurse practitioner. She stated she did not have any excuses for why she did neither of these things.<br><br>No further information was provided prior to exit.<br><br>REFERENCES<br>(1) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, | F 842 | | |

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|---|---|---|---|
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| F 842 | Continued From page 33<br>perfusion, co-morbidities and condition of the soft tissue." This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf .<br><br>(2) 'The wound bed may be covered with necrotic tissue (non-viable tissue due to reduced blood supply), slough (dead tissue, usually cream or yellow in color), or eschar (dry, black, hard necrotic tissue). Such tissue impedes healing." This information is taken from the website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360405/. | F 842 | | |
| F 882 SS=E | Infection Preventionist Qualifications/Role<br>CFR(s): 483.80(b)(1)-(4)(c)<br><br>§483.80(b) Infection preventionist<br>The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must:<br><br>§483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;<br><br>§483.80(b)(2) Be qualified by education, training, experience or certification;<br><br>§483.80(b)(3) Work at least part-time at the facility; and<br><br>§483.80(b)(4) Have completed specialized training in infection prevention and control.<br><br>§483.80 (c) IP participation on quality assessment and assurance committee. | F 882 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495255 | A. BUILDING _____ B. WING _____ | C 12/29/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SKYVIEW SPRINGS REHAB AND NURSING CENTER | 30 MONTVUE DRIVE LURAY, VA 22835 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 882 | Continued From page 34<br>The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to ensure that a designated person met the qualifications for the Infection Preventionist role.<br><br>The findings include:<br><br>On 12/29/21 at 2:45 PM, RN (registered nurse) #1, the infection preventionist was asked to provide evidence of her certification in infection prevention.<br><br>RN #1 stated, "I started here three weeks ago and have not completed the education on CDC (centers for disease control) or APIC (association for professionals in infection control). I have done two modules in the CDC certification. I have other education from my previous employer and proceeded to show certificates for hand hygiene from on line course. No other education pertaining to infection prevention was provided.<br><br>An interview was conducted on 12/29/21 at 3:30 pm with ASM (administrative staff member) #2, the director of nursing. When asked about the qualifications for the Infection Preventionist, ASM #2 stated, "She came with me and had only been here about 3 weeks. She is working on her certification through CDC."<br><br>On 12/29/21 at 4:30 PM, ASM #1, the | F 882 | F882 Infection Preventionist Qualifications/Role<br><br>1. The facility staff failed to ensure that a designated person met the qualifications for the Infection Preventionist role.<br>2. All other residents may have potentially been affected. The designated Infection Preventionist has completed the certification in infection prevention from the CDC.<br>3. The Administrator/Designee will verify that employees possess required certification upon hire and employee professional certifications will be kept on file in the facility.<br>4. The Administrator/Designee will perform a monthly assessment of employee professional certifications to ensure that licenses are current and valid for all employees that are required to be professionally certified. The Administrator/Designee will prohibit any employees not possessing a valid certification | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 882 | Continued From page 35<br>administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations and ASM #4, the regional nurse consultant, were informed of the concern and asked for the Infection Preventionist job description.<br><br>The facility's "Infection Control Program" dated 5/21/21, which documented in part, "The infection control program initiatives and responses will be coordinated with the local and/or state health departments."<br><br>The facility's "Infection Preventionist job description" documented in part, "Qualified candidate: certification in infection control and epidemiology (i.e.: CIC [certified infection control] preferred) or attainment prior to employment."<br><br>According to the SOM (State Operations Manual) requirements to meet 882, section §483.80(b)(4) Have completed specialized training in infection prevention and control. | F 882 | from working in the position that requires a certification until the time that the employee obtains a valid certification. The Administrator/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee monthly x3. | 1/21/22 |