DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	02/08/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/06/2022 through 02/08/2022. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.	E 007	E 007 1. Categories of the patient population that would be at risk during an emergency have been identified. The Response Concept of Operations section in E-007 of the Emergency Preparedness Manual has been updated to more clearly identify the services that the facility will be able to provide during an emergency. The Structural Leadership section in E-007 of the Emergency Preparedness Manual has been updated to more clearly identify how the facility plans to continue operations during an emergency. 2. A new report of "At Risk and Vulnerable Patients" has been developed to include patients in the following categories: Residents Requiring Insulin, Residents with Memory Impairment, Residents Requiring Significant Assistance to Transport, Residents Requiring Dialysis, Residents with Significant Medication Needs, Residents Requiring Portable Oxygen, Residents	

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

Administrator 2/25/22

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

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E 007	Continued From page 1 *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to evidence documentation of patient populations that would be at risk during an emergency event, services that the facility would be able to provide during an emergency, and how the facility plans to continue operations during an emergency. The findings include: On 02/08/2022 at approximately 10:40 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, maintenance director. Review of the facility's emergency preparedness plan failed to evidence documentation of patient populations that would be at risk during an emergency event, services that the facility would be able to provide during an emergency, and how the facility plans to continue operations during an emergency. OSM # 1 stated, "We don't have it." On 02/08/2022 at approximately 1:50 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 4, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit.	E 007	with Significant Medical Treatments, and Residents with Special Diets. The new report listing the identified residents has been developed and placed in the Emergency Preparedness Manual under the E007 Section. All staff will be in-serviced by the Administrator, designee on the identified updates to the manual. All residents both in writing and the Resident Council Meetings will be educated in the process. 3. The Director of Nurses, or designee, will run an updated report identifying the "At Risk and Vulnerable Patients" on a weekly basis and place it in the Emergency Preparedness Manual under the E007 Section. 4. The Administrator will monitor the Emergency Preparedness Manual at least monthly to ensure the "At Risk and Vulnerable Patients" report continues to be updated appropriately. These findings will be reported and discussed during the Quality Assurance and Performance Improvement meeting quarterly. 5. Corrective action will be completed by 3/18/2022.	

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E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.	E 018	E-018 1. The current emergency preparedness section E-018 will be updated to include the new policy and procedure, "Emergency Preparedness Resident and Staff Tracking". The policy includes how tracking will be coordinated. In addition, new Resident and Staff Tracking forms will be developed. 2. The new policy and procedure, "Emergency Preparedness Resident and Staff Tracking" and the newly developed Resident and Staff tracking forms will be placed in the Emergency Preparedness Manual under section E-018. All residents can be affected by this and therefore communications in writing and vis the Resident Council will be educated. 3. The facility Director of Nurses, Assistant Director of Nurses, Nursing Unit Managers, Nursing Supervisors, and the facility Maintenance Director will be educated on the new policy and tracking forms to ensure they are familiar with the new process.	

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E 018	Continued From page 3 *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by:	E 018	4. A Tabletop exercise will be held within the next quarter to review and improve the facility's emergency evacuation policies and procedures, including this new policy and forms, to ensure efforts are made for continued improvement in the plan and to ensure the plan is able to be well implemented, should it be needed. 5. Corrective Action will be completed by 3/18/2022.	

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E 018	Continued From page 4 Based on staff interview and facility document review, it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to develop a tracking system to document locations of patients and staff. The findings include: On 02/08/2022 at approximately 10:40 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, maintenance director. Review of the facility's emergency preparedness plan failed to evidence a tracking system to document the locations of patients and staff. OSM # 1 stated, "We don't have it." On 02/08/2022 at approximately 1:50 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 4, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit.	E 018		
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan	E 034	E-034 1. The current emergency preparedness communication plan will be updated to include the new policy and procedure, "Sharing Information on Occupancy / Needs." The policy includes the procedures for reporting the facility needs, reporting of a facility's ability to provide assistance, and facility occupancy reporting.	

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E 034	Continued From page 5 that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to provide evidence of documentation that the communication plan includes a means of providing information about the facility's needs, and about its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee by reviewing the communication plan and documentation that the communication plan	E 034	2. The new policy and procedure, "Sharing Information on Occupancy / Needs" has been added to the Emergency Preparedness Manual to ensure the changes are in place and actionable for the safety of all residents. All residents can be affected by this and therefore communications in writing and vis the Resident Council will be educated. 3. The facility Director or Nurses, Assistant Director of Nurses, Nursing Unit Managers, Nursing Supervisors, and the facility Maintenance Director will be educated on the new policy and procedure to ensure they are familiar with the new process. 4. A Tabletop exercise will be held within the next quarter to review and improve the facility's emergency evacuation policies and procedures, including this new policy, to ensure efforts are made for continued improvement in the plan and to ensure the plan is able to be well implemented, should it be needed. 5. Corrective Action will be completed by 3/18/2022.	

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E 034	Continued From page 6 includes a means of providing information about their occupancy. The findings include: On 02/08/2022 at approximately 10:40 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, maintenance director. Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan included a means of providing information about the facility's needs, and about its ability to provide assistance, to the authority having jurisdiction, the incident Command Center, or designee by reviewing the communication plan and documentation that the communication plan included a means of providing information about their occupancy. OSM # 1 stated, "We don't have it." On 02/08/2022 at approximately 1:50 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 4, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit.	E 034		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). "[For RNCHIs at §403.748, ASCs at §416.54,	E 036	E-036 1. An Emergency Preparedness Training and Testing program has been developed to include the "Emergency Preparedness Training and Testing Policy."	

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E 036	Continued From page 7 Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at	E 036	2. The new program and policy have been added to the Emergency Preparedness Manual to ensure the changes are reflected in the plan for the benefit of all residents. The Administrator will in-service all department heads on the new program and policy by 3/11/2022. All residents can be affected by this and therefore communications in writing and via the Resident Council will be educated. 3. The Administrator will be required to coordinate the first of the two annual training and testing exercises within two weeks. The first training and testing exercise will involve the facilities' new fire safety plan (keeping in compliance with the 1135 waiver). The Regional Director of Risk Management will verify that the training and testing exercise has been completed. 4. The Administrator will report to the Quality Assurance and Performance Improvement committee quarterly to discuss the Emergency Preparedness Hazard and Vulnerability Assessment, policies and procedures related to any upcoming training and testing exercises and report on the compliance of the program as related in the policy. 5. Corrective action will be completed by 3/18/2022.	

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E 036	Continued From page 8 least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). "[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to provide evidence of documentation that the facility has a written training and testing program that meets the requirements of the regulation, and documentation that the training and testing program has been reviewed and updated on at least an annual basis. The findings include: On 02/08/2022 at approximately 10:40 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, maintenance director. Review of the facility's emergency preparedness plan failed to evidence that the facility has a	E 036		

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E 036	Continued From page 9 written training and testing program that meets the requirements of the regulation, and documentation that the training and testing program has been reviewed and updated on at least an annual basis. OSM # 1 stated, "We don't have the documentation." On 02/08/2022 at approximately 1:50 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 4, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit.	E 036		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). "[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training.	E 037	E-037 1. All current staff employment records will be audited by the Human Resources Manager to determine who does not have documentation of receiving either the initial and/or annual emergency preparedness training. This is a New Employee Orientation Agenda section. 2. All identified staff members who do not have documentation of having received either the initial or annual emergency preparedness training will receive the required training. Training will be performed by the Maintenance Director or designee. All residents can be affected by this and therefore communications in writing and via the Resident Council will be educated.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	495255	A. BUILDING _____ B. WING _____	02/08/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 10 (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037	3. The Human Resources Manager will audit all newly hired staff files monthly to ensure they have received the Emergency Preparedness training. In addition, the HR manager will develop and maintain a tracking form for all staff's annual Emergency Preparedness training. The Human Resources Manager will report audit findings to the facility Administrator monthly. 4. The Administrator will report audit findings to the Quality Assurance and Performance Improvement committee quarterly. The committee will discuss the findings and determine if any further improvements to this process is needed. 5. Corrective Action will be completed by 3/18/2022. RECEIVED FEB 25 2022 VDH/OLC	

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E 037	Continued From page 11 (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.	E 037		

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E 037	Continued From page 12 (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster	E 037		

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E 037	Continued From page 13 authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to provide evidence of documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings, and documentation that facility staff have received initial and annual emergency preparedness training.	E 037		

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E 037	Continued From page 14 The findings include: On 02/08/2022 at approximately 10:40 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, maintenance director. Review of the facility's emergency preparedness plan failed to evidence documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings, and documentation that facility staff have received initial & annual emergency preparedness training. OSM # 1 stated that they were not able to provide evidence of training. On 02/08/2022 at approximately 1:50 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 4, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit.	E 037		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on	E 041	E-041 1. To complete a full load bank test, a full load test has been scheduled to be performed by a certified electrician. In addition, the policy entitled "Emergency Power" has been updated to include how to keep the generator operational during an emergency. 2. The updated policy entitled "Emergency Power" has been added to the Emergency Preparedness Manual under section E-041 to	

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E 041	Continued From page 15 the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041	ensure the process can be easily found during an emergency, In addition, a copy of the generator contracts has been copied and added to this section for easy access. 3. The Administrator will in-service the Director of Maintenance, the Director of Nursing, Assistant Director of Nursing, and the nursing supervisors on the updated policy entitled "Emergency Power". In addition, they will be shown how to locate the policy and contracts in the manual. 4. The Administrator will report to the QAPI Committee quarterly to discuss the use and needs of the generator during an emergency to facilitate any further improvements that can be developed under E-041. 5. Corrective Action will be completed by 3/18/2022.	

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E 041	Continued From page 16 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

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E 041	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to evidence documentation that the facility has the required emergency standby power systems to meet the requirements of the facility's emergency, and corresponding policies and procedures and documentation of a plan for how to keep the generator operational during an emergency unless they plan to evacuate. The findings include: On 02/08/2022 at approximately 10:40 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, maintenance director. Review of the facility's emergency preparedness plan failed to evidence documentation the facility has the required emergency standby power systems to meet the requirements of the facility's emergency, and corresponding policies and procedures and documentation of a plan for how to keep the generator operational during an emergency unless they plan to evacuate. OSM # 1 stated, "We don't have the documentation." On 02/08/2022 at approximately 1:50 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 4, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit.	E 041		

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/6/22 through 02/8/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow. Corrections are required for compliance with F-888 of 42 CFR Part 483 Federal Long Term Care requirement(s). The census in this 120 certified bed facility was 105. Of the 105 current residents, seven residents were currently positive for the COVID-19 virus. The survey sample consisted of 48 current residents and three closed record reviews.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding	F 577	F577 1. The findings and plan of correction(s) for the complaint survey ending 12/29/21 were immediately placed in the Survey Binder always available in the main Lobby of Skyview Springs Rehab and Nursing Center for its residents and guests. 2. All residents and guests were affected by this practice. A written communication will be provided to all residents and guests informing them of the availability of survey results for the past 3 years in the Main Lobby.	

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F 577	Continued From page 19 years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to make available the results of the most recent survey. The facility staff failed to include the results of the abbreviated survey ending 12/29/2021 in the survey results notebook in the lobby. The findings include: Observation was made of the survey results book located in the lobby of the facility on 2/6/2022 at 2:00 p.m. and on 2/7/2022 at 8:05 a.m. The most recent survey results in the book were dated June 2021. The results from the most recent survey, ending on 12/29/2021, were not in the book. An interview was conducted with ASM (administrative staff member) #1, the administrator, on 2/8/2022 at 10:29 a.m. When the above observation was shared with ASM #1, ASM #1 stated he had just gotten to the facility a few weeks ago. ASM #1 stated he really had not thought to look at that. When asked the process for making the survey results available for the residents and resident representatives, ASM #1 stated the most current survey results should be available in the binder in the lobby.	F 577	3. The Administrator or the Administrative Assistant and/or designee will assure that 3 years of survey results with plans of correction will be made available to all residents and guests, in the Main Lobby, immediately upon receipt of approved survey results and plans of correction. 4. The administrative office staff, offices located in the Main Lobby, will audit the Survey Binder daily for 30 days to assure the past 3 years of survey results and plans of correction are available. Exceptions will be reported to the Administrator and copies of said surveys and plans of correction will always be made immediately available. Completion Date: 3/18/2022	

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F 577	Continued From page 20 The facility policy, "Resident Rights" documented in part, "18. The Resident has a right to examine the results of the most recent survey of the Facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the Facility." ASM #1, ASM #2, the director of nursing, ASM #3, the regional vice president of clinical services, were made aware of the above concern on 2/8/2022 at 2:05 p.m. No further information was obtained prior to exit.	F 577		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a	F 585	F 585 1. The facility has resolved the grievance for Resident # 21. 2. All other residents may have potentially been affected. The Social Service Dept/Designee will conduct a facility audit looking back through 3 months of grievances to determine if grievances have been addressed or resolved. 3. The Social Service Dept/Designee will educate all staff on the Grievances /Complaints, Filing including but not limited to importance of timely completion of the grievance/complaint.	

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	495255	A. BUILDING _____ B. WING _____	02/08/2022

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

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F 585	Continued From page 21 grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;	F 585	4. Social Service Dept/ Designee will review all grievances weekly for 4 weeks and then monthly to ensure grievances are identified and will report to QAPI weekly for additional oversight or recommendations. 5. Corrective Action/Audits to be completed by 3/18/2022.	

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F 585	Continued From page 22 (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to act upon a reported grievance for missing personal items for one of 51 residents in the survey sample, Resident #21. The facility staff failed to promptly respond to a	F 585		

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F 585	Continued From page 23 known grievance for missing clothing items for Resident #21. The findings include: On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/9/2021, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. On 2/6/2021 at 5:00 p.m., an interview was conducted with Resident #21. The resident stated that they had received several items of clothing from their son and his girlfriend for Christmas and had sent them to the laundry to be labeled which had not been returned. The resident stated that they were missing a sweatshirt, two pairs of sweatpants and a pajama set and they had spoken to [Name of OSM (other staff member) #5, environmental services director] about these but had not gotten any follow up on the items. Review of the facility grievances for the past 12 months revealed a grievance dated 1/11/2022 for Resident #21 completed by social services. The grievance documented in part, "...Missing items: clothing; Date item last seen: 12/25/21; Describe the missing item: set of pajamas multi colored size small. Gray nilon [sic] hoody [sic], pink short sleeve shirt/v-neck, 2 to 3 pair of black sweat pants...Initial Action Taken: I have looked for the said items above in laundry & the residents closet & didn't find the items. To my conclusion, the items were not sent to the laundry dept. (department) 1/13/22 [Staff signature]." The form failed to evidence any follow up actions taken or	F 585		

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F 585	Continued From page 24 resolution of the grievance. Review of the resident council minutes documented a meeting held on 1/31/2022 which documented in part, "...Resident feels like they are being redirecting [sic] in their issues/concerns. Resident feels that they are not being heard. Laundry- House clothes not being return..." The minutes documented resident comments/concerns from Resident #21 dated 1/31/2022 regarding clothing not being returned. The comments documented, "I [Name of OSM #5] have notified the laundry dept (department) of the above said issue. I also have looked for items myself & have not found them. 02/01/22. [Signature of OSM #5]" On 2/7/2022 at 4:00 p.m., an interview was conducted with OSM #5, the environmental services director. OSM #5 stated that when they receive a grievance for missing clothing or personal items they searched the laundry for them and also the residents room. OSM #5 stated that whether they found them or not they completed the grievance form and returned it to the social services department. OSM #5 stated that Resident #21 had sent a bag of new clothes down to the laundry to be labeled. OSM #5 stated that they had labeled the clothing and returned them in the same bag back to the resident in the closet in the room. OSM #5 stated that the clothing had been down to be washed several times since then and returned to the resident. OSM #5 stated that if there were missing clothing it was not sent to the laundry because they had returned everything. At that time, OSM #5 went to Resident #21's room and spoke with them regarding missing clothing. Resident #21 informed OSM #5 that they were	F 585		

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F 585	Continued From page 25 still missing pajamas, sweatpants and a sweatshirt. OSM #5 advised Resident #21 that the clothing may have been mixed in the the linen by the nursing staff, which was sent outside of the facility. OSM #5 checked Resident #21's closet and stated that the clothing that gets mixed in with the linen was not returned by the linen service. On 2/7/2022 at 4:30 p.m., an interview was conducted with OSM #6, social services. OSM #6 stated that when they received a grievance for missing items they completed the grievance form and forwarded it to the appropriate department. OSM #6 stated that if missing clothing was not located right away they continued to look for them and offered replacement or reimbursement for the items. OSM #6 stated that they had spoken with Resident #21 that morning about the missing clothing items. OSM #6 stated that Resident #21 had advised her that they did not care about the clothing or getting them replaced. At that time, OSM #6 went to Resident #21's room and spoke with them regarding the missing clothing. Resident #21 became tearful explaining that the clothing was a gift from her son and his girlfriend for Christmas and she did want them back. OSM #6 discussed speaking with Resident #21's son regarding reimbursement or replacement of the clothing items. Resident #21 appeared satisfied with the agreement to discuss the concern with her son. On 2/8/2022 at approximately 1:50 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy on personal property. The facility policy "Resident Rights" documented	F 585		

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F 585	Continued From page 26 In part, "...17. The Resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal. Such grievances include those with respect to care and treatment which have been furnished as well as that which have not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC (long term care) facility stay. The resident has the right to and the facility must make prompt efforts to resolve grievances the resident may have. The resident has the right to obtain a written decision regarding his or her grievance..." The facility policy "Grievances/Complaints, Filing" dated April 2017 provided during survey entrance on 2/6/2022 documented in part, "Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (e.g., the State Ombudsman). The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative...All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response...Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint...The results of all grievances files, investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision..."	F 585		

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F 585	Continued From page 27 On 2/7/2022 at approximately 5:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations and ASM #4, the vice president of clinical services were made aware of the concern. No further information was presented prior to exit.	F 585		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(I)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (I) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;	F 622	F 622 1. The clinical record for resident # 96 failed to reveal the NP or physician documentation regarding the transfer. The facility failed to document information provided to hospital staff for resident # 81 and # 54. 2. All residents may have potentially been affected. Nursing staff will be educated in Facility Transfers and Discharges. An initial audit will be completed with a look back of 14 days to ensure required documentation by NP/physician regarding transfers were completed in documentation provided to hospital staff is included in record. 3. The Director of Nursing /Designee will educate all nursing staff on Policy Facility Initiated Transfer and Discharge. Medical Director educated Staff of Transfers and Discharges.	

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F 622	Continued From page 28 or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of	F 622	4. The Director of Nursing/Designee will conduct an audit of all resident transfers to ensure that appropriate paperwork is filled out and sent with resident. An initial audit will be completed with a look back of 14 days to ensure required documentation by NP/physician regarding transfers were completed in documentation provided to hospital staff is included in record. The audit will be an ongoing audit. The Director of Nursing will submit the results of the audit to QAPI for review and recommendations. 5. Corrective Action/Audits to be completed by 3/18/2022	

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F 622	Continued From page 29 this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement facility initiated transfer requirements for 3 of 51 residents in the survey sample, Residents #96, #81 and #54. The facility staff failed to evidence a physician note regarding facility initiated hospital transfers for Residents #96 and #81 and failed to evidence required information provided to hospital staff for facility initiated transfers for Residents #81 and #54. The findings include: 1. Resident #96 was admitted to the facility on 6/6/19. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/18/21, the resident scored 3 out of 15 on the BIMS (brief interview for mental status), indicating the	F 622		

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F 622	Continued From page 30 resident is severely cognitively impaired for making daily decisions. Review of Resident #96's clinical record revealed the resident was transferred to the hospital on 11/8/21 for a fever and altered mental status. Further review of Resident #96's clinical record failed to reveal physician or nurse practitioner documentation regarding the transfer. On 2/7/22 at 4:28 p.m., an interview was conducted with ASM (administrative staff member) #5 (nurse practitioner). ASM #5 stated she documents a note regarding resident transfers to the hospital if she is in the facility at the time of transfer but does not document a note if she is not in the facility at the time of transfer. On 2/8/22 at 1:52 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional vice president of clinical services) were made aware of the above concern. The facility policy titled, "Facility Initiated Transfer and Discharge" documented, "3. Facility initiated transfers/discharges will be implemented when any one or more of the following conditions are met: a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; i. The medical record will contain documentation by the attending physician to include the identification of the resident's specific needs that cannot be met by the facility and of the facility's attempt to meet those needs." No further information was presented prior to exit.	F 622		

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F 622	Continued From page 31 2. Resident #81 was admitted to the facility on 8/10/19... On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/31/22, the resident scored 6 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely cognitively impaired for making daily decisions. Review of Resident #81's clinical record revealed the resident was transferred to the hospital on 1/5/22 due to a fall with a deep laceration to the back of the head. Further review of Resident #81's clinical record failed to reveal physician or nurse practitioner documentation regarding the transfer, and failed to reveal the information provided to hospital staff. On 2/7/22 at 4:28 p.m., an interview was conducted with ASM (administrative staff member) #5 (nurse practitioner). ASM #5 stated she documents a note regarding resident transfers to the hospital if she is in the facility at the time of transfer but does not document a note if she is not in the facility at the time of transfer. On 2/8/22 at 11:52 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that nurses provide hospital staff with a care plan, face sheet, do not resuscitate order (if applicable), physician's orders, pertinent labs or x-rays, recent nurses notes, physician notes and a copy of the bed hold agreement when residents are transferred to the hospital. LPN #2 stated nurses are supposed to document the information provided to hospital staff in a progress note and make a copy to keep in the facility records.	F 622		

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	495255	A. BUILDING _____ B. WING _____	02/08/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 32 On 2/8/22 at 1:52 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional vice president of clinical services) were made aware of the above concern. The facility policy titled, "Facility Initiated Transfer and Discharge" documented,"4. The medical record: a. Will clearly identify the basis or reason for transfer or discharge b. Identify information provided to the receiving provider which at a minimum will include: I. Contact information of the practitioner who was responsible for the care of the resident; II. Resident representative information, including contact information; III. Advance directive information; iv. Special instructions and/or precautions for ongoing care, as appropriate, which must include, if applicable, but are not limited to treatments and devices (oxygen, implants, IVs, tubes/catheters); v. Precautions such as isolation or contact; vi. Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions; vii. The resident's comprehensive care plan goals; and viii. All information necessary to meet the resident's needs, which includes, but may not be limited to: (1) Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs; (2) Diagnoses and allergies; (3) Medications (including when last received); and (4) Most recent relevant labs, other diagnostic	F 622		

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F 622	Continued From page 33 tests, and recent immunizations ix. Discharge summary if the resident is not expected to return to the facility." No further information was provided prior to exit. 3. Resident #54 was admitted to the facility on 3/16/21. On the most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 1/2/22, the resident scored 7 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely cognitively impaired for making daily decisions. Review of Resident #54's clinical record revealed the resident was transferred to the hospital on 12/27/21 for respiratory distress. Further review of Resident #54's clinical record failed to reveal the information provided to hospital staff. On 2/8/22 at 11:52 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that nurses provide hospital staff with a care plan, face sheet, do not resuscitate order (if applicable), physician's orders, pertinent labs or x-rays, recent nurses notes, physician notes and a copy of the bed hold agreement when residents are transferred to the hospital. LPN #2 stated nurses are supposed to document the information provided to hospital staff in a progress note and make a copy to keep in the facility records. On 2/8/22 at 1:52 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional vice president of clinical services) were made aware of the above concern.	F 622		

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F 622	Continued From page 34 No further information was provided prior to exit.	F 622		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to provide an accurate assessment for one of 51 residents, Resident #32. The facility staff failed to complete an accurate MDS (minimum data set), an annual assessment, for Resident #32. The findings include: During the entrance conference on 2/6/22, request was made for the facility to provide a list for smoking times and residents that smoke. There were five residents from the south wing and three residents from the north wing on the list provided 2/6/22 at 3:30 PM; Resident #32 was included on the list. On 2/7/22 at 3:00 PM, Resident #32 was observed to go to the outside smoking area. The smoking area for South wing residents was supervised by two staff, with five residents smoking. LPN (licensed practical nurse) #8 distributed cigarettes and then lit each resident's cigarette. The smoking area contained a smoke blanket and a fire extinguisher with inspection tag	F 641	F 641 1. Resident #32 was modified for correction and accuracy on 2/7/2022. 2. All residents may have potential been affected. The MDS Nurse will audit the most recent MDS of all current residents that smoke will be conducted to identify any further inaccurate assessments. 3. The MDSC will maintain an up-to-date list of current residents that smoke. This list will be updated and reviewed at each Quality Assurance Meeting. 4. MDSC will audit any resident MDSs completed weekly x4 weeks to maintain accuracy. 5. Corrective Action/Audits to be completed by 3/18/2022	

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F 641	Continued From page 35 dated 2020-2021, and punch holes on months of June and September 2020. Resident #32 was admitted to the facility on 10/2/14 with diagnoses that included but were not limited to: nicotine dependence. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/14/21, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. On the MDS Section G- Functional Status, the resident was coded as being independent with bed mobility, transfers, dressing, personal hygiene, bathing, eating and locomotion; walking did not occur. A review of the annual MDS assessment with an ARD of 8/6/21 revealed Resident #32 was documented has having "no" current tobacco use in Section J-Health Conditions. A review of Resident #32's comprehensive care plan dated 10/15/21, revealed, in part, "FOCUS-Resident is a smoker and it has been determined that [Resident #32] is a safe smoker with supervision. INTERVENTIONS-Resident educated on facility smoking times and compliance requirements to safely smoke. No O2 (oxygen) is to be in area of smokers. Smoking assessment on admission, re-admission, quarterly and PRN (as needed) with changes in condition. Will be educated on designated area and will comply with limiting smoking to that area. Will voice understanding of smoking area, smoking times and facility policy related to smoking."	F 641		

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F 641	Continued From page 36 A review of the smoking evaluation dated 10/15/21 at 4:19 PM revealed, in part, "Evaluation: Resident utilizes tobacco. Poor vision or blindness: No. Balance problems while sitting or standing: No. Total or limited ROM (range of motion) in arms or hands: No. Insufficient fine motor skills needed to securely hold cigarette: No. Lethargic / falls asleep easily during tasks or activities: No. Burns skin, clothing, furniture or other: No. Drops ashes on self: No. Follow the facility's policy on location and time of smoking: Yes. Concerns: Able to light a cigarette safely. Able to hold a cigarette safely. Able to extinguish a cigarette safely. Able to use ashtray to extinguish a cigarette." A review of the nursing progress note dated 3/28/21 at 10:59 AM revealed, in part, "Late entry: Yesterday evening at 3:20 PM, resident came back down onto the floor from the offices. Resident was upset because they had not yet been out to smoke due to not having a staff member to assist with taking them out. This member was unable to, and the 3-11 staff was doing rounds/med pass and unable to take them out. Resident continued to go off and he went into room. This writer talked to resident about not having a member available and resident finally began to calm down." A review of the nursing progress note dated 7/14/21 at 5:37 PM revealed, in part, "Nicotine patch was offered to resident for next two weeks. Resident refused." An interview was conducted on 2/7/22 at 11:00 AM with Resident #32. When asked if he smoked, Resident #32 stated, "Yes, I have been smoking for years." When asked where he	F 641		

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F 641	Continued From page 37 smokes, Resident #32 stated, "I smoke outside in the closed-in area. We go out of the doors on this wing now, because of COVID." An interview was conducted on 2/7/22 at 4:00 PM with RN (registered nurse) #2, the MDS coordinator. When asked to review the annual MDS dated 8/6/21 for Resident #32, Section J-tobacco use, RN #2 stated, "It is documented as 'No'." When shown the care plan and safe smoking evaluation for Resident #32, RN #2 stated, "The MDS is incorrect. I will correct it." When asked what standard is followed for the MDS, RN #2 stated, "We follow the RAI (resident assessment instrument)." On 2/7/22 at 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations, ASM #4, the regional vice president of clinical services and LPN (licensed practical nurse) #3, the assistant director of nursing were made aware of the concern. No further information was provided prior to exit. According to the RAI version three, "Section J-tobacco use: Steps for Assessment 1. Ask the resident if he or she used tobacco in any form during the 7-day look-back period. 2. If the resident states that he or she used tobacco in some form during the 7-day look-back period, code 1, yes."	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		

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F 656	Continued From page 38 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656	F 656 1. Resident # 88 failed to have documentation documenting non-pharmacological pain interventions. Resident # 52 failed to have documentation that a shower was refused, or a shower was given. Resident # 11 observed to not have doughnut pillow to left ankle to alleviate pressure. The residents care plan documented to be on at all times. Residents # 10, Residents #41 and Resident # 74 care plans were immediately updated. 2. All other residents may have been potentially affected. The Director of Nursing/Designee will educate nursing staff on policy Care Planning-Comprehensive Person-Centered, including but not limited to importance of ensuring all orders have been reviewed and care plans have interventions implemented. 3. The Director of Nursing/Designee will educate nursing staff on policy Care Planning-Comprehensive Person-Centered, including but not limited to importance of ensuring all care plans have interventions implemented and orders reviewed.	

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	495255	A. BUILDING _____ B. WING _____	02/06/2022

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F 656	Continued From page 39 section. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for six of 51 residents in the survey sample, Residents # 10, # 41, # 88, # 52, # 11 and # 74. The findings include: 1. The facility staff failed to implement Resident # 10's comprehensive care plan for the use of fall mats. Resident # 10 was admitted to the facility with a diagnosis that included but was not limited to lack of coordination. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/16/2021, the resident scored 4 (four) out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired of cognition for making daily decisions. On 02/06/2022 at approximately 2:22 p.m., an observation of Resident # 10 revealed they were lying in bed with a fall mat on the floor to the resident's left side. On 02/07/2022 at approximately 9:52 a.m., an observation of Resident # 10 revealed they were lying in bed with a fall mat on the floor to the resident's left side.	F 656	4. The Director of Nursing /Designee will complete an audit of residents with oxygen to ensure that oxygen concentrator is set on the appropriate liter flow per MD orders and comprehensive care plan. This audit will be weekly for 4 weeks then monthly. The Director of Nursing will submit to the QAPI committee for review and recommendations. The Director of Nursing /Designee will complete an audit of residents with mats to ensure orders and comprehensive care plans is implemented. This audit will be weekly for 4 weeks then monthly. The Director of Nursing will submit to the QAPI committee for review and recommendations. The Director of Nursing/Designee will review 20 residents scheduled showers weekly for 4 weeks. The Director of Nursing will submit to the QAPI committee for review and recommendations. The Director of Nursing/Designee will complete an audit of residents with pain medications. The Director of Nursing/Designee will complete an audit of residents with pressure relieving devices weekly x 4weeks. The Director of Nursing will submit to QAPI for review and recommendations.	

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F 656	Continued From page 40 On 02/07/2022 at approximately 2:10 p.m., an observation of Resident # 10 revealed they were lying in bed with a fall mat on the floor to the resident's left side. The current POS (physician order sheet) for Resident # 10 documented in part, "Floor mats to both sides of bed Q (every) shift. Every shift. Order Date: 02/07/2022. Start Date: 02/07/2022." The comprehensive care plan for Resident # 10 documented in part, "Focus: [Resident # 10] is at risk for falls r/t (related to) Gait/balance problems...Revision on: 10/29/2021." Floor mats at bedside on right side. Date Initiated: 06/14/2021." On 02/07/2022 at approximately 10:35 a.m., an interview was conducted with LPN (licensed practical nurse) # 1. When asked to describe the orientation of placing a fall mat on the right or left side of a resident's bed, LPN # 1 stated that it referred to the resident's left or right side. When asked what should happen if a resident's care plan documents a procedure or the use of a device/equipment, LPN # 1 stated, "It should be implemented or in place." On 02/07/2022 at approximately 2:20 p.m., an observation Resident # 10's fall mat and interview was conducted with LPN # 1. When asked to describe the location of Resident # 10's fall mat LPN # 1 stated, "It's on the left side of [Name of Resident # 10's] bed." After reviewing the comprehensive care plan for Resident # 10, LPN # 1 was asked if the care plan was being implemented for the placement of the fall mat. LPN # 1 stated no.	F 656	5. Corrective Action/Audits to be completed by 3/18/2022.	

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F 656	Continued From page 41 The facility's policy "Care Planning - Comprehensive Person-Centered" documented, in part, "2. The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process." On 02/07/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, ASM # 3, regional vice president of operations, ASM # 4, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit. 2. Facility staff failed to implement Resident # 41's comprehensive care plan for the administration of oxygen at one liter per minute. Resident # 41 was admitted to the facility with diagnoses that included but were not limited to: respiratory failure and chronic obstructive pulmonary disease. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/10/2021, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 41 as receiving oxygen in the facility during the look back period.	F 656		

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F 656	Continued From page 42 On 02/06/2022 at approximately 3:23 p.m., an observation of Resident # 41 revealed they were lying in bed receiving oxygen by nasal cannula. Observation of the flow meter on oxygen concentrator revealed an oxygen flow rate between 0.5 and 1 liters per minute. On 02/07/2022 at approximately 8:20 a.m., an observation of Resident # 41 revealed they were lying in bed receiving oxygen by nasal cannula. Observation of the flow meter on oxygen concentrator revealed an oxygen flow rate between 0.5 and 1 liters per minute. On 02/07/2022 at approximately 2:15 p.m., an observation of Resident # 41 revealed they were lying in bed receiving oxygen by nasal cannula. Observation of the flow meter on oxygen concentrator revealed an oxygen flow rate between 0.5 and 1 liters per minute. The physician order for Resident #41 documented, "O2 (oxygen) at 1LPM (one liter per minute) via (by) NC (nasal cannula) every shift. Order Date: 12/01/2020." The comprehensive care plan for Resident # 41 dated 11/02/2021 documented in part, "Focus: The resident has altered respiratory status/difficulty breathing r/t (related to) COPD (chronic obstructive pulmonary disease), respiratory failure. Date Initiated: 11/02/2021...OXYGEN as ordered. Date Initiated: 11/02/2021." On 02/07/2022 at approximately 2:30 p.m., an observation Resident # 41's flow meter on their oxygen concentrator and interview was conducted with LPN (licensed practical nurse) #	F 656		

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F 656	Continued From page 43 1. When asked the oxygen flow rate was for Resident # 41 who was receiving oxygen by nasal cannula LPN # 1 read the flow meter and stated, "One and a half liters per minute." After reviewing the comprehensive care plan for Resident # 41's respiratory care, LPN # 1 was asked if the care plan was being followed. LPN # 1 stated no. On 02/07/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, ASM # 3, regional vice president of operations, ASM # 4, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit. 3. The facility staff failed to implement Resident #88's comprehensive care plan for implementing non-pharmacological interventions prior to the administration of Norco (hydrocodone-acetaminophen) (1). Resident # 88 was admitted to the facility with a diagnosis that included but was not limited to chronic pain. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/26/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section J0400 "Pain Frequency" coded Resident # 88 as "Frequently." Under "J0600. Pain Intensity," it documented, "A. Numeric Rating Scale (00-10) Ask resident: "Please rate your worst pain over the last 5 days on a zero to ten	F 656		

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F 656	Continued From page 44 scale, with zero being no pain and ten as the worst pain you can imagine." (Show resident 00-10 pain scale). Enter two-digit response. Enter 99 if unable to answer." Resident # 88 was coded a "6 (six)." The POS (physician's order sheet) for Resident # 88 documented in part, "Norco Tablet 5-325 (five to 325) MG (HYDROcodoneAcetaminophen). Give 1 (one) tablet by mouth every 4 hours as needed for Pain. For pain 1-5 Tyl 6-10 Norco. Order Date: 08/04/2020. Start Date: 08/04/2020." The comprehensive care plan for Resident # 88 dated 08/12/2021 documented in part, "Focus: [Resident # 88] has the potential for pain/discomfort. Date Initiated: 08/12/2021 ..."Offer non-pharm (non-pharmacological) interventions for pain. Date Initiated: 10/27/2021." The eMAR (electronic medication administration record) for Resident # 88 dated January 2022 documented the physician's order as stated above. Further review of the eMAR revealed Resident # 88 received 5-325 mgs of Norco on the following dates and times, with no evidence of non-pharmacological interventions being attempted: 01/01/2022 at 2:06 a.m.; 01/02/2022 at 4:00 a.m., and at 7:23 p.m.; 01/03/2022 at 7:33 p.m.; 01/04/2022 at 2:00 a.m., and at 7:22 p.m.; 01/05/2022 at 1:30 a.m.; 01/06/2022 at 1:00 a.m.; 01/07/2022 at 12:00 a.m., and at 7:30 p.m.; 1/08/2022 at 7:14 p.m.; 01/09/2022 at 1:30 a.m., and at 7:46 p.m.; 01/10/2022 at 1:00 a.m.; 01/11/2022 at 1:00 a.m.; 01/12/2022 at 2:24 a.m., and at7:24 p.m.; 01/13/2022 at12:30 a.m., and at 8:14 p.m.; 01/14/2022 at 8:33 p.m.; 01/18/2022 at 7:54 p.m.; 01/20/2022 at 2:34 a.m.; 01/2/1/2022 at 2:03 a.m.; 01/22/2022 at 7:23 p.m.;	F 656		

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F 656	Continued From page 45 01/23/2022 at 9:43 p.m.; 01/24/2022 at 2:00 a.m.; 01/25/2022 at 2:00 a.m.; 01/26/2022 at 12:25 a.m., and at 7:40 p.m.; 01/27/2022 at 1:00 a.m.; 01/28/2022 at 2:00 a.m., and at 7:46 p.m.; 01/29/2022 at 1:45 a.m.; and on 01/31/2022 at 7:25 a.m. The eMAR for Resident # 88 dated February 2022 documented the physician's order as stated above. Further review of the eMAR revealed Resident # 88 received 5-325 mgs of Norco on the following dates and times, without no evidence of non-pharmacological interventions being attempted: 02/02/2022 at 1:45 a.m., and at 7:58 p.m.; 02/04/2022 at 2:10 a.m.; 02/05/2022 at 7:22 p.m.; 02/06/2022 at 1:30 a.m., and at 7:42 p.m.; 07/07/2022 at 1:30 a.m. Review of the facility's nursing progress notes for Resident # 88 dated 12/01/2021 through 02/07/2022 failed evidence documentation non-pharmacological interventions attempted for the dates Resident # 88 received 5-325 mgs of Norco listed above. On 02/06/22 at 2:10 p.m., an interview was conducted with Resident # 88 regarding their pain. Resident # 88 stated that they have arthritis pain in their hand and left knee. When asked if they receive pain medication as needed, Resident # 88 stated yes. When asked if nursing staff try to alleviate their pain before administering their medication Resident # 88 stated, "No, they just give me the pain medication and say I hope it helps." On 02/08/2022 at approximately 11:04 a.m., an interview was conducted with LPN # 1. LPN # 1 was asked if there was documentation that	F 656		

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F 656	Continued From page 46 non-pharmacological interventions were attempted prior to Resident # 88 receiving the physician ordered pain medication of Norco. LPN # 1 stated no. After reviewing the care plan for Resident # 88, LPN # 1 was asked if the care plan was implemented for the use of non-pharmacological interventions prior to the administration for the pain medication on the dates listed above. LPN # 1 stated no. On 02/08/2022 at approximately 1:50 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit. References: (1) Hydrocodone is an opioid pain medication. An opioid is sometimes called a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of hydrocodone. The combination of acetaminophen and hydrocodone is used to relieve moderate to severe pain. This information was obtained from the website: https://www.rxlist.com/norco-5-325-drug/patient-images-side-effects.htm. 4. The facility staff failed to implement the comprehensive care plan for bathing for Resident #52. Resident #52 was admitted to the facility on 11/22/2021. On the most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 12/30/2021, the resident scored an 8 of 15 on the BIMS (brief interview for mental status), indicating the	F 656		

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F 656	Continued From page 47 resident is severely cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as not having had a shower or bath during the lookback period. The comprehensive care plan dated 11/29/2021 documented, in part, "Focus: The resident has an ADL self-care performance deficit r/t (related to) Dementia, Limited Mobility ...BATHING/SHOWERING - Provide sponge bath when a full bath or shower cannot be tolerated." There was no documentation in the care plan that the resident has refused baths/showers. An interview was conducted with the resident's family member on 2/6/2022 at 3:11p.m. When asked if she had any concerns, the family representative stated she is concerned that her mother is not getting baths/showers. She stated that the staff is telling her that the resident is refusing them. The ADL (activities of daily living) records for the following months documented: - For November 2021, the resident received a bed bath on 11/24/2021. The activity (bathing) did not occur on 11/23/2021, 11/25/2021, 11/26/2021, 11/27/2021, 11/28/2021, 11/29/2021 and 11/30/2021. On the following dates, bathing did not occur, and "Hair Only" was documented: 11/26/2021, 11/28/2021, and 11/29/2021. - For December 2021 there were only six days of documentation of bathing. 12/1/2021 - the resident received a bed bath. 12/2/2021 - the resident did not receive any bathing. 12/3/2021 - the resident received a partial bed	F 656		

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F 656	Continued From page 48 bath on day shift and a bed bath on night shift. 12/4/2021 - there was no documentation of any bathing. 12/5/2021 - the resident received a bed bath on night shift. 12/6/2021 - the resident received a bed bath on night shift. - For January 2022, the resident's showers were scheduled on the evening shift on Tuesday and Friday. There was no documentation until 1/14/2022. On 1/14/2022, 1/18/2022, 1/21/2022, 1/25/2022, and 1/28/2022, it was documented that the bathing activity did not occur; however, an "S" was documented for each date. - For February 2022, on 2/1/2022 and 2/4/2022 the bathing activity did not occur. For both of these, it was documented "hair only." The nurse's notes from 11/22/2021 through 2/7/2022 were reviewed. There was no documentation of the resident's refusal of baths/showers. An interview was conducted with CNA (certified nursing assistant) #7 on 2/8/2022 at 9:03 a.m. The above ADL records was reviewed with CNA #7. CNA #7 was informed that family members had expressed concerns about the resident not receiving baths/showers. CNA #7 stated the resident refuses them. When asked how facility staff are to document a resident's refusal of a bath/shower, CNA #7 stated the staff has nowhere to document the refusal. She stated they were told to document the task was not completed, and then to document what should have been given. She stated the January 2022 documentation referenced above shows that the	F 656		

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F 656	Continued From page 49 bath/shower did not occur, but that a shower should have been given. When asked if a resident refuses what action should the CNA take, CNA #7 stated, "We have to tell the nurse." CNA #7 stated she has not seen the ADL records printed in this manner. At this time, LPN (licensed practical nurse) #3 was asked to provide any documentation that Resident #52 had received a bath/shower on the above referenced dates. An interview was conducted with LPN (licensed practical nurse) #1, on 2/8/2022 at 11:07 a.m. When asked the purpose of the care plan, LPN #1 stated it's a guide to patient care. When asked if it should be followed, LPN #1 stated, yes. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of clinical services, were made aware of the above concern on 2/8/2022 at 2:05 p.m. No further information was obtained prior to exit. 5. The facility staff to implement the comprehensive care plan for the placement of a pressure relieving device for Resident #11. The donut pillow was not in place per the comprehensive care plan. Resident #11 was admitted to the facility 7/11/2015. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/17/2021, the resident was coded as having short and long term memory problems and severely cognitively impaired for making daily decisions. In Section M - Skin Conditions, the resident was coded as having one stage III	F 656		

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F 656	Continued From page 50 pressure injury. "Pressure Injury: 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. Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible." (1). The comprehensive care plan dated 11/9/2021, and revised on 2/7/2022, documented in part, "Focus: The resident has a pressure ulcer of left shoulder ..."Donut pillow to left ankle to alleviate pressure." Observation was made of Resident #11 on 2/7/2022 at 8:11 a.m. The resident was seated in a reclining chair with her legs bent at her knees. There was not donut pillow around the resident's left ankle. A second observation was made on 2/7/2022 at 3:31 p.m. The resident was in her bed with her covers over her. The donut pillow was noted on the top of her nightstand. CNA (certified nursing assistant) #6 came into the room. When asked if the resident was to have the donut pillow on her left ankle, CNA #6 stated that she always puts it on her. It's supposed to be on all the time. CNA #6 confirmed the donut pillow was sitting on the nightstand and not on the resident. The physician orders dated, 12/16/2021, documented in part, "Donut pillow to left foot at all times, every shift for changes in skin texture."	F 656		

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F 656	Continued From page 51 An interview was conducted with LPN (licensed practical nurse) #8 on 2/7/2022 at 3:32 p.m. The above observation was shared with LPN #8. When asked if the physician ordered donut pillow should be in place as prescribed, LPN #8 stated, yes. When asked if the resident's care plan stating the donut pillow should be in place is being followed, LPN #8 stated, no. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of clinical services, were made aware of the above concern on 2/8/2022 at 2:05 p.m. No further information was obtained prior to exit. References: (1) This information was obtained from the following website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf 6. The facility staff failed to develop a care plan for the use of oxygen for Resident #74. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/19/2022, the resident was coded as being severely impaired for making daily decisions. Section O documented the resident receiving oxygen at the facility during the look back period. On 2/6/2022 at approximately 2:15 p.m., Resident #74 was observed in bed wearing an oxygen nasal cannula with a humidifier bottle dated 2/4/22; the equipment was attached to an oxygen concentrator. Resident #74 was observed to be	F 656		

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F 656	Continued From page 52 alert, awake and non-verbal. Additional observations of Resident #74 on 2/6/2022 at approximately 4:15 p.m. and 2/7/2022 at approximately 8:15 a.m. revealed oxygen being administered by nasal cannula as described above. The comprehensive care plan for Resident #74 failed to evidence documentation of oxygen administration. The physician order's for Resident #74 documented in part, "Oxygen therapy at 2 (two) liters per minute via nasal cannula. Start Date: 1/18/2022." On 2/7/2022 at approximately 2:35 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the purpose of the care plan was to guide the care of the patient. LPN #1 stated that oxygen should be included on the care plan. LPN #1 observed Resident #74's oxygen and stated it was set at 1.5 liters per minute, and that she would verify the orders and the care plan and correct this as needed. The facility policy "Care planning" documented in part, "...2. The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process..." On 2/7/2022 at 5:00 p.m., ASM #1, the	F 656		

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F 656	Continued From page 53 administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations and ASM #4, the vice president of clinical services were made aware of the findings. No further information was provided prior to exit.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on family interview, facility document review, and clinical record review, it was determined the facility staff failed to provide ADL (activities of daily living) care for one of 51 residents in the survey sample, Resident #52. Resident #52, a dependent resident, was not provided baths. The findings include: Resident #52 was admitted to the facility on 11/22/2021. On the most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 12/30/2021, the resident scored an 8 of 15 on the BIMS (brief interview for mental status), indicating the resident is severely cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as not having had a shower or bath during the lookback period. The comprehensive care plan dated 11/29/2021 documented, in part, "Focus: The resident has an	F 677	F 677 1. Resident # 52 failed to have documentation that a shower was refused, or a shower was given. 2. All other residents may have been potentially affected. The Staff Educator /Designee will educate the nursing staff on ADL Care and Documentation. 3. The Staff Educator /Designee will educate the nursing staff on ADL Care and Documentation. 4. The Director of Nursing /Designee will review 20 residents scheduled showers weekly for 4 weeks. The Director of Nursing will submit to QAPI committee for review and recommendations. 5. Corrective Action/Audits to be completed by 3/18/2022	

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F 677	Continued From page 54 ADL self-care performance deficit r/t (related to) Dementia, Limited Mobility ...BATHING/SHOWERING - Provide sponge bath when a full bath or shower cannot be tolerated." There was no documentation in the care plan that the resident has refused baths/showers. An interview was conducted with the resident's family member on 2/6/2022 at 3:11p.m. When asked if she had any concerns, the family representative stated she is concerned that her mother is not getting baths/showers. She stated that the staff is telling her that the resident is refusing them. The ADL (activities of daily living) records for the following months documented: - For November 2021, the resident received a bed bath on 11/24/2021. The activity (bathing) did not occur on 11/23/2021, 11/25/2021, 11/26/2021, 11/27/2021, 11/28/2021, 11/29/2021 and 11/30/2021. On the following dates, bathing did not occur, and "Hair Only" was documented: 11/26/2021, 11/28/2021, and 11/29/2021. - For December 2021 there were only six days of documentation of bathing. 12/1/2021 - the resident received a bed bath. 12/2/2021 - the resident did not receive any bathing. 12/3/2021 - the resident received a partial bed bath on day shift and a bed bath on night shift. 12/4/2021 - there was no documentation of any bathing. 12/5/2021 - the resident received a bed bath on night shift. 12/6/2021 - the resident received a bed bath on night shift.	F 677		

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F 677	Continued From page 55 - For January 2022, the resident's showers were scheduled on the evening shift on Tuesday and Friday. There was no documentation until 1/14/2022. On 1/14/2022, 1/18/2022, 1/21/2022, 1/25/2022, and 1/28/2022, it was documented that the bathing activity did not occur; however, an "S" was documented for each date. - For February 2022, on 2/1/2022 and 2/4/2022 the bathing activity did not occur. For both of these, it was documented "hair only." The nurse's notes from 11/22/2021 through 2/7/2022 were reviewed. There was no documentation of the resident's refusal of baths/showers. An interview was conducted with CNA (certified nursing assistant) #7 on 2/8/2022 at 9:03 a.m. The above ADL records was reviewed with CNA #7. CNA #7 was informed that family members had expressed concerns about the resident not receiving baths/showers. CNA #7 stated the resident refuses them. When asked how facility staff are to document a resident's refusal of a bath/shower, CNA #7 stated the staff has nowhere to document the refusal. She stated they were told to document the task was not completed, and then to document what should have been given. She stated the January 2022 documentation referenced above shows that the bath/shower did not occur, but that a shower should have been given. When asked if a resident refuses what action should the CNA take, CNA #7 stated, "We have to tell the nurse." CNA #7 stated she has not seen the ADL records printed in this manner. At this time, LPN (licensed practical nurse) #3 was asked to provide any	F 677		

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F 677	Continued From page 56 documentation that Resident #52 had received a bath/shower on the above referenced dates. On 2/8/2022 at 9:59 a.m. LPN #3 provided documentation that Resident #52 received three baths/showers. The dates were 1/28/2022, 2/3/2022 and 2/7/2022. LPN #3 stated the facility could not find any other documentation that the resident received any other showers/baths. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of clinical services, were made aware of the above concern on 2/8/2022 at 2:05 p.m. The facility policy, "Activities Of Daily Living (ADLs)" documented in part, "Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene...2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care)." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of clinical services, were made aware of the above concern on 2/8/2022 at 2:05 p.m. No further information was obtained prior to exit.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		

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F 686	Continued From page 57 §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 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement the physician ordered interventions for the prevention of pressure injuries for one of 51 residents in the survey sample, Resident # 11. The facility staff failed to place a donut pillow on the resident's left ankle. The findings include: Resident #11 was admitted to the facility 7/11/2015. On the most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 11/17/2021, the resident was coded as having short and long term memory problems and as being severely cognitively impaired for making daily decisions. In Section M - Skin Conditions, the resident was coded as having one stage III pressure injury. "Pressure Injury: A pressure injury is localized damage to the skin and	F 686	F 686 1. Resident # 11 recommendations relative to wound have been implemented and dough nut pillow applied as per physician order. 2. All residents have the potential to be affected by this alleged deficient practice of ensuring necessary pressure relieving devices are provided to promote healing and or prevent decline in pressure ulcers. The Staff Educator /Designee will educate nursing staff on the Policy Pressure Injury Prevention and management. A facility audit was completed by the Wound Nurse through observation to ensure that residents with pressure relieving devices are in place and implemented per physician order. 3. The Staff Educator /Designee will educate nursing staff on the Policy Pressure Injury Prevention and management. A Mandatory Nursing Inservice has been scheduled with the Wound Physician and Wound Nurse. 4. The Director of Nursing/Designee will complete an audit of residents with pressure relieving devices weekly x 4weeks. The Director of Nursing will submit to QAPI for review and recommendations.	

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F 686	Continued From page 58 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. Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible." (1) Observation was made of Resident #11 on 2/7/2022 at 8:11 a.m. The resident was seated in a reclining chair with her legs bent at her knees. There was no donut pillow around the resident's left ankle. A second observation was made on 2/7/2022 at 3:31 p.m. The resident was in her bed with her covers over her. The donut pillow was noted on the top of her nightstand. CNA (certified nursing assistant) #6 came into the room. When asked if the resident was supposed to have the donut pillow on her left ankle, CNA #6 stated that she always puts it on the resident. She added: "It's supposed to be on all the time." CNA #6 confirmed the donut pillow was sitting on the nightstand and not placed on the resident. The physician orders dated, 12/16/2021, documented in part, "Donut pillow to left foot at all times, every shift for changes in skin texture." The February 2022 TAR (treatment administration record) documented the above order. The donut pillow was documented as being in place for day shift on 2/7/2022. The comprehensive care plan dated 11/9/2021, and revised on 2/7/2022, documented in part,	F 686	5. Corrective Action/Audits to be completed by 3/18/2022	

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F 686	Continued From page 59 "Focus: The resident has a pressure ulcer of left shoulder ...Donut pillow to left ankle to alleviate pressure." The wound care consultant note dated 12/21/2021 documented a new wound on the left ball of the foot. It was described as a pressure - suspected deep tissue injury (Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister.) (1). The wound measurements were 2.3 centimeters (cm) in length, by 1.6 cm in width, and no depth. The wound consultant note dated 1/11/2022, documented the wound on the ball of the left foot has healed. The wound consultant note dated 1/25/2022 did not document anything about the ball of the left foot. An interview was conducted with LPN (licensed practical nurse) #8 on 2/7/2022 at 3:32 p.m. The above observation was shared with LPN #8. When asked if the physician-ordered donut pillow should be in place as prescribed, LPN #8 stated yes. When asked if the resident currently has a pressure injury on her left foot, LPN #8 stated she had one but it healed. The facility policy, "Pressure Injury Prevention And Management" documented in part, "Preventative Measures: 1. Preventive interventions will be implemented based on the pressure ulcer/injury risk assessment, other related factors, and resident preferences. Such interventions may include:... c. Use of pressure reducing/relieving support surfaces or devices	F 686		

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F 686	Continued From page 60 that assist with pressure redistribution and tissue load...Treatment Protocols:1. Treatments will be ordered by the physician / practitioner. Treatment and interventions may include but are not limited to: c. Use of support devices." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 2/8/2022 at 2:05 p.m. No further information was obtained prior to exit. References: (1) This information was obtained from the following website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to implement interventions to prevent an accident for two of 51 residents in the survey sample, Residents # 10 and #32.	F 689	F 689 1. The facility failed to make sure that the environment remained free of accident of hazard for resident # 32, resident # 10 fall matts were placed bilaterally immediately. The Fire Extinguisher in the outdoor smoking area for resident 32 was immediately provided with a current inspection tag. 2. All other residents may have been potentially affected. Unit Managers will perform an audit of all residents with fall mat orders and all residents who use the outdoor smoking area.	

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F 689	Continued From page 61 The findings include: 1. The facility staff failed to provide two fall mats and place one fall mat on Resident # 10's right side of the bed. Resident # 10 was admitted to the facility with a diagnosis that included but was not limited to lack of coordination. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/16/2021, the resident scored 4 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired of cognition for making daily decisions. On 02/06/2022 at approximately 2:22 p.m., an observation of Resident # 10 revealed they were lying in bed with a fall mat on the floor to the resident's left side. On 02/07/2022 at approximately 9:52 a.m., an observation of Resident # 10 revealed they were lying in bed with a fall mat on the floor to the resident's left side. On 02/07/2022 at approximately 2:10 p.m., an observation of Resident # 10 revealed they were lying in bed with a fall mat on the floor to the resident's left side. The current POS (physician order sheet) for Resident # 10 documented in part, "Floor mats to both sides of bed Q (every) shift. Every shift. Order Date: 02/07/2022. Start Date: 02/07/2022." The comprehensive care plan for Resident # 10	F 689	3. The Director of Nursing /Designee will review all residents with fall mats and physicians' orders, and ensure implementation is per physician orders. The Maintenance Director will inspect the designated smoking area weekly for a fire extinguisher for a current inspection tag for 4 weeks and then ongoing monthly. 4. The Director of Nursing or Designee will complete an audit of all residents with fall mats weekly x4 weeks. The Director of Nursing will submit to QAPI for review and recommendations. The Maintenance Director will complete an audit of the designated smoking area for 4 weeks to assure compliance. Findings will be presented at QAPI meetings with recommendations. 5. Corrective Action/Audit to be completed by 3/18/2022	

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F 689	Continued From page 62 with a revision date of 10/29/2021 documented in part, "Focus: [Resident # 10] is at risk for falls r/t (related to) Gait/balance problems...Revision on: 10/29/2021 ...Floor mats at bedside on right side. Date Initiated: 06/14/2021." On 02/07/2022 at approximately 10:35 a.m., an interview was conducted with LPN (licensed practical nurse) # 1. When asked to describe the orientation of placing a fall mat on the right or left side of a resident's bed LPN # 1 stated that it referred to the resident's left or right side. On 02/07/2022 at approximately 2:20 p.m., an observation of Resident # 10's fall mat and interview was conducted with LPN # 1. When asked to describe the location of Resident # 10's fall mat LPN # 1 stated, "It's on the left side of [Name of Resident # 10's] bed." After reviewing the physician's order, LPN # 1 was asked to interpret the order. LPN # 1 stated, "I take 'mats' to be plural so there should be two mats, but I would like to confirm it with the unit manager and will get back to you." On 02/07/2022 at approximately 3:20 p.m., LPN # 1 stated, "There should have been a fall mat on both sides of Resident # 10's bed." On 02/07/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, ASM # 3, regional vice president of operations, and ASM # 4, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit.	F 689		

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F 689	Continued From page 63 2. The facility staff failed to provide and maintain safety equipment in the area where Resident #32 was observed smoking. During the entrance conference on 2/6/22, request was made for the facility to provide a list for smoking times and residents that smoke. Resident #32 was included in the five residents from the south wing and three residents from the north wing on the list provided on 2/6/22 at 3:30 PM. Resident #32 was admitted to the facility on 10/2/14 with diagnoses that included but were not limited to nicotine dependence. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/14/21, the resident scored 15 out of 15 on the BIMS (brief interview for mental status, indicating the resident is cognitively intact for making daily decisions. In section G of the MDS, the resident was coded as being independent with bed mobility, transfers, dressing, personal hygiene, bathing, eating and locomotion; walking did not occur. A review of the annual MDS assessment with an ARD of 8/6/21 revealed that in Section J-Health Conditions, the resident was coded as "no" for current tobacco use. A review of Resident #32's comprehensive care plan dated 10/15/21, revealed, in part, "FOCUS-Resident is a smoker and it has been determined that [name of Resident #32] is a safe smoker with supervision ...Resident educated on facility smoking times and compliance requirements to safely smoke. No O2 (oxygen) is to be in area of smokers. Smoking assessment	F 689		

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F 689	Continued From page 64 on admission, re-admission, quarterly and PRN with changes in condition. Will be educated on designated area and will comply with limiting smoking to that area. Will voice understanding of smoking area, smoking times and facility policy related to smoking." A review of the smoking evaluation dated 10/15/21 at 4:19 PM revealed, in part, "Evaluation: Resident utilizes tobacco. Poor vision or blindness: No. Balance problems while sitting or standing: No. Total or limited ROM in arms or hands: No. Insufficient fine motor skills needed to securely hold cigarette: No. Lethargic / falls asleep easily during tasks or activities: No. Burns skin, clothing, furniture or other: No. Drops ashes on self: No. Follow the facility's policy on location and time of smoking: Yes. Concerns: Able to light a cigarette safely. Able to hold a cigarette safely. Able to extinguish a cigarette safely. Able to use ashtray to extinguish a cigarette." An interview was conducted on 2/7/22 at 11:00 AM with Resident #32. When asked if he smoked, Resident #32 stated, "Yes, I have been smoking for years." When asked where he smokes, Resident #32 stated, "I smoke outside in the closed-in area. We go out of the doors on this wing now, because of COVID." On 2/7/22 at 3:00 PM, Resident #32 was observed to go to outside smoking area. The smoking area for South wing residents was supervised by two staff, with five residents smoking. LPN (licensed practical nurse) #8 distributed cigarettes and then lit each resident's cigarette. The smoking area contained a smoke blanket and a fire extinguisher with inspection tag	F 689		

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F 689	Continued From page 65 dated 2020-2021, and punch holes on months of June and September. An interview was conducted on 2/7/22 at 3:30 PM with OSM (other staff member) #6, social services. OSM #6 was one of the employees supervising the smoking area during the 3:00 PM smoking time for the south wing. OSM #6 was shown the fire extinguisher inspection tag and asked the purpose of the tag. OSM #6 stated, "It shows when the tag is inspected." When asked if the inspections were current, OSM #6 stated, "No, it is not." When asked what the dates 2020-2021 meant, OSM #6 stated, "It means the year." When asked who is responsible to maintain the fire extinguisher, OSM #6 stated, "I believe that would be maintenance." An interview was conducted on 2/7/22 at 3:54 PM with OSM #1, the maintenance director. When asked about the inspection tag on the fire extinguisher, OSM #1 stated, "Maintenance is responsible to check them monthly and then we have a company come in and perform the yearly check. I am not sure how this one was missed. I have replaced it now with one that is inspected." When asked when it was last inspected per the inspection tag, OSM #1 stated, "It was last checked September 2020." On 2/7/22 at 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations, ASM #4, the regional vice president of clinical services, and LPN (licensed practical nurse) #3, the assistant director of nursing were made aware of the concern. According to the facility's "Smoking Permitted"	F 689		

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F 689	Continued From page 66 policy, "Residents, visitors, and staff may smoke in designated areas only: a. Smoking area will be clearly identified; b. Smoking times will be identified; c. Oxygen will not be used in the smoking area d. The area will be kept clean and free of liter from smoking activities e. The area will be equipped with self-containing ashtrays f. The area will be equipped with smoking blanket(s) g. The facility will provide reasonable access to a call system h. A fire extinguisher will be kept in close proximity." No further information was provided prior to exit.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview and facility document review it was determined that the facility staff failed to provide respiratory services as ordered, and in a sanitary manner, for three of 51 residents in the survey sample, Residents #74, #28, and #41.	F 695	F 695 1. Residents # 74, Resident #28, and Residents # 41 oxygen flow rate was corrected immediately per physician order. 2. Director of Nursing/Designee will conduct an audit of all residents that utilize concentrators to ensure that they are on correct liter per physician orders. 3. The Director of Nursing/ Designee will educate the nursing staff regarding respiratory care, so that oxygen is provided consistent with professional standards of practice and delivered per physician orders.	

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F 695	Continued From page 67 The findings include: 1. The facility staff failed to administer oxygen at the ordered flow rate to Resident #74. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/19/2022, the resident was coded as being severely impaired for making daily decisions. Section O documented the resident receiving oxygen while a resident at the facility. On 2/6/2022 at approximately 2:15 p.m., Resident #74 was observed in bed wearing an oxygen nasal cannula with a humidifier bottle dated 2/4/22; this equipment was attached to an oxygen concentrator. The oxygen flow rate on the concentrator was observed to be set at 1.5 lpm (liters per minute). Resident #74 was observed to be alert, awake and non-verbal. Additional observations of Resident #74 on 2/6/2022 at approximately 4:15 p.m. and 2/7/2022 at approximately 8:15 a.m. revealed the oxygen flow rate to be set at 1.5 lpm. The physician order's for Resident #74 documented in part, "Oxygen therapy at 2 (two) liters per minute via nasal cannula. Start Date: 1/18/2022." The comprehensive care plan for Resident #74 failed to evidence documentation of oxygen administration. On 2/7/2022 at 2:35 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that staff checked the oxygen	F 695	4. The Director of Nursing/Designee will complete an audit of all residents with oxygen concentrators to ensure that that oxygen concentrator is set on the appropriate liter flow per physician order weekly x 4 weeks. The Director of Nursing will report to QAPI for review and recommendations. 5. Corrective Action/Audits to be completed by 3/18/2022.	

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F 695	Continued From page 68 settings every shift. LPN #1 stated that the oxygen rate was set by centering the metal ball of the flowmeter on the line showing the ordered oxygen flow rate on the concentrator. LPN #1 observed Resident #74's oxygen and stated that it was set at 1.5 lpm and she would verify the orders and correct this if needed. On 2/7/2022 at approximately 3:30 p.m., LPN #1 stated that they had confirmed the ordered oxygen rate of 2 lpm for Resident #74. The facility policy "Oxygen Administration" documented in part, "... 5. Turn on the oxygen at the number of liters / minute as ordered by the physician/practitioner. 6. Place appropriate oxygen device on the resident (i.e., mask, nasal cannula and/or nasal catheter). 7. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered..." On 2/7/2022 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations, and ASM #4, the vice president of clinical services were made aware of the findings. No further information was provided prior to exit. 2. The facility staff failed to store respiratory equipment in a sanitary manner for Resident #28. Resident #28 was admitted to the facility on 4/28/2016 with diagnoses that include, but were not limited to, chronic obstructive pulmonary disease (COPD). On the most recent MDS (minimum data set) assessment, an annual	F 695		

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F 695	Continued From page 69 assessment, with an ARD (assessment reference date) of 12/13/2021, the resident scored 13 out of 15 on the BIMS (Brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions. In Section O - Special Treatments, Procedures and Programs, the resident was coded as using oxygen while a resident at the facility. Observation was made of Resident #28 on 2/6/2022 at 2:59 p.m. The resident was in bed. She was not using her oxygen at that time. The oxygen tubing and nasal cannula were draped over the oxygen concentrator, and were not in a clean plastic bag. There was a plastic bag on the floor that was dated 1/13/2022. The resident was observed on 2/7/2022 at 7:41 a.m. in her bed with her oxygen in use via the nasal cannula. A third observation was made on 2/7/2022 at 3:23 p.m. The resident was in her bed, not using her oxygen at the time. The oxygen tubing with nasal cannula were draped over the oxygen concentrator, and it were not in a clean plastic bag. The physician order dated, 6/2/2021, documented, "Oxygen at 2L/min (liters per minute) via nasal cannula continuous as resident tolerates every shift." The comprehensive care plan dated 1/6/2022 documented, in part, "Focus: [Resident #28] has COPD, left middle lung malignancy, at risk for respiratory alterations...Oxygen as ordered." On 2/7/2022 at 3:24 p.m., LPN (licensed practical nurse) #8 was brought into Resident #28's room and asked to observe the oxygen tubing. When asked where oxygen tubing should be stored	F 695		

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F 695	Continued From page 70 when not in use, LPN #8 stated, it's supposed to be stored in a plastic bag, when not in use. LPN #3 went to get a bag. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #2, the director of nursing, ASM #4, the vice president of clinical operations, and LPN #3, the assistant director of nursing, were made aware of the above concern on 2/7/2022 at approximately 4:45 p.m. A review of the facility policy "Oxygen Administration" failed to reveal information related to the storage of oxygen equipment when not in use. No further information was obtained prior to exit. 3. The facility staff failed to maintain Resident # 41's oxygen flow rate at one liter per minutet, according to the physician's orders. Resident # 41 was admitted to the facility with diagnoses that included but were not limited to: respiratory failure and chronic obstructive pulmonary disease. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/10/2021, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 41 for "Oxygen Therapy" while a resident. On 02/06/2022 at approximately 3:23 p.m., an	F 695		

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F 695	Continued From page 71 observation of Resident # 41 revealed they were lying in bed receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate between 0.5 and 1.0 liters per minute. On 02/07/2022 at approximately 8:20 a.m., an observation of Resident # 41 revealed they were lying in bed receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate between 0.5 and 1.0 liters per minute. On 02/07/2022 at approximately 2:15 p.m., an observation of Resident # 41 revealed they were lying in bed receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate between 0.5 and 1.0 liters per minute. The physician order for Resident #41 documented, "O2 (oxygen) at 1 LPM (one liter per minute) via (by) NC (nasal cannula) every shift. Order Date: 12/01/2020." The comprehensive care plan for Resident # 41 dated 11/02/2021 documented, in part, "Focus: The resident has altered respiratory status/difficulty breathing r/t (related to) COPD (chronic obstructive pulmonary disease), respiratory failure. Date Initiated: 11/02/2021... OXYGEN as ordered. Date Initiated: 11/02/2021." On 02/07/2022 at approximately 2:30 p.m., an observation of Resident # 41's flow meter on their oxygen concentrator and interview was conducted with LPN (licensed practical nurse) # 1. When asked what the oxygen flow rate was	F 695		

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F 695	Continued From page 72 for Resident # 41, LPN # 1 read the flow meter and stated, "One and a half liters per minute." After reviewing the physician's order for Resident # 41's oxygen, LPN # 1 stated, "It should be one liter per minute." When asked why it was important to maintain the oxygen flow rate according to the physician's orders LPN # 1 stated, "They could become more dependent on it." On 02/07/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, ASM # 3, regional vice president of operations, and ASM # 4, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit.	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement a complete pain management program by documenting the location of the resident's pain and implementing non-pharmacological interventions prior to the administration of prn (as needed) pain medications for two of 51 residents in the survey	F 697	**F 697** 1. Non- pharmacological interventions for resident#25 and # 88 have been updated. 2. All residents may have been potentially affected. An audit will be done of all residents receiving pain medications. A Pain Intervention Order will be utilized for non-pharmacological interventions. 3. The Staff Educator/Designee will educate Nursing staff on the Policy Pain Management and Implementation/documentation.	

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F 697	Continued From page 73 sample, Residents # 25 and # 88. The findings include: 1. The facility staff failed to document the location of the Resident #25's pain and implementing non-pharmacological interventions prior to the administration of Tramadol (1). Resident # 25 was admitted to the facility with a diagnosis that included by not limited to osteoarthritis. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/10/2021, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section J0400 "Pain Frequency" coded Resident # 25 as "Almost constantly." Under "J0600. Pain Intensity" it documented, "A. Numeric Rating Scale (00-10) Ask resident: "Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine." (Show resident 00-10 pain scale).Enter two-digit response. Enter 99 if unable to answer." Resident # 25 was coded a "10." The physician's order sheet for Resident # 25 dated February 2022 documented in part: "Tramadol HCl (hydrogen chloride) Tablet. Give 25 mg (milligrams) by mouth every 6 (six) hours as needed for moderate to severe pain. Will come in 1/2 (half) tabs (tablets). Order Date: 06/17/2021. Start Date: 06/17/2021." The comprehensive care plan for Resident # 25	F 697	4. The Director of Nursing/Designee will review medical records of 10 residents weekly for 4 weeks to ensure non- pharmacological interventions are offered. The Director of Nursing will submit to QAPI for review and recommendations. 5. Corrective Action/Audit to be completed by 3/18 /2022	

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F 697	Continued From page 74 dated 08/01/2021 documented in part, "[Resident # 25] has the potential for pain/discomfort...The resident is able to: call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increase or alleviates pain. Date Initiated: 07/27/2021." The eMAR (electronic medication administration record) for Resident # 25 dated December 2021 documented the physician's order as stated above. Further review of the eMAR revealed Resident # 25 received 25 mgs (milligrams) of Tramadol on 12/08/2021 at 9:33 p.m. with pain level of eight, 12/15/2021 at 9:33 p.m. with pain level of four, 12/25/2021 at 4:06 a.m. with pain level of four and on 12/28/2021 at 8:43 a.m. with pain level of ten. Further review of the eMAR failed to evidence documentation of the location of Resident # 25's pain and non-pharmacological interventions attempted. The eMAR (electronic medication administration record) for Resident # 25 dated January 2022 documented the physician's order as stated above. Further review of the eMAR revealed Resident # 25 received 25 mgs of Tramadol on 01/09/2022 at 1:26 p.m. with pain level of eight, 01/12/2022 11:16 p.m. with pain level of eight, 01/17/2022 at 3:12 a.m. with pain level of four, 01/23/2022 at 10:31 a.m. with pain level of eight, 01/24/2022 at 4:30 a.m. with pain level of six, 01/26/2022 at 12:13 p.m. with pain level of eight, 01/27/2022 at 11:55 a.m. with pain level of five, 01/28/2022 at 4:30 a.m. with pain level of six and on 01/31/2022 at 2:21 a.m. with pain level of one. Further review of the eMAR failed to evidence documentation of the location of Resident # 25's pain and non-pharmacological interventions	F 697		

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F 697	Continued From page 75 attempted. The eMAR (electronic medication administration record) for Resident # 25 dated February 2022 documented the physician's order as stated above. Further review of the eMAR revealed Resident # 25 received 25 mgs of Tramadol on 02/02/2022 at 3:45 a.m. with pain level of seven. Further review of the eMAR failed to evidence documentation of the location of Resident # 25's pain and non-pharmacological interventions attempted. Review of the facility's nursing progress notes for Resident # 25 dated 12/01/2021 through 02/07/2022 failed evidence documentation of the location of Resident # 25's pain and non-pharmacological interventions attempted for the dates Resident # 25 received 25 mgs of Tramadol on the dates and times stated above on the eMARs. On 02/06/22 at 2:37 p.m., an interview was conducted with Resident # 25 regarding pain. When asked if they experience pain and where their pain is located Resident # 25 stated, "I have pain in my stomach." When asked if they receive pain medication as needed Resident # 25 stated yes. When asked if nursing staff try to alleviate their pain before administering their medication Resident # 25 stated no. On 02/07/2022 at approximately 10:35 a.m., an interview was conducted with LPN (licensed practical nurse) # 1 regarding the procedure for administering prn pain medication and documentation of non-pharmacological interventions. LPN # 1 stated, "Assess the resident's pain, where the pain is and using a	F 697		

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F 697	Continued From page 76 scale one to ten, with ten being the worse pain. Attempt other techniques to alleviate their pain, if it doesn't work check the order for prn pain medication and administer it. Recheck the resident 30 minutes after giving the medication to see if it was effective." When asked how often the non-pharmacological interventions should be attempted LPN # 1 stated, "Every time when giving the prn pain medication." When asked about documenting location of the resident's pain and attempts of non-pharmacological interventions LPN # 1 stated, "It's documented on the comments section of the MARs (medication administration record) or the nurses' notes." On 02/08/2022 at approximately 11:04 a.m., an interview was conducted with LPN # 1. After reviewing the physician's orders, eMARs dated December 202, January 2022 and February 2022, the nurses' progress notes dated 12/01/2021 through 02/07/2022 for Resident # 25, LPN # 1 was asked if there was documentation of the location Resident # 25's pain and that non-pharmacological interventions were attempted prior to Resident # 25 receiving the physician ordered pain medication of Tramadol. LPN # 1 stated no. The facility's policy "Pain Management" documented in part, "Various strategies and modalities may be utilized to assist the resident in achieving optimal comfort. Such strategies and modalities may include, but are not limited to: a. Non-pharmacological interventions may be appropriate alone or in conjunction with medications. Some non-pharmacological interventions include: i. Environmental - adjusting the room temperature, smoothing the linens, providing a pressure-reducing mattress,	F 697		

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F 697	Continued From page 77 repositioning, etc.; ii. Physical - ice packs, cool or warm compresses, baths, transcutaneous electrical nerve stimulation (TENS), massage, acupuncture, etc.; iii. Exercise - range of motion exercises to prevent muscle stiffness and contractures; iv. Cognitive or Behavioral - relaxation, music, diversions, activities, etc." On 02/08/2022 at approximately 1:50 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit. References: (1) Tramadol is used to relieve moderate to moderately severe pain. Tramadol is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html. 2. The facility staff failed to by documenting the location of the Resident # 88's pain and implementing non-pharmacological interventions prior to the administration of Norco (hydrocodone-acetaminophen) (1). Resident # 88 was admitted to the facility with a diagnosis that included but was not limited to chronic pain. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment	F 697		

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F 697	Continued From page 78 reference date) of 01/26/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section J0400 "Pain Frequency" coded Resident # 88 as "Frequently." Under "J0600. Pain Intensity" it documented, "A. Numeric Rating Scale (00-10) Ask resident: "Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine." (Show resident 00-10 pain scale).Enter two-digit response. Enter 99 if unable to answer." Resident # 88 was coded a "6 (six)." The current POS (physician's order sheet) for Resident # 88 documented in part, "Norco Tablet 5-325 (five to 325) MG (HYDROcodoneAcetaminophen). Give 1 (one) tablet by mouth every 4 hours as needed for Pain. For pain 1-5 Tyl 6-10 Norco. Order Date: 08/04/2020. Start Date: 08/04/2020." The comprehensive care plan for Resident # 88 dated 08/12/2021 documented in part, "Focus: [Resident # 88] has the potential for pain/discomfort r/t Arthritis ...Offer non-pharm (non-pharmacological) interventions for pain Date initiated: 10/27/2021." The eMAR (electronic medication administration record) for Resident # 88 dated January 2022 documented the physician's order as stated above. Further review of the eMAR revealed Resident # 88 received 5-325 mgs of Norco on 01/01/2022 at 2:06 a.m. with pain level of six, 01/02/2022 at 4:00 a.m. with pain level of seven and at 7:23 p.m. with pain level of eight, 01/03/2022 at 7:33 p.m. with pain level of six,	F 697		

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F 697	Continued From page 79 01/04/2022 at 2:00 a.m. with pain level of six and at 7:22 p.m. with pain level of six, 01/05/2022 at 1:30 a.m. with pain level of six, 01/06/2022 at 1:00 a.m. pain level of six, 01/07/2022 at 12:00 a.m. with pain level of seven and at 7:30 p.m. with pain level of seven, 01/08/2022 at 7:14 p.m. with pain level of six, 01/09/2022 at 1:30 a.m. with pain level of seven and at 7:46 p.m. with pain level of six, 01/10/2022 at 1:00 a.m. with pain level of six, 01/11/2022 at 1:00 a.m. with pain level of seven, 01/12/2022 at 2:24 a.m. with pain level of eight and at 7:24 p.m. with pain level of seven, 01/13/2022 at12:30 a.m. with pain level of seven and at 8:14 p.m. with pain level of six, 01/14/2022 at 8:33 p.m. with pain level of six, 01/18/2022 at 7:54 p.m. with pain level of six, 01/20/2022 at 2:34 a.m. with pain level of six, 01/2/1/2022 at 2:03 a.m. with pain level of eight, 01/22/2022 at 7:23 p.m. with pain level of six, 01/23/2022 at 9:43 p.m. with pain level of six, 01/24/2022 at 2:00 a.m. with pain level of seven, 01/25/2022 at 2:00 a.m. with pain level of seven, 01/26/2022 at 12:25 a.m. with pain level of six and at 7:40 p.m. with pain level of six, 01/27/2022 at 1:00 a.m. with pain level of six, 01/28/2022 at 2:00 a.m. with pain level of six and at 7:46 p.m. with pain level of six, 01/29/2022 at 1:45 a.m. with pain level of six, and on 01/31/2022 at 7:25 a.m. with pain level of six. Further review of the eMAR failed to evidence documentation of the location of Resident # 88's pain and non-pharmacological interventions attempted. The eMAR (electronic medication administration record) for Resident # 88 dated February 2022 documented the physician's order as stated above. Further review of the eMAR revealed Resident # 88 received 5-325 mgs of Norco on 02/02/2022 at 1:45 a.m. with pain level of seven	F 697		

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F 697	Continued From page 80 and at 7:58 p.m. with pain level of six, 02/04/2022 at 2:10 a.m. with pain level of six, 02/05/2022 at 7:22 p.m. with pain level of six, 02/06/2022 at 1:30 a.m. with pain level of six and at 7:42 with pain level of six and on 07/07/2022 at 1:30 a.m. with pain level of six. Further review of the eMAR failed to evidence documentation of the location of Resident # 88's pain and non-pharmacological interventions attempted. Review of the facility's nursing progress notes for Resident # 88 dated 12/01/2021 through 02/07/2022 failed to evidence documentation of the location of Resident # 88's pain and non-pharmacological interventions attempted for the dates Resident # 88 received 5-325 mgs of Norco on the dates and times stated above on the eMARs. On 02/06/22 at 2:10 p.m., an interview was conducted with Resident # 88 regarding their pain. Resident # 88 stated that they have arthritis pain in their hand and left knee. When asked if they receive pain medication as needed Resident # 88 stated yes. When asked if nursing staff try to alleviate their pain before administering their medication Resident # 88 stated, "No, they just give me the pain medication and say I hope it helps." On 02/07/2022 at approximately 10:35 a.m., an interview was conducted with LPN (licensed practical nurse) # 1 regarding the procedure for administering prn (as needed) pain medication and documentation of non-pharmacological interventions. LPN # 1 stated, "Assess the resident's pain, where the pain is and using a scale one to ten, with ten being the worse pain. Attempt other techniques to alleviate their pain, if	F 697		

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F 697	Continued From page 81 it doesn't work check the order for prn pain medication and administer it. Recheck the resident 30 minutes after giving the medication to see if it was effective." When asked how often the non-pharmacological interventions should be attempted LPN # 1 stated, "Every time when giving the prn pain medication." When asked about documenting location of the resident's pain and attempts of non-pharmacological interventions LPN # 1 stated, "It's documented on the comments section of the MARs (medication administration record) or the nurses' notes." On 02/08/2022 at approximately 11:04 a.m., an interview was conducted with LPN # 1. After reviewing the physician's orders, eMARs dated December 202, January 2022 and February 2022, the nurses' progress notes dated 12/01/2021 through 02/07/2022 for Resident # 88, LPN # 1 was asked if there was documentation of the location Resident # 88's pain and that non-pharmacological interventions were attempted prior to Resident # 88 receiving the physician ordered pain medication of Norco. LPN # 1 stated no. On 02/08/2022 at approximately 1:50 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 4, vice president of clinical services, were made aware of the findings. No further information was provided prior to exit. References: (1) Hydrocodone is an opioid pain medication. An opioid is sometimes called a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of hydrocodone. The	F 697		

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F 697	Continued From page 82 combination of acetaminophen and hydrocodone is used to relieve moderate to severe pain. This information was obtained from the website: https://www.rxlist.com/Norco-5-325-drug/patient-images-side-effects.htm.	F 697		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to complete an assessment for the use of side rails and/or failed to have consent, after discussion of the risks and benefits for the use of the bed rails, for	F 700	F 700 1. Consent has been obtained for use of bedrails for Residents # 11, #40, and #28. 2. All other residents may have potentially been affected. A facility audit was completed by the Director of Nursing/Designee for all residents who have bed rails to ensure informed consent has been completed. 3. The Director of Nursing/Designee will educate all nursing staff on the UDA documentation for Bedrail consents and assessments. 4. The Director of Nursing /Designee will review medical records of newly admit residents weekly for 4 weeks to ensure that Bed Rail consents are completed, and UDAs are initiated. The Director of Nursing will provide QAPI for review and recommendations. 5. Corrective Action/Audits to be completed by 3/18/2022.	

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F 700	Continued From page 83 three of 51 residents in the survey sample, Residents #11, #40 and #28. The findings include: 1. The facility staff failed to obtain consent, after a discussion of the risks and benefits for the use of the bed rails, from the responsible party, for Resident #11. Resident #11 was admitted to the facility 7/11/2015. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/17/2021, the resident was coded as having short and long term memory problems and severely cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of two staff members for moving in the bed. Observation was made of Resident #11 on 2/6/2022 at 2:10 p.m. The resident observed to be in her bed, with both side rails up. The "Bed Rail Assessment" dated, 2/4/2022 at 1:31 p.m., failed to evidence documentation of the discussion of the risks and benefits for the use of the bed rails, with the responsible party. The nurse who completed this assessment was not available for interview during the survey. Review of the nurse's notes failed to evidence documentation of the discussion and consent for the use of the side rails with the responsible party. The physician orders dated, 5/29/2019,	F 700		

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F 700	Continued From page 84 documented, "1/4 (quarter) side rails to aid with bed mobility and positioning as needed." The comprehensive care plan dated, 11/17/2021, documented in part, "Focus: [Resident #11] has an ADL (activities of daily living) self-care performance deficit r/t (related to) Alzheimer's Dementia." The "Interventions" documented in part, "1/4 side rails to aid with bed mobility and positioning." An interview was conducted with LPN (licensed practical nurse) #2 on 2/8/2021 at 11:52 a.m. The above side rail assessment was reviewed with LPN #2. When asked how does the nurse complete the side rail assessment, LPN #2 stated she didn't think she had done one like the form above. I feel like therapy assesses for side rails. LPN #2 stated everything has changed with the assessments. I feel we do them with the quarterly assessment along with the fall assessments. When asked if the facility should have consent for the use of side rails, after a discussion with the resident and/or responsible party, LPN #2 stated, yes, we document it in the nurse's notes. An interview was conducted with LPN, the unit manager, #7 on 2/8/2022 at 1:17 p.m. When asked the process for a resident to have side rails, LPN #7 stated, for most residents they are used for bed mobility. When asked if a consent and discussion with the resident and/or responsible party is required for the use of the side rails, LPN #7 stated there once was a form included in teh admission paperwork that was signed upon admission. When asked if that document stated the risks and benefits for the use of the side rails, LPN #7 stated she could not	F 700		

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F 700	Continued From page 85 remember. The above bed rail assessment was reviewed with LPN #7. When asked who the nurse completing the assessment documents the discussion with the resident and/or responsible party and the consent to use them, LPN #7 asked if there was a second page to this assessment, she was told that was what was received. LPN #7 requested to look into the matter and get back with this writer. On 2/8/2022 at 1:50 p.m., LPN #7 returned and stated that when the new company took over this building the consents are part of the admission paperwork. LPN #7 further stated they have nothing for [Resident #11] as she has been here for a long time. The facility policy, "Bed Inspection and Safety" documented in part, "1. The resident's sleeping environment shall be evaluated by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of clinical services, were made aware of the above concern on 2/8/2022 at 2:05 p.m. No further information was obtained prior to exit. 2. The facility staff failed to complete an assessment and obtain consent, after a discussion of the risks and benefits for the use of the bed rails, from the resident and/or responsible party, for Resident #40.	F 700		

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F 700	Continued From page 86 Resident #40 was admitted to the facility on 11/19/2019. On the most recent MDS (minimum data set), a quarterly assessment with an ARD of 12/17/2021, the resident scored a 12 out of 15 om the BIMS (brief interview for mental status) indicating the resident is moderately cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member for moving in the bed. Observation was made of Resident #40 on 2/6/2022 at 2:10 p.m. The resident was in her bed, with both side rails up. Review of the clinical record failed to evidence documentation of a bed rail assessment. Review of the nurse's notes failed to evidence documentation of a discussion with the resident and/or responsible party for the risks and benefits for the use of side rails. The physician orders dated 11/20/2019, documented, "quarter rails to bed to promote turn and repositioning as well as independence." The comprehensive care plan dated, 8/17/2021, documented in part, "Focus: [Resident #40] has the potential for ADL self-care performance deficit r/t depression, dizziness, anxiety." The "Interventions" documented in part, "1/4 side rails to promote independence with repositioning." On 2/7/2022 at 1:36 p.m. ASM (administrative staff member) #2, the director of nursing, stated the facility doesn't have side rails assessments or consents for most of the residents.	F 700		

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F 700	Continued From page 87 On 2/7/2022 at 4:57 p.m., ASM #2 stated they had no side rail assessments or consents for Resident #40. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of clinical services, were made aware of the above concern on 2/8/2022 at 2:05 p.m. No further information was obtained prior to exit. 3. The facility staff failed to complete an assessment and obtain consent, after a discussion of the risks and benefits for the use of the bed rails, from the resident and/or responsible party, for Resident #28. Resident #28 was admitted to the facility on 4/28/2016. On the most recent MDS (minimum data set) assessment, an annual assessment, with an ARD of 12/13/2021, the resident scored 13 out of 15 on the BIMS, indicating the resident is not cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member for moving in the bed. Observation was made of Resident #28 on 2/6/2022 at 2:12 p.m. The resident was observed to be in her bed, with both side rails up. Review of the clinical record failed to evidence documentation of a side bed rail assessment. Review of the nurse's notes failed to evidence	F 700		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	02/08/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 88 documentation of a discussion with the resident and/or responsible party for the risks and benefits for the use of side rails. The physician order dated, 5/20/2019, documented in part, "Quarter side rails up x2 (both sides) for independence in position and bed mobility." The comprehensive care plan dated, 7/22/2021, documented in part, "Focus: [Resident #28] has a potential for ADL self-care performance deficit r/t hx (history) of CVA (stroke) with right sided weakness." The "Interventions" documented in part, "1/4 side rails to promote independence with positioning and bed mobility." On 2/7/2022 at 1:36 p.m. ASM (administrative staff member) #2, the director of nursing, stated the facility doesn't have side rails assessments or consents for most of the residents. On 2/7/2022 at 4:57 p.m., ASM #2 stated they had no side rail assessments or consents for Resident # 28. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of clinical services, were made aware of the above concern on 2/8/2022 at 2:05 p.m. No further information was obtained prior to exit.	F 700		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review	F 730	F 730 1. CNA # 3 has had a documented performance review completed.	

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F 730	Continued From page 89 of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and employee record review, it was determined that the facility staff failed to evidence documentation for one of four CNA (certified nursing assistant) employee records reviewed, CNA #3. For CNA #3, the facility staff failed to evidence documentation of an annual performance review. The findings include: A review was conducted of four CNA employee records for the documentation of an annual performance review. CNA #3 failed to have documented evidence of a performance review. A request was made for the above records on 2/7/2022 at the end of day meeting at approximately 4:45 p.m. On 2/8/2022 at approximately 9:00 a.m., OSM (other staff member) # 3, human resources, reviewed the requested documents with this surveyor and stated she'd return with answers after looking further. On 2/8/2022 at 11:00 a.m., OSM #3 presented a "Critical Skills Checklist" dated 7/8/2021. OSM #3 stated she could not find any other documentation of an annual performance review for CNA #3.	F 730	2. All employees' files will be audited by Human Resources for yearly Performance Review due dates. A schedule and a tracking sheet will be developed and implemented for each employee. 3. The Human Resource Dept will disperse to Department Heads, as appropriate to complete evaluations within a time frame for completion for yearly performance reviews. The Human Resource Department will Educate the Department Heads on the importance of completing annual evaluations timely. 4. The Human Resource Department will do an audit of all employees to ensure yearly review has been completed timely. 5. Corrective Action/Audits to be completed by 3/18/2022	

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F 730	Continued From page 90 The facility policy, "Nurse Aide In-service Training," documented in part, 2: "The facility completes a performance review of nurse aides at least annually." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 2/8/2022 at 2:05 p.m. No further information was obtained prior to exit.	F 730		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to	F 732	F 732 1. The facility failed to post the daily nursing staff data for the public to view. 2. The staffing posting information will be updated and posted to reflect the current census and changes to the staffing by the receptionist and Charge Nurse staff daily every am and beginning of every shift. 3. The Staffing Coordinator will educate and inservice the all the Receptionists and Charge Nurse Staff on the posting of the nursing staff data. 4. The Staffing Coordinator will audit the posting of the daily staffing to ensure that the posting is up daily with the number of staff and current staff and current census daily for 4 weeks. 5. Corrective Action/Audits to be completed by 3/18/2022.	

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F 732	Continued From page 91 residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility staff failed to post the daily nursing staff posting on 2/6/2022. The findings include: Observation was made of the nursing staff posting on the wall outside the door to the receptionist area on 2/6/2022 at 1:00 p.m. The nursing staff posting was dated 2/4/2022. Observation was made of the nursing staff posting outside the receptionist area on 2/7/2022 at 7:30 a.m. The nursing staff posting was dated 2/4/2022. An interview was conducted with OSM (other staff member) #8, the staffing coordinator, on 2/7/2022 at 11:44 a.m. When asked who does the staff posting sheets, OSM #8 stated, [name of OSM #9]. An interview was conducted with OSM #9, the	F 732		

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F 732	Continued From page 92 accounts payable/receptionist, on 2/7/2022 at 11:45 a.m. When asked the process for the staff posting, OSM #9 stated she gets the information from the [name of computer program] that gives her the staff and times. When asked when she puts the paper in the frame in the lobby, OSM #9 stated she arrives at the around 7:30 a.m., does her rounds and then posts it. When asked who changes the staff posting based on changes in the schedules, OSM #9 stated, [name of OSM #3]. When asked who posts the document on the weekends, OSM #9 stated there is no one to put it up on the weekends, as the weekend staff do not have access to the computer program. An interview was conducted with OSM #3, the human resources staff member on 2/7/2022 at 11:54 a.m. When asked how the posting is done on a daily basis, OSM #3 stated the daily schedule is put in [name of computer program] and then the receptionist puts it up on the wall. When asked who does the posting on the weekends, OSM #3 stated the part-time receptionist is responsible for putting it up. The facility policy, "Posting Direct Care Daily Staffing" documented in part, "POLICY: Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. SPECIFIC PROCEDURES / GUIDANCE: 1. At the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format ...The shift supervisor or designee will compute the number of direct care	F 732		

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F 732	Continued From page 93 staff and complete the facility designated form. The shift supervisor /designee will date the form, record the census, and post the staffing information in the location(s) designated by the administrator. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 2/8/2022 at 2:05 p.m. No further information was obtained prior to exit.	F 732		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to provide food at a palatable temperature during lunch service on 2/7/2022, with the potential to affect 53 of 54 residents on the North unit receiving a meal tray. The findings include: Review of the resident council minutes from a	F 804	F 804 1. Food will be served at a safe and appetizing temperature. The meals for Resident 88, 25, 28, 8 will be monitored for temperature and taste at time of service. 2. All residents may potentially be affected by this finding. 3. Upon inspection, it was found the dual sided plate warmer heating unit on one side, had a malfunctioning heating unit. The heating unit has been ordered and plates are additionally being warmed in a heated cart to help plates aid in keeping plates and food at temperature.	

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F 804	Continued From page 94 meeting held on 1/31/2022. The minutes stated: "...1. Food- not being cooked/too tough. Cold food- Getting trays late. Resident requested hot..." A resident comments/concerns form dated 1/31/22 included in the minutes documented in part, "...Resident c/o (complains of) food being cold when they get it. 2. They want hot coffee. 3. Some of the food is too tough to eat. - The food is at temp (temperature) when it leaves the kitchen- we do not have any control of when it is delivered. The coffee is served at 160 (degrees) in an insulated mug. We will speak to DON (director of nursing). Tough food is most likely pork chops. We are working on that as we speak. Trying to find a way to tenderize them better. [Signature of OSM (other staff member) #7, dietary manager]." Resident #88's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/26/2022, coded the resident as being cognitively intact. On 2/6/2022 at 2:06 p.m., an interview was conducted with Resident #88. The resident stated the facility food was sometimes cold. Resident #25's most recent MDS, a quarterly assessment with an ARD of 12/10/2021, coded the resident as being cognitively intact. On 2/6/2022 at 2:40 p.m., an interview was conducted with Resident #25. The resident stated the facility food had no taste and was not always hot when served. Resident #28's most recent MDS, an annual assessment with an ARD of 12/13/2021, coded the resident as being cognitively intact. On 2/6/2022 at 3:23 p.m., an interview was conducted with Resident #28. The resident stated the facility food was cold when they	F 804	4. A test tray on each food delivery cart will be created and food component temperatures taken at the time the cart leaves the kitchen and at the time the last tray is served. Variances will be recorded on an Audit Tool to monitor performance. This will occur for 4 weeks to assure meals are served at a safe and appetizing temperature. The results will be acted on immediately and reported at the monthly QAPI Meeting. 5. Completion Date: 3/18/2022	

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F 804	Continued From page 95 received it. Resident #8's most recent MDS, an admission assessment with an ARD of 11/9/2021, coded the resident as being moderately impaired. On 2/6/2022 at 3:07 p.m., an interview was conducted with Resident #8. The resident stated the facility food was bland and sometimes cold. On 2/7/2022 at 11:25 a.m., the holding temperatures of lunch food items were obtained from the service line in the kitchen and were (in degrees Fahrenheit): Pot roast- 167 Peas- 190 Butter noodles- 164 Puréed noodles- 172 Puréed peas- 176 Puréed beef- 178 After the holding temperatures were obtained, plates were prepared, covered with a lid, placed in food carts and taken to units. On 2/7/2022 at 12:28 p.m., a test tray was plated and sent to the North unit in the food cart with resident trays. On 2/7/2022 at 12:44 p.m. (when the final meal was served on the North unit), the temperatures of the food on the test tray were obtained by OSM #7, the dietary manager and OSM #4, the dietary supervisor. The temperatures were: Pot roast- 90 Peas- 90 Buttered noodles- 108 Puréed noodles- 104 Puréed peas- 110 Puréed beef- 90 The food on the test tray was sampled by two surveyors who determined the pot roast, peas,	F 804		

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F 804	Continued From page 96 pureed beef and buttered noodles were not warm enough to be palatable. OSM #4 confirmed this and stated these food items could be warmer. On 2/8/2022 at approximately 1:50 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy on serving food at a palatable temperature. The facility policy, "Food and Nutrition Services" documented in part, "Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident..." On 2/7/2022 at 5:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations, and ASM #4, the vice president of clinical services, were made aware of the findings. No further information was presented prior to exit.	F 804		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted	F 842	F 842 1. Level II PASARR information was obtained for #83 and scanned into medical records on 2/22/2022. 2. 100 0/0 audit will be completed by the Social Worker to identify any potential residents that could have been affected regarding the need for Level II PASARR 3. Admission Director/Designee will review PASARR's of all new admissions for completions of PASARRs and all recommendations are followed through.	

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F 842	Continued From page 97 professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842	4. Admissions Director/Designee will audit all new admission PASARRs weekly for 4 weeks then monthly on an ongoing basis to ensure PASARRs are complete and scanned into medical records. A report will be given monthly at QAPI meeting. 5. Corrective Action/Audit to be completed by 3/18/2022	

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F 842	Continued From page 98 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate clinical record for 1 of 51 residents in the survey sample, Resident #83. The facility staff failed to ensure that the PASRR (Pre-admission Screening and Resident Review) level 2 screening was available on the clinical record. The findings include: Resident #83 was admitted to the facility on 3/13/18 and had the diagnoses of but not limited to stroke, bipolar, and depression. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/25/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. The resident was coded as requiring extensive assistance for bathing and supervision for all other areas of	F 842		

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F 842	Continued From page 99 activities of daily living. A review of the clinical record revealed a PASRR level 1 screening dated 2/14/18 that documented, "5. Recommendation....Refer for secondary assessment...." Further review of the clinical record failed to reveal any evidence that the level 2 screening had been completed. On 2/08/22 at 9:06 AM, ASM #2 (Administrative Staff Member, the Director of Nursing) stated, "We do not have the level 2 at this time. The resident came from another facility, plus the current ownership does not have access to previous company records. We are making calls to see what they can get." On 2/08/22 at 11:17 AM, an interview was conducted with OSM #2 (Other Staff Member, the Director of Social Services). She stated that she "was not in this department at that time. Typically, a level 2 is done before admission. This is the first time I ever ran into this. Typically when the Level 1 was done and they recommended the Level 2, it should have been followed through with before we admitted her." On 2/08/22 at 1:05 PM, OSM #2 provided this surveyor a copy of the level 2 screening. This screening had a fax date stamp of 2/8/22 at 12:39 PM, indicating the facility received it from elsewhere and that it had not been on the clinical record. A review of the level 2 screening, which was dated 3/2/18, documented, "Specialized services are not indicated." OSM #2 stated that the company that performed the level 2 screening apologized for not having provided the level 2	F 842		

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	495255	A. BUILDING _____ B. WING _____	02/08/2022

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F 842	Continued From page 100 documentation to the facility at the time of the screening. On 2/08/22 at 2:08 PM, at the "End of Day" meeting, ASM #1 (the Administrator) and ASM #2 were made aware of the findings. No further information was provided by the end of the survey. A review of the facility policy "Charting and Documentation" revealed, "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, will be documented in the resident's medical record. The medical record will facilitate communication between the interdisciplinary team regarding the resident's condition and response to care." No further information was provided prior to exit.	F 842		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (I) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (II) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (III) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883	F 883 1. Resident # 91 was administered the pneumococcal vaccine. 2. All other residents may have potentially been affected. The Staff Educator/Designee will educate all nursing staff on policy Pneumococcal Vaccine and documentation requirements. 3. The Staff Educator/Designee will educate all nursing staff on policy Pneumococcal Vaccine and documentation requirements and importance of implementation. A facility audit was completed of all	

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F 883	Continued From page 101 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 883	residents who consented to a pneumococcal vaccine to ensure administration was complete. 4. The ADON/Designee will complete an audit of all residents. The Director of Nursing will submit to QAPI for review and recommendations. 5. Corrective Action/Audits to be completed by 3/18/2022	

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F 883	Continued From page 102 Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to administer the pneumococcal immunization for one of five resident immunization record reviews, Resident 91. Resident #91's RR (resident representative) provided consent for the pneumococcal immunization on 12/29/21. The facility staff failed to evidence the immunization was administered to the resident. The findings include: Resident #91 was admitted to the facility on 7/11/14. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/27/22, the resident scored 5 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely cognitively impaired for making daily decisions. Review of Resident #91's clinical record revealed a consent for the pneumococcal immunization form dated 12/29/21 that documented a check mark beside, "I hereby GIVE the facility permission to administer a pneumonia VACCINATION, unless medically contraindicated." The verbal consent was obtained from Resident #91's RR via phone by two nurses. Further review of Resident #91's clinical record, including the immunization record, failed to reveal documentation regarding the administration of the pneumococcal immunization. On 2/8/22 at 11:52 a.m., an interview was	F 883		

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F 883	Continued From page 103 conducted with LPN (licensed practical nurse) #2. LPN #2 stated nurses obtain consent for the pneumococcal immunization from residents' family members if the residents are not their own representative, and then the immunization is ordered by the physician, obtained from the pharmacy and usually administered within a few days. On 2/8/22 at 1:52 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional vice president of clinical services) were made aware of the above concern. The facility policy "Pneumococcal Vaccine" documented, "6. Consent for the administration of the pneumococcal vaccination will be obtained from the resident and/or resident's representative prior to administration of the vaccine...7. Administration of the pneumococcal vaccination will be documented on the Medication Administration Record and/or Vaccination Log for the month/hear given, manufacturer, expiration date and lot number and name of person administering the vaccine." No further information was presented prior to exit.	F 883		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(l)(1)-(3)(i)-(x) §483.80(l) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed	F 888	F 888 1. A list was obtained from the facility hospice care provider (the facility had 1 hospice patient served by said company) documenting the hospice company's employee proof of vaccination per facility policy and procedure. Proof of vaccination was obtained for the	

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F 888	Continued From page 104 a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for	F 888	various hospice company employees who entered the facility. 2. Communications were provided to the hospice company(ies) regarding immediate updates to the facility when a change may occur, i.e., a new employee is retained and served the facility resident. 3. A sign-in log has been added to assure identification of any vendors who enter the facility, they are screened and reminded of the requirement to be fully vaccinated or exempted from vaccination for use of special PPE to always include the use of an N95 while in the facility and proof of weekly testing with negative results. This was communicated to the hospice provider. 4. The Infection Control Preventionist will audit the sign-in log for vendors and matched to adherence to the vaccination policy of the facility. 5. Completion date: 3/18/2022	

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F 888	Continued From page 105 whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (l)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all	F 888		

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F 888	Continued From page 106 applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff	F 888		

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F 888	Continued From page 107 failed to track all employees' COVID-19 vaccination status, and failed to implement the facility policy for employee vaccination tracking for 6 of 100 employees sampled, OSM (other staff member) #10, #11, #12, #13, #14, and #15. The facility staff failed to implement their policy for COVID-19 employee vaccination status tracking, and failed to track COVID-19 vaccination status for OSM #10, #11, #12, #13, #14, and #15, all employees of [name of Hospice Company]. The findings include: The facility policy titled, "COVID-19 (SARS-CoV-2) Vaccination Policy- Employee" documented, "4. Procedures- [Name of facility company] requires all employees, and all volunteers and contractors working on-site, to be 'fully vaccinated' against COVID-19. Employees must provide proof of full vaccination status either by proof of vaccination via the Vaccination Attestation form...To establish they have received the COVID-19 vaccine, employees must [sic] one of the following: CDC (Centers for Disease Control) vaccination card (recommended); Healthcare provider documentation; or State immunization information system documentation..." Review of the facility staff COVID-19 vaccination matrix failed to reveal documentation regarding Hospice contract staff. On 2/8/22 at 9:07 a.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated "[name of Hospice Company] can only give	F 888		

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F 888	Continued From page 108 us a statement that all staff are vaccinated." On 2/8/22 at 9:34 a.m., an interview was conducted with OSM (other staff member) #2 (the social services director). OSM #2 stated she had not previously addressed Hospice staff vaccination status but she talked to someone from the Hospice human resources department this morning. OSM #2 stated the hospice company would not send copies of employees' COVID-19 vaccination cards due to confidentially but the company would send a letter documenting all employees follow vaccine mandates unless it's an approved exemption. On 2/8/22 at 10:03 a.m., an interview was conducted with OSM #3 (human resources director). OSM #3 stated the facility usually obtains copies of employees' COVID-19 vaccination cards but the facility had not obtained validation of [name of Hospice Company's] employees COVID-19 vaccination cards. On 2/8/22 at 1:52 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional vice president of clinical services) were made aware of the above concern. No further information was presented prior to exit.	F 888		
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased	F 909	F 909 1. The bed inspection for residents 11, 40 and 28 will be completed to assure bed safety; to include the bed rails. Monthly bed checks are performed as part of our bed	

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F 909	Continued From page 109 separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to have an annual inspection of three resident beds of 52 beds in the survey sample, Resident #11, #40, and #28. The findings include: 1. For Resident #11, the facility staff failed to complete an annual bed inspection. Resident #11 was admitted to the facility 7/11/2015. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/17/2021, the resident was coded as having short and long term memory problems and severely cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of two staff members for moving in the bed. Observation was made of Resident #11 on 2/6/2022 at 2:10 p.m. The resident observed to be in her bed, with both side rails up. The physician orders dated, 5/29/2019, documented, "1/4 (quarter) side rails to aid with bed mobility and positioning as needed." The comprehensive care plan dated, 11/17/2021, documented in part, "Focus: [Resident #11] has	F 909	safety quality assurance with an annual inspection through a contract service. 2. The potential for missed bed inspections can affect all residents. A comprehensive bed inspection will be completed to assure all beds have been inspected. 3. Ongoing bed inspections will take place monthly, with an annual inspection completed by a contract service. Findings will be reviewed daily for action, as needed. 4. An interim audit of 15 bed inspections per week will be completed for 4 weeks and findings will be documented and reviewed at the monthly QAPI meeting. 5. Completion date: 3/18/2022	

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F 909	Continued From page 110 an ADL (activities of daily living) self-care performance deficit r/t (related to) Alzheimer's Dementia ...1/4 side rails to aid with bed mobility and positioning." A request was made on 2/7/2022 at 10:30 a.m. for the documentation of the bed inspections. On 2/7/2022 at 3:09 p.m. OSM (other staff member) #1, the maintenance director, stated that the beds that were requested had not been inspected when other beds in the facility were reviewed at the time of the previous inspection. OSM #1 further stated that at the time of the last inspection, 2/24/2021, the facility was in an outbreak of COVID and the inspectors would not go behind the plastic barrier walls to do the inspection. The facility policy "Bed Inspections and Safety" documented in part, "2.To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall conduct regular bed safety inspections and will promote the following approaches: a) Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 2/8/2022 at 2:05 p.m. No further information was obtained prior to exit.	F 909		

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	495255	A. BUILDING _____ B. WING _____	02/08/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 909	Continued From page 111 2. For Resident #40, the facility staff failed to complete an annual bed inspection. Resident #40 was admitted to the facility on 11/19/2019. On the most recent MDS (minimum data set), a quarterly assessment with an ARD of 12/17/2021, the resident scored a 12 out of 15 om the BIMS (brief interview for mental status) indicating the resident is moderately cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member for moving in the bed. Observation was made of Resident #40 on 2/6/2022 at 2:10 p.m. The resident was in her bed, with both side rails up. The physician orders dated 11/20/2019 documented, " ...quarter rails to bed to promote turn and repositioning as well as independence." The comprehensive care plan dated 8/17/2021 documented in part, "Focus: [Resident #40] has the potential for ADL self-care performance deficit ...1/4 side rails to promote independence with repositioning." A request was made on 2/7/2022 at 10:30 a.m. for the documentation of the bed inspections. On 2/7/2022 at 3:09 p.m. OSM (other staff member) #1, the maintenance director, stated that the beds that were requested had not been inspected when other beds in the facility were reviewed at the time of the previous inspection. OSM #1 further stated that at the time of the last inspection, 2/24/2021, the facility was in an	F 909		

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F 909	Continued From page 112 outbreak of COVID and the inspectors would not go behind the plastic barrier walls to do the inspection. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 2/8/2022 at 2:05 p.m. No further information was obtained prior to exit. 3. For Resident #28, the facility staff failed to complete an annual bed inspection. Resident #28 was admitted to the facility on 4/28/2016. On the most recent MDS (minimum data set) assessment, an annual assessment, with an ARD of 12/13/2021, the resident scored 13 out of 15 on the BIMS, indicating the resident is not cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member for moving in the bed. Observation was made of Resident #28 on 2/6/2022 at 2:12 p.m. The resident was observed to be in her bed, with both side rails up. The physician order dated, 5/20/2019, documented in part, "Quarter side rails up x2 (both sides) for independence in position and bed mobility." The comprehensive care plan dated, 7/22/2021, documented in part, "Focus: [Resident #28] has a potential for ADL self-care performance deficit...1/4 side rails to promote independence	F 909		

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F 909	Continued From page 113 with positioning and bed mobility." A request was made on 2/7/2022 at 10:30 a.m. for the documentation of the bed inspections. On 2/7/2022 at 3:09 p.m. OSM (other staff member) #1, the maintenance director, stated that the beds that were requested had not been inspected when other beds in the facility were reviewed at the time of the previous inspection. OSM #1 further stated that at the time of the last inspection, 2/24/2021, the facility was in an outbreak of COVID and the inspectors would not go behind the plastic barrier walls to do the inspection. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 2/8/2022 at 2:05 p.m. No further information was obtained prior to exit.	F 909		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as	F 947	**F 947** 1. CNA # 2 received the required Dementia training. 2. A facility wide audit was conducted to determine staff that have met the required Dementia training. Any staff identified not meeting requirements have been provided Dementia training. 3. The staff Educator/Designee will conduct Inservice training, Health Care Academy Training completion and report before yearly review date.	

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F 947	Continued From page 114 determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and employee record review, it was determined the facility staff failed to ensure one of four CNA (certified nursing assistants) had required training, CNA #2. The facility failed to provide CNA #2 training in dementia care. The findings include: The employee education records of four CNAs were reviewed. It was noted that CNA #2 failed to have any documented dementia training. A request was made for CNA #2's dementia training records on 2/7/2022 at the end of day meeting at approximately 4:45 p.m. On 2/8/2022 at approximately 9:00 a.m. OSM (other staff member) # 3, human resources, reviewed the requested documents with this surveyor and stated she would return with further information. On 2/8/2022 at 11:00 a.m., OSM #3 stated she could not find the documentation of any dementia training for CNA #2. The facility policy "Nurse Aide In-service Training" documented, in part, "4. Annual in-services: e.	F 947	4. The Staff Educator /Designee will conduct a monthly review of in-services on facility nursing aids to ensure nursing aides are attending Inservice education and completing Health Care Academy Courses. The Staff Educator of Designee will submit to QAPI for review and recommendations. 5. Corrective Action/Audits to be completed by 3/18/2022	

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F 947	Continued From page 115 Include training that addresses the care of residents with cognitive impairment; and f. include training in dementia management, infection control, and abuse prevention." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional vice president of clinical services, were made aware of the above concern on 2/8/2022 at 2:05 p.m. No further information was obtained prior to exit.	F 947		