PRINTED: 01/06/2022 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				B, WING			С
		495255	B, WING			12/	29/2021
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SKYVIEW	SPRINGS REHAB AND I	NURSING CENTER			0 MONTVUE DRIVE		
				L	URAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD 6			(X5) COMPLETION DATE
F 000	An unannounced Medistandard and FIC sunthrough 12/30/2021. (VA00053999- substant VA00053760- unsubstant deficiencies, and VA00 with no deficiencies) with 42 CFR Part 483 Requirements.  The census in this 120 107 at the time of the COVID-19 positive resistant resident review Resident #22) and two (Resident #22) and two (Resident #1 and Resident #1 a	dicare/Medicaid abbreviated vey was conducted 12/28/21 Three complaints ntiated with deficiencies, stantiated with unrelated 0052295- unsubstantiated vere investigated during the re required for compliance Federal Long Term Care  O certified bed facility was survey. There were no sidents at the time of the ample consisted of twenty vs (Resident #3 through o closed record reviews ident #2).  (3)  ve Person-Centered Care fare Plans lity must develop and care plan for each resident actions needed to provide entered care of the resident standards of quality care.	TAG	0000	CROSS-REFERENCED TO THE APPROPRIA	e. s de e ts.	
	admission.  (ii) Include the minimul necessary to properly of including, but not limite (A) Initial goals based of the including of the includ	ed to-			Nursing staff will be educate baseline care plans and importance of timely update		
	(B) Physician orders.				admission/readmission.	1	
APODATORY	IDECTOR'S OR DROVIDER/SI	IPPLIER REPRESENTATIVE'S SIGNATURE			TM F		X6) DATE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MDIM11

Facility ID: VA0166

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II	TIPL	E CONSTRUCTION		9. 0938-0391
	F CORRECTION	IDENTIFICATION NUMBER:	1 ' '		ECONSTRUCTION		SURVEY PLETED
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		495255	B. WING				29/2021
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	care plan if the compretion of the baseline daministered by the facility. Any updated inform of the comprehensive of the planting of the facility. (ii) Any services and to administered by the faction behalf of the facility. (iv) Any updated inform of the comprehensive of the comprehensive of the course of a complait determined that the facility staff failed to blan to address Resider	endation, if applicable.  lity may develop a lan in place of the baseline whensive care plan- 48 hours of the resident's  ents set forth in paragraph epting paragraph (b)(2)(i) of  lity must provide the esentative with a summary an that includes but is not the resident, esident's medications and reatments to be sility and personnel acting ation based on the details are plan, as necessary, s not met as evidenced  staff interview, facility al record review, and in nt investigation, it was lity staff failed to develop two of 22 residents in the	F	655	<ol> <li>The Director of Nursing/Deswill educate nursing staff or policy "Care Planning — Comprehensive Person-Centered", including but not limited to importance of time update on admission/readmission to fato include risk assessment identifications.</li> <li>The Director of Nursing/desiwill review medical records on newly admitted residents we for 4 weeks to ensure that riassessment identifications at identified and baseline care updated appropriately. When variances are identified in the weekly audits, the variance be investigated, and the responsible nurse will be educated/counseled on the incident. The Director of Nursing/Designee will track weekly audits for trends and summary will be provided to QAPI Committee for addition oversight/recommendation monthly x3.</li> </ol>	gnee of eekly sk re plan n e e will e the d a to the onal	
Į.	olan to address Resider	nt #4's and Resident #1's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495255	A. BUILDING		C	2024	
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CIT	Y, STATE, ZIP CODE	12/29/	2021
SKYVIEW	SPRINGS REHAB AND I	NURSING CENTER		30 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CO	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIA DEFICIENCY)	- 1	(X5) DMPLETION DATE
	10/11/21 with diagnos chronic pain. On the n data set), an admissio (assessment reference Resident #4 was code impaired for making discored 12 out of 15 or for mental status). She pressure injuries, and developing a pressure always being incontine bowel.  A review of Resident # Scale for Predicting Prevealed that the resid developing a pressure on the assessment.  A review of Resident # dated 10/11/21, reveal RisksSkin RiskCur (box not checkedHis (box not checked)." Further than the residence of the dated 10/11/21, reveal RisksSkin RiskCur (box not checked)." Further than the residence of the dated 10/11/21, reveal RisksSkin RiskCur (box not checked)." Further than the residence of the dated 10/11/21, reveal RisksSkin RiskCur (box not checked)." Further than the residence of the dated 10/11/21, reveal RisksSkin RiskCur (box not checked)." Further than the residence of the r	Imitted to the facility on es including arthritis and nost recent MDS (minimum in assessment with an ARD e date) of 10/20/21, d as being moderately aily decisions, having in the BIMS (brief interview e was coded as having no as being at risk for injury. She was coded as ent of both bladder and  4's admission "Braden essure Ulcer Risk" ent was "at risk" for injury, having scored a 16  4's baseline care plan, ed, in part: "H. Safety rrent skin integrity issues tory of skin integrity issues rther review failed to reveal terventions for Resident	F	55			
	nurse) #5, the assistan interviewed. She stated developing Resident # stated she normally obcare plan from the resident, the family, an	t director of nursing, was I she was responsible for I's baseline care plan. She tains information for the dent's hospital records, the					

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<u> </u>	COT OIL MEDIONICE OF	INCOIOMID OCITATOCO				OIMD IA	<u>U. 0936-</u> 0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A, BUILD		E CONSTRUCTION		E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER					12	/29/2021
TWANE OF F	ROVIDER OR SUFFLIER			`	STREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	10		DROWNED BY AN OF CORDITORION		
PREFIX		Y MUST BE PRECEDED BY FULL	ID PREF	ΙΧ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	=	(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
			1		<u> </u>		
F 655	Continued From page	. 9	_				
1 000	' *			655			i j
i		n effect until the admission					
		be completed, and the					!
		lan developed. She stated					
		ly start the initial care plan,					] [
	but she goes behind the						1
	everything is complete	e. LPN #5 stated the					i I
	admitting nurse perfor						İ
- 1		nitial pressure injury risk					
ľ		Assessment). She stated	1				i I
		nt information should be					
ŀ		e care plan. She stated that					
	the Braden Accessmen	nt information that Resident					
		oping a pressure injury was					
1		ident's baseline care plan,					
- 1	and about the resi	ident's baseline care plan,					
		included. LPN #5 stated,		ŀ			l i
	"We should have had s	something in place."					
	On 12/30/21 at 9:43 a.	m., ASM (administrative	100				
- !		administrator, ASM #2, the	i			i	
		M #3, the regional director	1	-			
		#4, the regional nurse	1	ŀ			I
	consultant, were inform		1				
	consultant, were impire	ied of these collecties.		-			
[	A review of the facility a	policy, ""Care Planning -					
		n-Centered," revealed, in				ļ	
		the resident's immediate					
		d maintained, a baseline					ł
		oped within 48 hours of the		-			
	resident's admission.	ped within 40 hours of the					
1	a. The Interdisciplina	n: Toom will review the					J
		veloping the baseline care					
	plan:	Aciobing are passine cate					
1 '		the time of eductions					
<b>I</b>		the time of admission					
1		on and assessment				-	
I .	· ·	plan will include at a					
- 1	minimum:						
ļi							
i	<ol> <li>The instructions ne</li> </ol>	eded to provide effective					
a	and person-centered ca	are that meets		1			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		(X3) DATE SURVEY COMPLETED		
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		495255	B, WING		<del></del>	12/	29/2021
NAME OF P	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		····
SKYVIEW	SPRINGS REHAB AND N	NURSING CENTER			30 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	needs; iv. Physician and die c. The baseline care comprehensive admis CAA review is being c d. The baseline care foundation of the comp be incorporated as the is developed."  No further information  (1) "A pressure injury i skin and underlying so bony prominence or re device. The injury can open ulcer and may be as a result of intense a or pressure in combina tolerance of soft tissue may also be affected b perfusion, co-morbiditi tissue." This informatio  Https://cdn.ymaws.con gr/online_store/npiap  2. Resident #1 was add 9/22/21 with diagnoses inflammatory demyelin disease, and bipolar di recent MDS (minimum assessment with an AF date) of 10/28/21, the r having no cognitive imp	s of quality care; mediate health and safety stary orders e plan will be used while the sion MDS assessment and conducted. e plan will form the prehensive care plan and a comprehensive care plan and a comprehensive care plan was provided prior to exit.  Is localized damage to the off tissue usually over a stated to a medical or other present as intact skin or an expainful. The injury occurs and/or prolonged pressure ation with shear. The off or pressure and shear by microclimate, nutrition, es and condition of the soft on is taken from the website on/npiap.com/resource/resm pressure_injury_stages.pdf  mitted to the facility on a including chronic ating polyneuritis (1), lung sorder (2). On the most data set), a quarterly RD (assessment reference esident was coded as pairment for making daily	F	655			
	decisions, having score	TO OUT OF THE STATE OF THE STAT			<u> </u>		

STATEMENT OF DEFICIENC AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR S		NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		-
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	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
BIMS (brie coded as to injury, and pressure in A review of Scale for Prevealed the developing on the asset A review of dated 9/22. RisksSkii (box not che (box not che any indication #1's assessinjury.  On 12/30/2 nurse) #5, to interviewed developing stated she accare plan for resident, the sources. LP on admission MDS assess comprehense the floor number she goe everything is admitting nuassessment the Braden with the Braden with the Braden with the good severation assessment the Braden with the Braden	peing at risk as having of as having of as having of a pressure essment.  If Resident # Predicting Predicting Predicting Predicting Predicting Predicting Predicting Pressure essment.  If Resident # Predicting Pressure essement for interest	for mental status). She was a for developing a pressure no current unhealed  #1's admission "Braden ressure Ulcer Risk" dent was "at high risk" for a injury, having scored a 12  #1's baseline care plan, and, in part: "H. Safety rrent skin integrity issues atterventions for Resident developing a pressure  m., LPN (licensed practical at director of nursing, was deshe was responsible for 4's baseline care plan. She attains information for the dent's hospital records, the dent's hospital records and the hospital records and the hospital records and the hospital rec	F	655			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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]	ROVIDER OR SUPPLIER	NURSING CENTER		31	TREET ADDRESS, CITY, STATE, ZIP CODE 0 MONTYUE DRIVE URAY, VA 22835	14	/29/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTION C				(X5) COMPLETION DATE
F 656 SS=D	the Braden Assessment was at risk of develor not included in the result and should have been "We should have had"  On 12/30/21 at 9:43 a staff member) #1, the director of nursing, AS of operations, and AS consultant, were informationally completed by programmer of the polyneuropathy (CIDP characterized by programpaired sensory functionally completed by programpaired by programpai	ant information that Resident oping a pressure injury was sident's baseline care plan, included. LPN #5 stated, something in place."  .m., ASM (administrative administrator, ASM #2, the SM #3, the regional director M #4, the regional nurse med of these concerns.  ENCY  tory demyelinating ) is a neurological disorder ressive weakness and tion in the legs and arms." en from the website gov/Disorders/All-Disorders-Demyelinating-Polyneurop-Page.  commerly called ss or manic depression) is causes unusual shifts in levels, concentration, and day-to-day tasks." This im the website ov/health/topics/bipolar-dis omprehensive Care Plan	F 6	555	DEFICIENCY 1		
	§483.21(b)(1) The facilimplement a comprehe						:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495255	B, WING			12/	29/2021
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
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	care plan for each res resident rights set fort §483.10(c)(3), that incoperatives and timefra medical, nursing, and needs that are identificassessment. The combescribe the following (i) The services that are or maintain the resider physical, mental, and required under §483.2 (ii) Any services that wunder §483.24, §483.2 provided due to the resunder §483.10, includit treatment under §483. (iii) Any specialized se rehabilitative services provide as a result of Frecommendations. If a findings of the PASAR rationale in the resident (iv) In consultation with resident's representating (A) The resident's goal desired outcomes.  (B) The resident's prefiture discharge. Facility whether the resident's community was assess local contact agencies entities, for this purpos	ident, consistent with the hat §483.10(c)(2) and studes measurable mes to meet a resident's mental and psychosocial ed in the comprehensive prehensive care plan must reto be furnished to attain at's highest practicable psychosocial well-being as 4, §483.25 or §483.40; and would otherwise be required as 5 or §483.40 but are not sident's exercise of rights and the right to refuse 10(c)(6).  Invices or specialized the nursing facility will PASARR facility disagrees with the R, it must indicate its at's medical record. The resident and the we(s)-is for admission and serence and potential for tites must document desire to return to the sed and any referrals to and/or other appropriate e. the comprehensive care	F	656	F656 Develop/Implement Comprehensive Care Plan  1. Resident #4 was observed to without a dressing on her pressure injury. The resident comprehensive care plan documented the resident's pressure injury should be tre as ordered. Resident #4's wo was immediately assessed an treated as ordered with no adverse outcome noted.  2. All other residents may have potentially been affected. The Director of Nursing/Designed educate nursing staff on poli "Care Planning — Comprehen Person-Centered", including not limited to importance of ensuring all care plans have interventions implemented. Nursing staff will be educate importance of alerting nurse timely when dressing is not it as ordered. Nursing staff will educated on timely treatment.	be 's ated und ad e will cy sive but d on	L/21/22
	requirements set forth i section. This REQUIREMENT	in paragraph (c) of this is not met as evidenced			and monitoring of pressure injuries per orders and comprehensive care plan.		
	bv:				Comprehensive care plant	1	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE	SURVEY
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	ROVIDER OR SUPPLIER SPRINGS REHAB AND I	IURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XS) COMPLETION DATE
	Based on observation document review, clin the course of a complete determined that the faimplement the compressore of 22 residents in the state. When the course of 22 residents in the state. The findings include:  Resident documented injury should be treated injury should be treated. The findings include:  Resident #4 was admit 10/11/21 with diagnost chronic pain. On the material data set), an admission (assessment reference Resident #4 was code impaired for making descored 12 out of 15 on for mental status). She pressure injuries, and developing a pressure coded as always being bladder and bowel.  On 12/29/21 at 9:59 a. of LPN (licensed practiprovided a dressing chack a dress	n, staff interview, facility ical record review, and in aint investigation, it was cility staff failed to shensive care plan for one survey sample, Resident 69 a.m., Resident #4 was to a dressing on her esident's comprehensive of the resident's pressure does ordered.  Itted to the facility on es including arthritis and east recent MDS (minimum in assessment with an ARD edate) of 10/20/21, does being moderately edity decisions, having the BIMS (brief interview is was coded as having no as being at risk for injury. Resident #4 was a incontinent of both  Incontinent of both  Incontinent #4 was lying on ervation revealed her re-relieving mattress. In the gother facility in the dressing, LPN #3 incontinence brief, When	F	656	3. The Director of Nursing/Desi will educate nursing staff on policy "Care Planning – Comprehensive Person-Centered", including but not limited to importance of ensuall care plans have interventionall plans timely when dressing is not intact as ordered nursing staff will be educated timely treatment and monitor of pressure injuries per ordered and comprehensive care plans will review medical records or residents weekly for 4 weeks ensure that ordered treatment are in place per comprehensional care plan and order. When variances are identified in the weekly audits, the variance weekly audits, the variance will be educated/counseled on the incident. The Director of Nursing/Designee will track weekly audits for trends and summary will be provided to	uring ons vill of red. d on oring rs n. gnee of 5 s to ents sive will the	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
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	TO THE PART OF THE		,	L	URAY, VA 22835		
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	pressure injury. She siden a dressing cover times, especially becar incontinent of bowel at the resident's brief commoment. She stated if removed the dressing injury should have becand never left open to urine or feces come in LPN #3 completed the pressure injury using ficienser) and Medihoragent). She covered the dressing.  A review of Resident # plan dated 10/22/21 ar revealed, in part: "The ulcer to the sacrum A ordered and monitor for reducing mattress to be A review of Resident # revealed the following: Cleansecoccyx with medihoney with a foam needed.)"  A review of Resident # administration records) had been provided as continuous assistant) #3 was intemprovided incontinence of Resident #4. She state a.m., she changed Resident R	tated there should have ring the pressure injury at all tuse the resident was and bladder. LPN #3 stated intained urine at that someone had accidentally at some point, the pressure en re-dressed and covered, the possibility of having to contact with the wound. It dressing of Resident #4's Dakins solution (a wound ney (a wound healing ne wound with a foam the wound with a foam the wound with a foam the wound healing ne wound with a foam the wound care and apply in dressing daily and prn (as the wound care ordered.  The wound cleanser and apply in dressing daily and prn (as the wound care ordered.  The wound care ordered.  The wound care ordered wound care ordered.  The wound care ordered wound care ordered.  The wound with a foam the wound care ordered.  The wound with a foam the wound care ordered.  The wound with a foam the wound care ordered.	F	656	QAPI Committee for additional oversight/recommendation monthly x3.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILDI		E CONSTRUCTION		SURVEY
		495255	B. WING			1	C /29/2021
	ROVIDER OR SUPPLIER  SPRINGS REHAB AND !	NURSING CENTER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835	120	2012021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
·	that the brief contained drainage. She stated a wound was supposed stated she could not reinformed about the lad believed she had infor #3 stated she did not be providing incontinence was aware of what Recare plan stated about stated she was an age was not fully aware of On 12/29/21 at 2:53 printerviewed. When ask comprehensive care plan directs the individition of a Resident. When a plan was being followed pressure injury was left stated it was not.  On 12/29/21 at 4:45 pradministrator, ASM #2 ASM #3, the regional of ASM #4, the regional reinformed of these concords. The person-center of the facility comprehensive Personart: "A person-center of plan that includes meatimetables to meet the	stated there was no #4's pressure injury, and d some evidence of wound she knew Resident #4's to have a dressing. She emember whom she had ck of a dressing, but med the wound nurse. CNA know what time the ten last changed prior to her e care. When asked if she esident #4's comprehensive t pressure injuries, CNA #3 ency staff member, and she Resident #4's care plan.  .m., LPN #2 was ked the purpose of a lan, she stated the care lual interventions for caring asked if Resident #4's care ed when the resident's if without a dressing, she  .m., ASM #1, the , the director of nursing, director of operations, and hurse consultant, were exerns.  policy, "Care Planning - n-Centered," revealed, in ed comprehensive care surable objectives and resident's medical, eychosocial needs shall be sidentThe facility will	F	656			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY PLETED
		495255	B. WING				C /29/2021
NAME OF F	PROVIDER OR SUPPLIER		<del>'                                    </del>	s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12	12312021
SKYVIEW	SPRINGS REHAB AND I	NURSING CENTER			0 MONTVUE DRIVE URAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	]		Fe	656			
		plan for each resident, that					
		objectives and timeframes redical, nursing, and mental					
		ds as identified throughout					
	the comprehensive Re	esident Assessment	1				
	Instrument (RAI) proce	9SS."					
	No further information	was provided prior to exit.					
	REFERENCES						
		s localized damage to the off tissue usually over a					
	bony prominence or re	elated to a medical or other				,	
		present as intact skin or an					
		e painful. The injury occurs and/or prolonged pressure					
	or pressure in combina	ation with shear. The				ĺ	
		for pressure and shear					
		y microclimate, nutrition, es and condition of the soft					
	•	on is taken from the website		ŀ			
		n/npiap.com/resource/resm					
	gr/online_store/npiap_	pressure_injury_stages.pdf		ļ			
F 657	. Care Plan Timing and	Revision	F 6	57			
	CFR(s): 483.21(b)(2)(i)						
	§483.21(b) Compreher						
	§483.21(b)(2) A compr be-	ehensive care plan must					
		days after completion of					
	the comprehensive ass	sessment.				Ì	
	(ii) Prepared by an inte						
r	includes but is not limite (A) The attending physical						
		with responsibility for the					
	resident.						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION		SURVEY PLETED
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		495255	B, WING		<del></del>	12	/29/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SKYVIEW	SPRINGS REHAB AND	JUDSING CENTED		30	MONTVUE DRIVE		
SKITIETT	SPRINGS REHAD AND I	OKSING CENTER		Ł	URAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	(C) A nurse aide with resident. (D) A member of food (E) To the extent practithe resident and the resident and the resident and their resident reprinct practicable for the resident's care plan. (F) Other appropriate disciplines as determined as requested by the (iii)Reviewed and revisteam after each assessments. This REQUIREMENT by: Based on observation document review and complaint investigation the facility staff failed to comprehensive care pin the survey sample, If the facility staff failed Residents #12, #14, #15 comprehensive care pin the facility staff failed Residents #12, #14, #15 comprehensive care pin the survey sample, If the facility staff failed Residents #12, #14, #15 comprehensive care pin the survey sample, If the facility staff failed Residents #12, #14, #15 comprehensive care pin the survey sample, If the facility staff failed Residents #12, #14, #15 comprehensive care pin the survey sample, If the facility staff failed Residents #12, #14, #15 comprehensive care pin the survey sample, If the facility staff failed Residents #12, #14, #15 comprehensive care pin the survey sample, If the facility staff failed Residents #12, #14, #15 comprehensive care pin the survey sample, If the facility staff failed Residents #12, #14, #15 comprehensive care pin the survey sample, If the facility staff failed Residents #12, #14, #15 comprehensive care pin the survey sample, If the facility staff failed Residents #15 care pin the survey sample, If the facility staff failed Residents #15 care pin the survey sample, If the facility staff failed Residents #15 care pin the survey sample, If the facility staff failed Residents #15 care pin the survey sample pin the surv	and nutrition services staff. ticable, the participation of esident's representative(s). the included in a resident's the participation of the resident the resident resentative is determined development of the staff or professionals in the by the resident's needs the resident. The resident resident resident the staff or professionals in the by the resident's needs the resident, the resident resident's needs the resident resident resident resident the parterly review  is not met as evidenced the staff interview and facility during the course of a the resident resident	F	657	F657 Care Plan Timing and Revision  The facility staff failed to revise and revise Residents #12, #14 #19, and #2's comprehensive care plans to address the residents' positive RSV (1) state and care. These care plans we immediately updated.  All residents with RSV diagnormay have potentially been impacted. All residents with current RSV diagnoses care were reviewed and updated necessary.  The Director of Nursing/Deswill educate interdisciplinary team with access to care plate appropriate on policy titled Plans, Comprehensive Person Centered". The education we include but not be limited to revising care plans annually, quarterly, and with significate changes, including but not	plans lif signee y ans as "Care on- vill o	
	The findings include:				limited to: new orders, new		
	The facility staff failed to Residents #12, #14, #1 comprehensive care placed residents' positive RSV	9, and #2's ans to address the			diagnoses, new preferences		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG	(X3) DATE	SURVEY PLETED
		495255	B. WING			C
NAME OF F	ROVIDER OR SUPPLIER	433233	10. 111110	STREET ADDRESS, CITY, STATE, ZIP CODE	12/	<u>/29/2021</u>
	SPRINGS REHAB AND I	NURSING CENTER		30 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE SE	(X5) COMPLETION DATE
	infection, malnutrition, most recent MDS (mir assessment with an A date) of 12/9/21, the rehaving no cognitive im decisions, having score BIMS (brief interview of the revealed laboratory redocumenting that the resident #1/23/21 revealed no it or isolation precautions.  Resident #14 was adm 10/20/21 with diagnost cellulitis, and diabetes an admission assessmential resident was coded as impairment for making scored 15 out of 15 on for mental status).  A review of Resident #revealed laboratory resident was coded as impairment for making scored 15 out of 15 on for mental status).	nitted to the facility on es including a urinary tract and failure to thrive. On the himum data set), a quarterly RD (assessment reference esident was coded as pairment for making daily ed 15 out of 15 on the or mental status).  212's clinical record sults dated 12/18/21 resident was positive for at's care plan dated information related to RSV s.  anitted to the facility on es including angina, On the most recent MDS, eent dated 10/27/21, the having no cognitive daily decisions, having the BIMS (brief interview  14's clinical record sults dated 12/21/21 esident was positive for  14's comprehensive care d updated 11/4/21	F	4. The Director of Nursing/De will perform an audit of 5 resident care plans weekly weeks to ensure care plans updated appropriately afte significant changes. The QA Coordinator/Designee will the weekly audits for trend a summary will be provided the QAPI Committee for additional oversight/recommendation monthly x3.	for 4 are r any crack s and	1/21/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A, BUILDI		ECONSTRUCTION	(X3) DATE COMP	SURVEY
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		495255	B, WING_			_12/	29/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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					URAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	: 14	F	357			
	Resident #19 was adr	nitted to the facility on					
		ses including chronic lung					
		i. On the most recent MDS,					
	•	nt with an ARD of 11/8/21, ed as having no cognitive					
		daily decisions, having					
	scored 15 out of 15 or	the BIMS.	ļ				
	A review of Resident	W4 Ole alining and an and	i				
	revealed laboratory re						
		resident was positive for					
	RSV.						
		#19's comprehensive care d updated 11/1/21 revealed to RSV or isolation					,0 ;
	Resident #21 was adn 9/8/20 with diagnoses	nitted to the facility on including dementia and					
	schizoaffective disorde						
	MDS, a quarterly asse 12/15/21, the resident	essment with an ARD of					
		paired for making daily					
		red five out of 15 on the					
	BIMS.						
	A review of Resident # revealed laboratory re- documenting that the r						
	RSV.						
		#21's comprehensive care d updated 7/27/21 revealed to RSV or isolation					į
		.m., ASM (administrative administrator, ASM #2, the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		LE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  SPRINGS REHAB AND I	NURSING CENTER	1.		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835	14	32312021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE	
	of operations, and AS consultant, were inform ASM #2 stated that up responsibility of "every members of the IDT (if attend the daily morning any nurse or IDT members of ID	is M #3, the regional director M #4, the regional nurse med of these concerns. Indating care plans is the vone," including all the interdisciplinary team) who are meetings. She stated liber is able to update the lithat all four residents' care in updated to include and the droplet isolation.  Was provided prior to exit. Itial virus, or RSV, is a lifects the lungs and lealthy people typically like symptoms and recover ever, RSV can be serious, and the elderly." This lim the website ov/diseases-conditions/resersv.  Is are used to prevent the last are passed through and do not survive for long the are relatively large and through coughing. This information is taken lectioncontrol/pdf/strive/PP		657				
	Services Provided Mee CFR(s): 483.21(b)(3)(i)	t Professional Standards	F6	58				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	12/	29/2021
	SPRINGS REHAB AND I	NURSING CENTER		30 MO	NTVUE DRIVE LY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	§483.21(b)(3) Compression of the services provided as outlined by the commust- (i) Meet professional some of the services provided as outlined by the commust- (ii) Meet professional some of the services of a complete of the course of the co	chensive Care Plans I or arranged by the facility, Inprehensive care plan, Istandards of quality. Its not met as evidenced In, staff interview, facility Ical record review, and in Interview and	F	2 3.	document clinical assessment Resident #4's pressure injury on a date prior to 11/5/21 a 11/5/21. Resident #4's pressinjury (1) was assessed and appropriate documentation completed in skin and wound module.  All other residents may have potentially been affected.  Nursing staff will be educated proper clinical documentation medical record of pressure injuries.	nts of y (1) nd on sure any ad don in in	
		ange for Resident #4's Resident #4 was lying on ervation revealed her					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		E SURVEY PLETED
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		495255	B. WING			12	/29/2021
SKYVIEW (X4) ID		TEMENT OF DEFICIENCIES	lD ID	3( L	TREET ADDRESS, CITY, STATE, ZIP CODE  MONTYUE DRIVE  LURAY, VA 22835  PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	mattress was a pressor #3 completed the dres pressure injury using I cleanser) and Medihor agent). The wound me (centimeters) by 5 cen wound could not be de wound contained appr She covered the wound A review of Resident # revealed the following: - "11/5/21Cleanse ar buttock with wound cle alginate and cover with needed)." - "11/8/21Cleanse ar buttock with wound cle alginate and cover with (every day) on Monday - "11/16/21 Cleansec and apply medihoney vand prn."  A review of Resident # administration records) December 2021 reveal pressure injury treatme  Further review of Resident assessment prior to on	cre-relieving mattress. LPN asing of Resident #4's Dakins solution (a wound ney (a wound healing easured 2.2 cm attimeters. The depth of the etermined because the oximately 20% slough (2). In a with a foam dressing.  Et's physician's orders  Etas to coccyx and right eanser, apply calcium in foam dressing PRN (as eas to coccyx and right eanser and apply calcium in foam dressing q day (a). Wednesday-Friday."  Execcyx with wound cleanser with a foam dressing daily  Et's TARs (treatment of the present of the present early daily early earl	F	658	4. The Director of Nursing/design will review medical records or residents weekly for 4 weeks ensure that pressure injuries have appropriate documentatin appropriate time frame in medical record. When varian are identified in the weekly audits, the variance will be investigated, and the responsion the incident. The Director Nursing/Designee will track to weekly audits for trends and summary will be provided to QAPI Committee for addition oversight/recommendation monthly x3.	of 5 to ation ces sible seled of he a the	1/21/22
	revealed, in part: "The	resident has pressure					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		LE CONSTRUCTION		SURVEY PLETED
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NAME OF D	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	12	/29/2021
THE OF T	NOTIDEN ON GOLF CICK		i				
SKYVIEW	SPRINGS REHAB AND I	NURSING CENTER			30 MONTVUE DRIVE		
					LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page	18	F6	358	3		
	ulcer to the sacrum/	Administer treatments as					
		or effectivenessPressure	i				
		ped." The care plan failed to	İ				
		presence of a pressure					
	injury prior to 11/16/21		1				
	,,						
	On 12/29/21 at 4:02 p	.m., ASM (administrative	1				
	staff member) #4, regi	ional nurse consultant) and					
	ASM #2 (director of nu	ursing) were asked to					
	provide evidence that	Resident #4's pressure					
	injury had been asses	sed prior to 11/16/21. At					
		ated she could not locate					
	•	lesident #4's pressure injury					
		stated the facility follows its					
	policies as its professi	onal standard of practice.					1
	0 40100104 4445						
	On 12/29/21 at 4:45 p						
		the director of nursing,					
		director of operations, and nurse consultant, were	Ì				
	informed of these cond						
	imornied or triese com	cellis.					
	On 12/30/21, LPN (lice	ensed practical nurse) #4	ŀ				
		presented copies of two					
	licensed nurse weekly	skin assessments for					
	Resident #4. The first	assessment was not dated.					
	The second assessme	ent was dated 11/5/21, LPN					
	#4 stated she had con	npleted both of these	ŀ				
	assessments, and she	had neglected to date the					
		ever, she was certain the					
		completed prior to 11/5/21,	ĺ				
	probably around 10/31						!
		ent documented a "red and					ŀ
		esident #4's sacrum. The				i	
		5/21 documented a 2 by 2					
I .		4's sacrum, which was					
I .		ough and drainage." When					
I .		ined these assessments,					i
	LPN #4 stated she was	s Resident #4's admitting					

						DIVID IT	<del>5. 0000-0001</del>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION			SURVEY
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		495255	B. WING _			12	29/2021
	PROVIDER OR SUPPLIER  SPRINGS REHAB AND I	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	10ULD BE		(X5) COMPLETION DATE
F 658	visible on that date. S completed the undate assessment sheets, b locker at the facility. S paper copies of asses includes the originals stated, however, that to include these two a clinical record. LPN #/ nurse practitioner on order was generated of treatment of Resident stated she is aware shassessments in the resthat she should have vabout her findings and with the nurse practitional have any excuses for these things. LPN #/4 and compliant with the required to offload present the second of the facility prevention and Manag "Treatments will be conducted by a findings will be document medical record.  3. Observations of mobe:  a. Reported to the plant further evaluation and to be referred to the deappropriate."	he stated she had d and 11/5/21 skin ut had put them in her the stated she always keeps sments, and usually in the clinical record. She she realized she had failed ssessments as part of the if stated she contacted the 11/5/21, and that is how the on 11/5/21 for the original #4's pressure injury. She he should have included the sident's clinical record, and written a progress note about her conversation oner. She stated she did not why she did neither of added that Resident #4 is turning and repositioning ssure from her sacrum.  policy, "Pressure Injury hement," revealed, in part: hered by the . Weekly skin observations licensed nurse and hented in the resident's  hew pressure ulcer/injury will hysician / practitioner for	F6	58			

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  30 MONTVUE DRIVE  LURAY, VA 22835  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X: PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL.)	AND PLAN OF	N OF CORRECTION	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL/A DE CORRECTION DENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  SKYVIEW SPRINGS REHAB AND NURSING CENTER  SKYVIEW SPRINGS REHAB AND NURSING CENTER  LURAY, VA 22835  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL						С	
SKYVIEW SPRINGS REHAB AND NURSING CENTER  30 MONTVUE DRIVE LURAY, VA 22835  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X: PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BY FULL PREFIX (EACH CORRECTI				B. WING	<del></del>	12/29/2021	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP			· · · · · · · · · · · · · · · · · ·		30 MONTVUE DRIVE		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  DAY  DEFICIENCY	PREFIX	IX (EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TION
REFERENCES  (1) "A pressure injury is localized damage to the skin and underlying soft lissue 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/resm gr/online_store/npiap_pressure_injury_stages.pdf  .  (2) "The wound bed may be covered with necrotic tissue (non-visible tissue due to reduced blood supphy), slough (dead tissue, usually cream or yellow in color), or eschar (dry, black, hard nacrotic tissue). Such tissue impedes healing." This information is taken from the website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC13 60405/.  Fetament/Svcs to Prevent/Heat Pressure Ulcer CFR(s). 483.25(b)(1)(i)(ii)  \$483.25(b)(5)(ii) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686 SS=D	REFERENCES  (1) "A pressure injury skin and underlying s bony prominence or r device. The injury car open ulcer and may be as a result of intense or pressure in combin tolerance of soft tissur may also be affected perfusion, co-morbidit tissue." This informati https://cdn.ymaws.coi.gr/online_store/npiap.  (2) "The wound bed matissue (non-viable tissue (non-viable tissue), slough (dead yellow in color), or est necrotic tissue). Such This information is tak https://www.ncbi.nlm.i.60405/.  Treatment/Svcs to Proceed CFR(s): 483.25(b)(1) Pressure Based on the comprehensional standard pressure ulcers and demonstrates that the (ii) A resident with president with pr	REFERENCES  (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/resm gr/online_store/npiap_pressure_injury_stages.pdf  (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/PMC13 60405/. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)  §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (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 (ii) A resident with pressure ulcers receives				

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILD	ING_		СОМ	COMPLETED	
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		495255	B. WING	_	<del></del>	12	/29/2021	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
SKYVIEW	SPRINGS REHAB AND I	NURSING CENTER		1	80 MONTVUE DRIVE			
			1		LURAY, VA 22835	<u>-</u>	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
	with professional stan promote healing, prev new ulcers from devel This REQUIREMENT by:  Based on observation document review, clinithe course of a comple determined that the facare and services to trone of 22 residents in Resident #4. On 12/25 #4 was observed to be pressure injury.  The findings include:  Resident #4 was admi 10/11/21 with diagnose chronic pain. On the mata set), an admission (assessment reference Resident #4 was code impaired for making descored 12 out of 15 on for mental status). She pressure injuries, and developing a pressure coded as always being bladder and bowel.  On 12/29/21 at 9:59 a. of LPN (licensed practiprovided a dressing chearal pressure injury, her right side, and obsemattress was a pressure material pressure injury.	dards of practice, to ent infection and prevent loping. is not met as evidenced in, staff interview, facility ical record review, and in aint investigation, it was cility staff failed to provide reat a pressure injury (1) for the survey sample, 8/21 at 9:59 a.m., Resident re without a dressing on her  tted to the facility on res including arthritis and rost recent MDS (minimum in assessment with an ARD red date) of 10/20/21, d as being moderately re was coded as having the BIMS (brief interview re was coded as having no as being at risk for injury. Resident #4 was incontinent of both  m., observation was made cal nurse) #3 as she ange for Resident #4's Resident #4 was lying on revation revealed her re-relieving mattress. In	F	686		be s essed no d on ntact l be nt		
		ng the dressing, LPN #3 incontinence brief. When						

F 686  Continued From page 22 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 injuly because the resident 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 Medinoney (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 could not be determined because the wound could not be determined because the wound could not be determined because the wound could not be determined because the wound could not be determined because the wound with a foam dressing.  A review of Resident #4's TARs (treatment administration records) revealed the wound care had been provided as ordered.  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 ulder to the sacrumAdminister treatments as		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A, BUILDI		E CONSTRUCTION		SURVEY PLETED
SETEMATE ADDRESS. CITY, STATE ZIP CODE 3 MONTHUS DRIVE LURAY, VA 22835  (CA) D PREFEX TAG SESSANDERS PLAN OF CORRECTION (CA) DRIVEN TAG SECOLATORY OR LSC DENTIFYING INFORMATION)  F 688 CONLINUED From page 22 she removed the brief, there was no dressing covering Resident #4's pressure injury. LPN #3 stated the residents brief contained urine at that moment. She stated 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 feece come into contact with the wound. LPN #3 completed the dressing of Resident #4's pressure injury subject to the savery of Resident #4's pressure injury using Dakins solution (a wound coleanser) and Meditoney (a wound healing agent). The wound measured 2.2 cm (centimeters) by 5 confinenters. The depth of the wound contained approximately 20% slough (2). She covered the wound with a foam dressing.  A review of Resident #4's physician's orders revealed the following: "111/E/21 (Cleansecoccyx with wound cleanser and apply medihoney with a foam dressing daily and pm (as needed.)"  A review of Resident #4's Completed the wound care had been provided as ordered.  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 ulor to the sacrumAdminister treatments as	:		495255				1	-
FREETY TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 686  Continued From page 22 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 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 Meditioney (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 could not be determined because the wound could not be determined because the wound could not be determined because the wound could not be determined because the wound could not be determined because the wound with a foam dressing.  A review of Resident #4's physician's orders revealed the following: "11/16/21 Cleansecoccyx with wound cleanser and apply meditioney with a foam dressing daily and prn (as needed.)."  A review of Resident #4's TARs (treatment administration records) revealed the wound care had been provided as ordered.  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 updoed to the to the searumAdministration records) revealed treatments are in place per comprehensive care plan and order. When variances are identified in the weekly audits, the variances are identified in the weekly audits, the variances are incontacted. The weekly audits for treats and a summary will be provided to the QAPI Committee for additional oversight/recommendation monthly x3.	SKYVIEW	SPRINGS REHAB AND I			30	0 MONTVUE DRIVE LURAY, VA 22835	, , , ,	
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 Medinoney (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 could not be determined because the wound could not with a foam dressing.  A review of Resident #4's physician's orders revealed the following: "11/16/21 Cleanseoccyx with wound cleanser and apply medihoney with a foam dressing daily and prn (as needed.)"  A review of Resident #4's TARs (treatment administration records) revealed the wound care had been provided as ordered.  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 ulder to the sacrumAdminister treatments as	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFI	×	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
ordered and monitor for effectivenessPressure reducing mattress to bed."		she removed the brief covering Resident #4' stated she was surprispressure injury. She sheen a dressing cover times, especially becar incontinent of bowel at the resident's brief commoment. She stated if removed the dressing injury should have becard never left open to urine or feces come in LPN #3 completed the pressure injury using the cleanser) and Medihor agent). The wound me (centimeters) by 5 cen wound could not be dewound contained appropriate She covered the wound A review of Resident # revealed the following: Cleansecoccyx with medihoney with a foam needed.)"  A review of Resident # administration records had been provided as  A review of Resident # plan dated 10/22/21 ar revealed, in part: "The ulcer to the sacrumA ordered and monitor for	there was no dressing spressure injury. LPN #3 sed to see the uncovered tated there should have ring the pressure injury at all use the resident was and bladder. LPN #3 stated intained urine at that isomeone had accidentally at some point, the pressure an re-dressed and covered, the possibility of having to contact with the wound. It dressing of Resident #4's Dakins solution (a wound ney (a wound healing easured 2.2 cm attimeters. The depth of the etermined because the eximately 20% slough (2). It will with a foam dressing.  Et's physician's orders in 11/16/21 wound cleanser and apply in dressing daily and print (as in the pressure dupdated 11/18/21, resident has pressure diminister treatments as an effectivenessPressure	F	586	4. The Director of Nursing/des will review medical records residents weekly for 4 week ensure that ordered treatmeare in place per comprehens care plan and order. When variances are identified in the weekly audits, the variance be investigated, and the responsible nurse will be educated/counseled on the incident. The Director of Nursing/Designee will track weekly audits for trends and summary will be provided to QAPI Committee for addition oversight/recommendation	of 5 s to ents sive le will the la o the	1/21/22

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		E SURVEY IPLETED
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		495255	B. WING			12	/29/2021
	ROVIDER OR SUPPLIER  SPRINGS REHAB AND I	NURSING CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE SO MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	A review of the most reasessment for Residerevealed the wound must be centimeters, and considered assistant) #3 was interprovided incontinence Resident #4. She stated a.m., she changed Rebrief. She stated the beamount of urine. She stated that the brief contained drainage. She stated swound was supposed stated she could not reinformed about the lace believed she had inform stated she did not know brief had been last chain continence care.  On 12/29/21 at 12:30 pustaff member) #6, the vinterviewed. He stated should have been proteurine and feces at all times at risk of worsening urine or feces. He stated was not 100% sure about apply, the wound should make the stated apply, the wound should make the stated apply, the wound should make the stated apply, the wound should make the stated apply, the wound should make the stated apply, the wound should make the stated apply, the wound should make the stated apply, the wound should make the stated apply, the wound should make the stated apply, the wound should make the stated apply, the wound should make the stated apply the stated apply, the wound should make the stated apply the wound should make the stated apply the wound should make the stated apply the wound should make the stated apply the wound should make the stated apply the wound should make the stated apply the wound should make the stated apply the wound should make the stated apply the wound should make the stated apply the stated apply the wound should make the stated apply the stated ap	ecent pressure injury ent #4, dated 12/22/21, reasured approximately 2 by ntained approximately 20%  a.m., CNA (certified nursing rviewed. She stated she care that morning to ed at approximately 8:45 sident #4 incontinence rief contained a "medium" stated there was no #4's pressure injury, and d some evidence of wound whe knew Resident #4's to have a dressing. CNA #3 emember whom she had k of a dressing, but med the wound nurse. She w what time the resident's ringed prior to her providing  a.m., ASM (administrative wound physician, was Resident #4's wound ected from contact with mes. He stated the wound g with contact with either ed even if the facility staff but which dressing to d at least have been f gauze, or with some sort sing until the proper ned.  m., ASM #1, the	F	686			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF F	ROVIDER OR SUPPLIER	499233	0, 11110	_		12/	29/2021	
	SKYVIEW SPRINGS REHAB AND NURSING CENTER			3	STREET ADDRESS, CITY, STATE, ZIP CODE TO 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 PREFI TAG			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
F 686	ASM #3, the regional ASM #4, the regional informed of these con A review of the facility Prevention and Mana, "Treatments will be or physician/practitioner. ulcer/injury treatment resident."  No further information REFERENCES  (1) "A pressure injury is skin and underlying so bony prominence or redevice. The injury can open ulcer and may be as a result of intense as or pressure in combinatolerance of soft tissue may also be affected be perfusion, co-morbidititissue." This information https://cdn.ymaws.comgr/online_store/npiap  (2) 'The wound bed matissue (non-viable tissue)	director of operations, and nurse consultant, were cerns.  policy, "Pressure Injury gement," revealed, in part: dered by theorders for pressure will be specific for each was provided prior to exit.  is localized damage to the off tissue usually over a elated to a medical or other present as intact skin or an e painful. The injury occurs and/or prolonged pressure	F	686				
	This information is take	tissue impedes healing."						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		495255	B. WING			12	12/29/2021	
	PROVIDER OR SUPPLIER  SPRINGS REHAB AND I	NURSING CENTER	l	3	TREET ADDRESS, CITY, STATE, ZIP CODE 0 MONTVUE DRIVE URAY, VA 22835			
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	Resident Records - Id CFR(s): 483.20(f)(5), §483.20(f)(5) Resident (i) A facility may not resident-identifiable to (ii) The facility may refresident-identifiable to accordance with a coragrees not to use or dexcept to the extent the to do so.  §483.70(i) Medical record systems and a standards must maintain medical that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically orgalized all information container regardless of the form records, except when in (i) To the individual, or representative where possible (iv) Required by Law; (iii) For treatment, payroperations, as permitted with 45 CFR 164.506; (iv) For public health as neglect, or domestic views.	entifiable Information 483.70(i)(1)-(5)  t-identifiable information, elease information that is the public, ease information that is an agent only in itract under which the agent isclose the information e facility itself is permitted  ords, dance with accepted and practices, the facility records on each resident  nted; and anized  ty must keep confidential ed in the resident's records, or storage method of the release is- their resident ermitted by applicable law; ment, or health care d by and in compliance  ctivities, reporting of abuse, plence, health oversight dministrative proceedings, ses, organ donation	1	842	F842 Resident Records - Identifiable Information  1. The facility staff failed to document feeding Resident 29 meals from 10/24/21 to 11/8/21, failed to ensure tw skin assessments were incluin Resident #4's clinical record. Resident #2 was assessed for weight loss, no adverse outdonted. Resident #4 had a skin assessment completed with new areas noted.  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.  3. The Director of Nursing/Designating educate nursing staff on policy titled, "Charting and Documentation". This educate will include but not be limited importance of accurate and timely documentation in the medical record.	orded ord. or come in no		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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SKYVIEW (X4) ID		NURSING CENTER  ATEMENT OF DEFICIENCIES	ID	30 A	REET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE RAY, VA 22835 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
F 842	medical examiners, fural serious threat to her by and in compliance §483.70(i)(3) The faci record information agrunauthorized use. §483.70(i)(4) Medical for- (i) The period of time in (ii) Five years from the there is no requirement (iii) For a minor, 3 year legal age under State §483.70(i)(5) The medicii) For a minor, 3 year legal age under State §483.70(i)(5) The medicii) A record of the resi (iii) The comprehensive provided; (iv) The results of any and resident review evaluated the training to the training to the training to the training to the training to the training to the training to the facility complete and accurate 22 residents in the surand Resident #4.  The facility staff failed	aneral directors, and to avert alth or safety as permitted with 45 CFR 164.512.  Itity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when in State law; or ars after a resident reaches law.  Idical record must containate to identify the resident; ident's assessments; we plan of care and services repreadmission screening valuations and cted by the State; so, and other licensed son the state; and other diagnostic quired under §483.50.  Is not met as evidenced  ew, clinical record review, it was estaff failed to maintain a e medical record for two of ovey sample, Resident #2	F	842	will review medical records or residents weekly for 4 weeks ensure that meals are documented timely. The Dire of Nursing/Designee will review residents weekly for 4 weeks ensure that skin assessments documented weekly. When variances are identified in the weekly audits, the variance who investigated, and the responsible nurse will be educated/counseled on the incident. The Director of Nursing/Designee will track to weekly audits for trends and summary will be provided to QAPI Committee for addition oversight/recommendation monthly x3.	ector eew 6 to s are e will	1/21/22

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495255	8. WING			l	C 12/29/2021	
NAME OF PROVIDER OR SUPPLIER  SKYVIEW SPRINGS REHAB AND NURSING CENTER		'	STREET ADDRESS, CITY, STATE, ZIP CODE  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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 842	Continued From page failed to ensure two slincluded in Resident #	kin assessments were	F	842				
	1. Resident #2 was ace 6/6/19 with diagnosis is limited to: diabetes mellitus (inabnormally in the body) ((progressive loss of moften accompanied by emotional instability) (stress disorder] (mood traumatic event) (3) and disorder with detachmin impaired perceptions, (4).  The most recent MDS assessment, a quarter	ental ability and function personality changes and 2), PTSD [post-traumatic disorder occurring after and psychoses (mental ent from reality and thinking and responses)  (minimum data set) by assessment, with an						
	ARD (assessment refecoded Resident #2 as the BIMS (brief intervier indicating the resident impaired. A review of the G-functional status condependant of assistant transfer, dressing, hygical assistance for eating a locomotion. A review of and Bladder coded the incontinent for bowel at A review of the ADL (as 10/24/21-11/8/21 for Remeals that had no document for documents of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview of the ADL (as 10/24/21-11/8/21 for Remeals that had no documents interview	rence date) of 8/8/21, scoring a 03 out of 15 on the for mental status) score, was severely cognitively the MDS Section led the resident as totally the for bed mobility, tene and bathing; extensive and supervision for f MDS Section H- Bowel resident as always						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		495255	B. WING		· · · · · · · · · · · · · · · · · · ·	12/29/2021	
NAME OF P	ROVIDER OR SUPPLIER			\$	TREET ADDRESS, CITY, STATE, ZIP CODE		
SKYVIEW	SPRINGS REHAB AND I	NURSING CENTER		3	0 MONTVUE DRIVE		
				L	URAY, VA 22835		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION OATE
F 842	10/24- supper, 10/25- 10/26-supper, 10/27- 10/29-supper, 10/30-libreakfast lunch/ supper, 11/2-su lunch/supper, 11/4-su 11/6-lunch/supper, 11/and 11/8-lunch/supper documentation evident complete feed, one per documentation evident complete feed, one per documentation evident at the potential for further function of the compression of	breakfast lunch/supper, breakfast lunch/supper, unch/supper, 10/31- er, 11/1- breakfast pper, 11/3- breakfast pper, 11/5-lunch/supper, /7- breakfast lunch/supper r. The remaining meal uced the resident was a erson assist.  ehensive care plan dated in part, "FOCUS-Resident urther ADL self-care	F	842	DEFICIENCY)		
	staff member) #1, the	M, ASM (administrative administrator and ASM #2, were made aware of the v's "Charting and					
ŀ		ed 5/21, which documents					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		495255	B. WING	_		12	/29/2021	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
SKANIEM	SPRINGS REHAB AND I	MIRRING CENTER			30 MONTVUE DRIVE			
SKIAIEAA	SPRINGS REHAB AND I	TORSING CENTER			LURAY, VA 22835			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE	
_			!					
F 842	in part, "All services provided to the resident, progress toward the care plan goals or any		F	842				
	changes in the resider	ocial condition, will be						
		sident's medical record.						
		tion is to be documented in						
i	the resident medical reservices performed.							
	procedures and treatn						j .	
	care-specific details."	TOTAL WILL INGUIGE						
	No further information	was provided prior to exit.						
	References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 160.							
	Non-Medical Reader, Chapman, page 25.	of Medical Terms for the 5th edition, Rothenberg and						
	Non-Medical Reader,	of Medical Terms for the 5th edition, Rothenberg and						
	Chapman, page 467. (4) Barron's Dictionary	of Medical Terms for the						
	•	5th edition, Rothenberg and						
					*1			
	chronic pain. On the m data set), an admission	es including arthritis and ost recent MDS (minimum n assessment with an ARD			1 2			
	(assessment reference							
	Resident #4 was code							
	impaired for making da						65	
		the BIMS (brief interview was coded as having no				Į		
I	pressure injuries, and a							
		injury. She was coded as						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/06/2022 FORM APPROVED

**CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING \_ C 495255 B. WING 12/29/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **30 MONTVUE DRIVE** SKYVIEW SPRINGS REHAB AND NURSING CENTER **LURAY, VA 22835** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 842 Continued From page 30 F 842 always being incontinent of both bladder and bowel. 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. A review of Resident #4's physician's orders revealed the following: "11/5/21...Cleanse areas to coccyx and right buttock with wound cleanser, apply calcium alginate and cover with foam dressing PRN (as needed)." "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." "11/16/21 Cleanse...coccyx with wound cleanser and apply medihoney with a foam dressing daily and prn." A review of Resident #4's TARs (treatment

administration records for November and December 2021 revealed she had received pressure injury treatments as ordered.

MANG OF PROVIDER OR SUPPLIER  SKYVIEW SPRINGS REHAB AND NURSING CENTER  WILLIAMY, VA 2835  PRESIX INCORPECTION STEEDERS OF PAUL REGULATORY OR ISC DENTIFYING INFORMATION)  F 842 Continued From page 31  F 842 Continued From page 31  F 844 Continued From page 31  A review of Resident #4's comprehensive care plan dated 10/22/21 and updated 11/18/21.  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 ulce to the sacrumAdminister treatments as ordered and monitor for effectivenessPressure reducing mattress to bad." The care plan failed to reveal evidence of the presence of a pressure injury prior to 11/16/21.  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 prior to 11/16/21.  On 12/29/21 at 4:05 p.m., ASM #1, the administration, 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.  On 12/20/21, 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.			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  SKYVIEW SPRINGS REHAB AND NURSING CENTER    CAN ID PREFIX   SUMMARY STATEMENT OF DEFICIENCIES			495255	B. WING				_	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 842  Continued From page 31  Further review of Resident #4's clinical record failed to reveal evidence of a pressure injury assessment prior on or before 11/5/21.  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 sacrumAdminister treatments as ordered and monitor for effectivenessPressure reducing mattress to bed." The care plan failed to reveal evidence of the presence of a pressure injury prior to 11/16/21.  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.  On 12/29/21 at 4:45 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, were informed of these concerns.  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				3	80 MONTVUE DRIVE	12/29/2021			
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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		Further review of Resifailed to reveal evident assessment prior on or A review of Resident applan dated 10/22/21 at revealed, in part: "The ulcer to the sacrumA ordered and monitor for reducing mattress to be reveal evidence of the injury prior to 11/16/21.  On 12/29/21 at 4:02 p. staff member) #4, regidence that a injury had been assessed 4:40 p.m., ASM #4 states any assessments of Reprior to 11/16/21.  On 12/29/21 at 4:45 p.1 administrator, ASM #2, ASM #3, the regional of ASM #4, the regional of ASM #4, the regional minformed of these concounty of the second 11/5/21. She stated she these assessments, and the first assessments for Reprior to 11/5/21, probably are to 11/5/21, probably are to 11/5/21, probably are to the second 11/5/21, probably are the first assessments and the first	dent #4's clinical record ce of a pressure injury r before 11/5/21.  4's comprehensive care nd updated 11/18/21, resident has pressure dminister treatments as or effectivenessPressure ed." The care plan failed to presence of a pressure .  m., ASM (administrative onal nurse consultant) and rsing) were asked to Resident #4's pressure ed prior to 11/16/21. At ted she could not locate esident #4's pressure injury  m., ASM #1, the the director of nursing, irector of operations, and urse consultant, were erns.  vas interviewed. She or licensed nurse weekly lesident #4. The first was assessment was dated or had completed both of d she had neglected to nt. However, she was nent was completed prior ound 10/31/21 or 11/1/21.	F	842				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		495255	B. WING			Į.	/29/2021
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>			STREET ADDRESS, CITY, STATE, ZIP CODE		
CLOOUTING	CODINICO DELLAD AND I	WINDOWS SENTED			30 MONTVUE DRIVE		
SVIAIEAA	SPRINGS REHAB AND I	NURSING CENTER			LURAY, VA 22835		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
F 842	Continued From page and blanchable" area The assessment date by 2 cm area on Resignation was described as "100 When asked where shassessments, LPN #4 #4's admitting nurse of skin issues visible on had completed the unassessment sheets, booker at the facility. Spaper copies of assessincludes the originals stated, however, that to include these two a clinical record. LPN #4 nurse practitioner on order was generated of treatment of Resident stated she is aware shassessments in the rethat she should have vabout her findings and with the nurse practitic have any excuses for these things.	on Resident #4's sacrum. d 11/5/21 documented a 2 dent #4's sacrum, which 0% slough and drainage." ne obtained these stated she was Resident on 10/11/21. There were no that date. She stated she dated and 11/5/21 skin out had put them in her she stated she always keeps isments, and usually in the clinical record. She she realized she had failed assessments as part of the 4 stated she contacted the 11/5/21, and that is how the on 11/5/21 for the original #4's pressure injury. She ne should have included the sident's clinical record, and written a progress note If about her conversation oner. She stated she did not		842	DEFICIENCY)		
	REFERENCES						
		s localized damage to the off tissue usually over a					
		elated to a medical or other					
		present as intact skin or an					
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		and/or prolonged pressure					
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		by microclimate, nutrition,					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	)0		STREET ADDRESS, CITY, STATE, 2IP CODE 30 MONTVUE DRIVE LURAY, VA 22835		12/29/2021	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE	
F 842	perfusion, co-morbidit tissue." This information https://cdn.ymaws.cor gr/online_store/npiap_	ies and condition of the soft on is taken from the website n/npiap.com/resource/resm pressure_injury_stages.pdf	F	342			
E 992	tissue (non-viable tissi supply), slough (dead yellow in color), or eso necrotic tissue). Such This information is tak	ue due to reduced blood tissue, usually cream or thar (dry, black, hard tissue impedes healing." en from the website hih.gov/pmc/articles/PMC13	-				
	CFR(s): 483.80(b)(1)-( §483.80(b) Infection por The facility must design individual(s) as the infe	4)(c) reventionist	F8	52		5	
	in nursing, medical tec epidemiology, or other	related field; fied by education, training,	32				
	§483.80(b)(3) Work at facility; and	least part-time at the					
	§483.80(b)(4) Have contraining in infection pre-						
	§483.80 (c) IP participa and assurance commit	ation on quality assessment lee.					

	STATEMENT OF DEFICIENCIES (X1) P AND PLAN OF CORRECTION ID	
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495255 B. WING 12/29/2		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  30 MONTVUE DRIVE  LURAY, VA 22835		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	
F 882  Continued From page 34  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:  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.  The findings include:  The findings include:  On 12/29/21 at 2:45 PM, RN (registered nurse) #1, the infection preventionist toole.  The findings include:  On 12/29/21 at 2:45 PM, RN (registered nurse) #1, the infection prevention.  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.  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, "I started here three weeks ago and have not completed the education pertaining to infection prevention. I have other education pertaining to infection prevention in infection prevention in infection prevention in the facility.  4. The Administrator/Designee will perform a monthly assessment of employee professional certifications in the cDC cartification in first the calciture of the provention from the CDC.  5. The Administrator/Designee will perform a monthly assessment of employee professional certifications or ensure that licenses are current and valid for all employees that are required to be professionally certified. The Administrator/Des	The individual designation on the individuals must be a member of assessment and assure to the committee on the This REQUIREMENT by:  Based on staff intervitand facility document the facility staff failed in person met the qualification is role.  The findings include:  On 12/29/21 at 2:45 P #1, the infection prevention.  RN #1 stated, "I started prevention.  RN #1 stated, "I started in the CE prevention in the CE prevention in the CE proceeded to show ce from on line course. Note that interview was conducted in the CE proceeded to show the common time course. Note that interview was conducted in the CE proceeded to show the common time course. Note that interview was conducted in the course in the CE proceeded to show the common time course. Note that interview was conducted in the course	

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		495255	B. WING				C /29/2021
SKYVIEW (X4) ID			STREET ADDRESS, CITY, STATE, ZIP CODE  30 MONTVUE DRIVE  LURAY, VA 22835  ID PROVIDER'S PLAN OF CORRECTIO				(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO			COMPLETION DATE
	administrator, ASM #2 ASM #3, the regional ASM #4, the regional informed of the conce Infection Preventionist  The facility's "Infection 5/21/21, which docum control program initiati coordinated with the lo departments."  The facility's "Infection description" document candidate: certification epidemiology (i.e.: CIC preferred) or attainment According to the SOM requirements to meet to	2, the director of nursing, director of operations and nurse consultant, were m and asked for the t job description.  a Control Program" dated ented in part, "The infection ives and responses will be ocal and/or state health  Preventionist job ed in part, "Qualified in In infection control and c [certified infection control] int prior to employment."  (State Operations Manual) 882, section §483.80(b)(4) alized training in infection	F	882	from working in the position to requires a certification until the time that the employee obtain valid certification. The Administrator/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee monthly x3.	ne ns a	1/21/22