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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY	
		495255	B. WING			02/0	08/2022
	PROVIDER OR SUPPLIER N SPRING8 REHAB	AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835			52000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments	85 EFFG1	E	000			
1	survey was conduct 02/08/2022. Correct compliance with 42 Requirement for Lot EP Program Patient CFR(s): 483.73(a)(ang-Term Care Facilities. It Population 3) 16.54(a)(3), §418.113(a)(3), 160.84(a)(3), §482.15(a)(3), 16.25(a)(3), §484.102(a)(3), 16.25(a)(3), §485.727(a)(3), 16.12(a)(3), §494.62(a)(3). In The [facility] must develop an ergency preparedness plan red, and updated at least every aust do the following:] I/client] population, including, ersons at-risk; the type of all has the ability to provide in continuity of operations, as of authority and succession at §483.73(a):] Emergency ty must develop and maintain aredness plan that must be ted at least annually. The he following: It population, including, but not at-risk; the type of services the ability to provide in an principal provide in an optimity of operations, as of authority and succession.			E.007 L. Categories of the patlent popular that would be at risk during an emergency have been identified. The Response Concept of Opera section in E-007 of the Emergency Preparedness Manual has been updated to more clearly identify services that the facility will be at to provide during an emergency Structural Leadership section in 007 of the Emergency Prepared Manual has been updated to more clearly identify how the facility procontinue operations during an emergency. A new report of "At Risk and Vulnerable Patlents" has been developed to include patlents in following categories: Residents Requiring Insulin, Residents with Memory Impairment, Residents Requiring Significant Assistance Transport, Residents Requiring Dialysis, Residents with Significant Medication Needs, Residents Requiring Portable Oxygen, Residents TITLE	the lible . The E-ness are plans . The to	FEB 25 2022
ABORATORY	DIRECTOR'S OR PROVID	1 1 1	ATURE		A smanuate at	·o-6 2	X8) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the petients. (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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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONS		(X3) DATE SURVEY COMPLETED		
		495255	B. WING			02/08/2022		
•	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		30 MON1	ADDRESS, CITY, STATE, ZIP CODE TVUE DRIVE , VA 22836			
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	hospice, PACE, HH RHC/FQHC, or ESF This REQUIREMEN by: Based on staff intereview, it was determined to have a compreparedness plan. Facility staff failed to patient populations emergency event, a be able to provide dithe facility plans to demergency. The findings include On 02/08/2022 at a review and interview preparedness plan (other staff member Review of the facility plan falled to eviden populations that woo emergency event, so be able to provide dithe facility plans to demergency. OSM # On 02/08/2022 at approvided the facility plans to demergency. OSM # On 02/08/2022 at approvided in the facility plans to demergency. OSM # On 02/08/2022 at approvided in the facility plans to demergency. OSM # On 02/08/2022 at approvided in the facility plans to demergency. OSM # On 02/08/2022 at approvided in the facility plans to demergency. OSM # On 02/08/2022 at approvided in the facility plans to demergency. OSM # On 02/08/2022 at approvided in the facility plans to demergency. OSM # On 02/08/2022 at approvided in the facility plans to demergency. OSM # On 02/08/2022 at approvided in the facility plans to demergency. OSM # On 02/08/2022 at approvided in the facility plans to demergency. OSM #	at risk" does not apply to: ASC, A, CORF, CMCH, RD facilities.] IT is not met as evidenced evidenced that the facility staff aplete emergency evidence documentation of that would be at risk during an ervices that the facility would uring an emergency, and how continue operations during an	E	3.	with Significant Medical Treatme and Residents with Special Diets. The new report listing the identification residents has been developed an placed in the Emergency Preparedness Manual under the E007 Section. All staff will be inserviced by the Administrator, designee on the identified update the manual. All residents both in writing and the Resident Council Meetings will be educated in the process. The Director of Nurses, or design will run an updated report identified on a weekly basis and place it in the Emergency Preparedness Manual under the E007 Section. The Administrator will monitor to Emergency Preparedness Manual least monthly to ensure the "At and Vulnerable Patients" report continues to be updated appropriately. These findings will reported and discussed during the Quality Assurance and Performa Improvement meeting quarterly Corrective action will be complete by 3/18/2022.	ied d es to ee, fyling nts" he lat Risk		
	No initial illipiiiisti	Obsoleta Super (D:87) 241		Sacility (D: V	* CA	The 10 - 0 1110		

FORM CMS-2557(02-99) Previous Versions Obsolete

Event (D: B7L21

Facility (D: VA015

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495255	B. WING			02/	08/2022
,	PROVIDER ÖR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		30	TREET ADDRÉSS, CITY, STATE, ZIP CODE D MONTVUE DRIVE URAY, VA 22835		
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ss=c	GFR(s): 483.73(b)(2) §403.748(b)(2), §41 and (v), §441.184(b) §482.15(b)(2), §483 §485.625(b)(2), §483 §494.62(b)(1). [(b) Policies and proceded planset forth in parameter and the communication the section. The policies and proceded planset forth in parameter and the communication the section. The policies and proceded following:] [(2) or (1)] A system on-duty staff and sheltered following: [(2) or (1)] A system on-duty staff and sheltered put the emergency, the specific name and it or other location. *[For PRTFs at §441 ICF/IIDs at §483.475 Policies and proceded location of on-duty staff and after an emerge sheltered residents a emergency, the [PRTF's, LTC, IC] and after an emerge sheltered residents a emergency, the [PRTF's]	6.54(b)(1), §418.113(b)(6)(ii))(2), §460.84(b)(2), .73(b)(2), §483.475(b)(2), 5.920(b)(1), §486.360(b)(1), cedures. The [facilities] must lent emergency preparedness ures, based on the emergency agraph (a) of this section, risk graph (a)(1) of this section, tion plan at paragraph (c) of licies and procedures must be ed at least every 2 years cilities]. At a minimum, the ares must address the to track the location of eltered patients in the gran emergency. If on-duty leatients are relocated during facility] must document the location of the receiving facility 1.184(b), LTC at §483.73(b), 6(b), PACE at §460.84(b):] ares. (2) A system to track the laft and sheltered residents in CF/IID or PACE] care during lare relocated during the TF's, LTC, ICF/IID or PACE] specific name and location of	EO	118	E-018 1. The current emergency prepared section E-018 will be updated to include the new policy and procedure, "Emergency Preparedness Resident and Staff Tracking". The policy includes he tracking will be coordinated. In addition, new Resident and Staff Tracking forms will be developed 2. The new policy and procedure, "Emergency Preparedness Reside 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 be affected by this and therefore communications in writing and vitthe Resident Council will be educated. 3. The facility Director of Nurses, Assistant Director of Nurses, Nursul Unit Managers, Nursing Supervisor and the facility Maintenance Dire will be educated on the new policiand tracking forms to ensure they are familiar with the new process	ent fee scan ss ctor	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
1		495255	B. WING	_		02/	08/2022	
j	PROVIDER OR SUPPLIER *** SPRINGS REHAB A	ND NURSING CENTER		3(TREET ADDRESS, CITY, STATE, ZIP CODE 0 MONTVUE DRIVE URAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)			(X5) COMPLETION DATE	
•	*[For Inpatient Hosp Policies and proced (ii) Safe evacuation includes considerationeds of evacues; transportation; identification(s) and primicommunication with assistance. (v) A system to track employees on-duty employees on-duty hospice's care during on-duty employees relocated during the must document the the receiving facility. *[For CMHCs at §48 procedures. (2) Safe which includes constreatment needs of responsibilities; transvacuation location(means of communications assistance. *[For OPOs at § 486 procedures. (2) A sydocumentation that I donor information, potential and actual secures and maintal. *[For ESRD at § 494 procedures. (2) Safe facility, which include needs of the patients.	pice at §418.113(b)(6):] ures. from the hospice, which ion of care and treatment staff responsibilities; tification of evacuation ary and alternate means of external sources of It the location of hospice and sheltered patients in the ig an emergency. If the or sheltered patients are emergency, the hospice specific name and location of or other location. IS.920(b):] Policles and e evacuation from the CMHC, ideration of care and evacuees; staff sportation; Identification of s); and primary and alternate cation with external sources of IS.360(b):] Policies and stem of medical preserves potential and actual rotects confidentiality of donor information, and ins the availability of records. IS.62(b):] Policies and evacuation from the dialysis es staff responsibilities, and	EO	18	4. A Tabletop exercise will be held within the next quarter to review improve the facility's emergency evacuation policies and procedul including this new policy and for to ensure efforts are made for continued improvement in the pland to ensure the plan is able to well implemented, should it be needed. 5. Corrective Action will be complete by 3/18/2022.	res, ms, lan be		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		e survey IPLETED
		495255	B. WING			02/	08/2022
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SKYVIEV	W SPRINGS REHAB A	ND NURSING CENTER			MONTVUE DRIVE IRAY, VA 22835		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF CORRECT PROPERTY OF THE APPLICATION OF THE APP			(X6) COMPLETION DATE
E 034 SS=C	Based on staff intereview, it was determined to have a compreparedness plan. Facility staff failed to document locations. The findings include On 02/08/2022 at a review and interview preparedness plan to (other staff member Review of the facility plan failed to eviden document the location OSM # 1 stated, "WO On 02/08/2022 at a fadministrative staff ASM # 2, director of president of clinical the findings. No further information in Occur CFR(s): 483.73(c)(7), §441.184(c)(7), §443.5483.73(c)(7), §483.5485.68(c)(5), §485.68(c)(5), §485.68(c	rview and facility document mined that the facility staff inplete emergency of develop a tracking system to of patients and staff. Exproximately 10:40 a.m. a of the facility's emergency was conducted with OSM (a) # 1, maintenance director. It is emergency preparedness are a tracking system to ons of patients and staff. The don't have it." Exproximately 1:50 p.m., ASM member) # 1, administrator, inursing, and ASM # 4, vice services, were made aware of on was provided prior to exit. Inpancy/Needs	E 0		E-034 1. The currentemergency prepared communication plan will be update include the new policy and procedure, "Sharing information Occupancy / Needs." The policy includes the procedures for repo	on orting	
		st develop and maintain an iness communication plan			the facility needs, reporting of a facility's ability to provide assista and facility occupancy reporting	ince,	

71	DENTIFICATION NUMBER:	, ,		DISTRUCTION	(X3) DATE SURVEY COMPLETED	
	495255	B. WING_			02/0	08/2022
NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NI	URSING CENTER		30 MC	ET ADDRESS, CITY, STATE, ZIP CODE DNTVUE DRIVE NY, VA 22835		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHI			(X5) COMPLETION DATE
E 034 Continued From page 5 that complies with Federa and must be reviewed an 2 years [annually for LTC communication plan must following: (7) [(5) or (6)] A means of about the [facility's] occupability to provide assistant having jurisdiction, the incenter, or designee. *[For ASCs at 416.54(c)]: providing information about its ability to provide assist having jurisdiction, the incenter, or designee. *[For Inpatient Hospice at means of providing information hospice's Inpatient occupability to provide assistant having jurisdiction, the incenter, or designee. This REQUIREMENT is by: Based on staff interview review, it was determined failed to have a complete preparedness plan. Facility staff failed to provide assistance, it was determined failed to have a complete preparedness plan. Facility staff failed to provide assistance, to the authori incident Command Center reviewing the communication that the color incident Command Center reviewing the communication that the color incident Command Center reviewing the communication that the color incident Command Center reviewing the communication that the color incident Command Center reviewing the communication that the color incident Command Center reviewing the communication that the color incident Command Center reviewing the communication that the color incident Command Center reviewing the communication that the color incident Command Center reviewing the communication that the color incident Command Center reviewing the communication that the color incident Center reviewing the communication that the color incident Center reviewing the communication that the center reviewing the center review reviewing the center reviewing the center rev	and updated at least every acidities]. The st include all of the st includent command	E 03	34	Procedure, "Sharing information on Occupa Needs" has been added to the Emergency Preparedness Manual ensure the changes are in place actionable for the safety of all residents. All residents can be affected by this and therefore communications in writing and with the Resident Council will be educated. The facility Director or Nurses, Assistant Director of Nurses, Nur Unit Managers, Nursing Supervisiand the facility Maintenance Directly Maintenance Directly Maintenance Directly Maintenance Directly to ensure they are familiar with the new process. A Tabletop exercise will be held within the next quarter to review improve the facility's emergency evacuation policies and procedu 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. Corrective Action will be completed by 3/18/2022.	is to and sissing sors, ector cy e	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
'		495255	B. WING	B. WING			08/2022
1	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		30 M	EET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE RAY, VA 22835		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 034	Continued From particulates a means of their occupancy. The findings include	f providing information about	EO	34			
()	On 02/08/2022 at an review and interview preparedness plan of (other staff member Review of the facility plan falled to eviden communication plan providing informatio and about its ability authority having juris Command Center, of communication plan communication plan	pproximately 10:40 a.m. a v of the facility's emergency was conducted with OSM by # 1, maintenance director. It is emergency preparedness and education that the included a means of a about the facility's needs, to provide assistance, to the addiction, the incident or designee by reviewing the and documentation that the included a means of a about their occupancy.					
1	(administrative staff ASM # 2, director of	oproximately 1:50 p.m., ASM member) # 1, administrator, nursing, and ASM # 4, vice services, were made aware of					:
	No further information EP Training and Tes CFR(s): 483.73(d)	on was provided prior to exit. iting	E 0		E <u>-036</u> 1. An Emergency Preparedness Train	ning	
	§403.748(d), §416.5 §441.184(d), §460.8 §483.475(d), §484.1 §485.625(d), §485.7 §486.360(d), §491.1	4(d), §482.15(d), §483.73(d), 02(d), §485.68(d), 27(d), §485.920(d),			and Testing program has been developed to include the "Emerge Preparedness Training and Testing Policy."	ency	
1	*[For RNCHIs at §40	03.748, ASCs at §416.54,				ŀ	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495255	B. WING			02/08/2022		
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
SKYVIE	N SPRINGS REHAB A	ND NURSING CENTER		-	MONTVUE DRIVE URAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO		BE	(XB) COMPLETION DATE	
E 036	Hospice at §418.11 at §460.84, Hospita §484.102, CORFs at §485.920, OPOs at §491.12:] (d) Training must develop and repreparedness training based on the emerging paragraph (a) of this paragraph (a) of this paragraph (a) of this paragraph (a) of this paragraph (b) of the communication section. The training be reviewed and up "[For LTC facilities a and testing. The LT maintain an emerge and testing program emergency plan set section, risk assess this section, policies (b) of this section, a paragraph (c) of this testing program muleast annually. *[For ICF/IIDs at §4 testing. The ICF/IID an emergency preprogram that is baseforth in paragraph (c) assessment at parapolicies and proced section, and the corparagraph (c) of this	3, PRTFs at §441.184, PACE is at §482.15, HHAs at at §485.68, CAHs at §486.625, Ier 485.727, CMHCs at §486.360, and RHC/FHQs at §486.360, and RHC/FHQs at an an emergency and testing program that is gency plan set forth in a section, risk assessment at this section, policies and graph (b) of this section, and plan at paragraph (c) of this g and testing program must dated at least every 2 years. at §483.73(d):] (d) Training TC facility must develop and ancy preparedness training at that is based on the aforth in paragraph (a) of this ment at paragraph (a) of this ment at paragraph (a) of this and procedures at paragraph at a section. The training and at be reviewed and updated at as a section. The training and must develop and maintain aredness training and testing and on the emergency plan set a) of this section, risk graph (a)(1) of this section, ures at paragraph (b) of this	EO	36	 The new program and policy have been added to the Emergency Preparedness Manual to ensure changes are reflected in the plant the benefit of all residents. The Administrator will in-service all department heads on the new program and policy by 3/11/202 residents can be affected by this therefore communications in whand via the Resident Council will educated. The Administrator will be require coordinate the first of the two are training and testing exercises with two weeks. The first training and testing exercises will involve the facilities' new fire safety plan (keeping in compliance with the swalver). The Regional Director of Risk Management will verify that training and testing exercise has been completed. The Administrator will report to Quality Assurance and Perform Improvement committee quart discuss the Emergency Prepare Hazard and Vulnerability Assess policies and procedures related any upcoming training and testing exercises and report on the compliance of the program as r in the policy. Corrective action will be completed by 3/18/2022. 	the for 2. All and iting be ed to inual hin limber the ance erly to dness iment, to ing	ETT	

FORM CM8-2567(02-99) Previous Versions Obsolete

Event ID: 87L211

Facility ID: VA0166

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495255	B. WING		<u></u>	02/0	08/2022
'_	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		3(TREET ADDRÉSS, CITY, STATE, ZIP CODE 0 MONTVUE DRIVE URAY, VA 22835		
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E 036	Continued From page 8			36			
10		The ICF/IID must meet the acuation drills and training at					
I	testing, and oriental	es at §494.62(d):] Training, llon. The dialysis facility must in an emergency					
)	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						
1	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.						
	documentation that	p provide evidence of the facility has a written program that meets the					
1	documentation that	the training and testing eviewed and updated on at				:	
	The findings include	o:					
	review and interview preparedness plan v (other staff member Review of the facility	oproximately 10:40 a.m. a of the facility's emergency was conducted with OSM) # 1, maintenance director. /'s emergency preparedness ce that the facility has a					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
ı	495255				4	02/08/2022	
NAME OF	PROVIDER OR SUPPLIER	,			T ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X8) COMPLETION DATE
E 036	written training and the requirements of documentation that program has been releast an annual bas have the document. On 02/08/2022 at all (administrative staff ASM # 2, director of president of clinical the findings. No further informative Fraining Program CFR(s): 483.73(d)(1), \$41, \$441.184(d)(1), \$45, \$483.73(d)(1), \$483, \$485.68(d)(1), \$485.920(d)(1), \$484, \$484.102, "Organ OPOs at \$486.360, (1) Training program the following: (i) Initial training in expolicles and procedustaff, individuals programagement, and vexpected roles. (ii) Provide emergentesst every 2 years,	testing program that meets the regulation, and the training and testing eviewed and updated on at is. OSM # 1 stated, "We don't ation." pproximately 1:50 p.m., ASM member) # 1, administrator, f nursing, and ASM # 4, vice services, were made aware of on was provided prior to exit. (a) (b) (c) (c) (d) (1) (d) (1) (d) (1) (d) (1) (d) (d) (1) (d) (d) (d) (e) (d) (e) (e) (e) (e) (e) (e) (e) (e) (e) (e	E 03	37	E-037 All current staff employment rewill be audited by the Human Resources Manager to determine who does not have documentate receiving either the Initial and/orannual emergency preparedness training. This is a New Employee Orientation Agenda section. All identified staff members who not have documentation of having received either the initial or annual emergency preparedness training. Training will be performed by the Maintenance Director or designation of the model of the mode	ne ion of ir is o do ing ival ing will ie ee.	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l''	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER N SPRINGS REHAB	AND NURSING CENTER			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CRO93-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
E 037	procedures. (v) If the emergency procedures are sign must conduct training procedures. *[For Hospices at § hospice must do all (i) Initial training in a policies and procedures are employees services under arra expected roles. (ii) Demonstrate staprocedures. (iii) Provide emerge least every 2 years. (iv) Periodically reviemergency prepare employees (includir special emphasis planting procedures necession others. (v) Maintain docume preparedness training (vi) If the emergency procedures are sign must conduct training procedures. *[For PRTFs at §44 program. The PRTF (i) Initial training in epolicies and procedures are staff, individuals procedures are staff, individuals procedures are staff, individuals procedures are staff.	aff knowledge of emergency y preparedness policies and inificantly updated, the [facility] ng on the updated policies and 418.113(d):] (1) Training. The of the following: emergency preparedness ures to all new and existing , and individuals providing ngement, consistent with their iff knowledge of emergency ncy preparedness training at ew and rehearse its dness plan with hospice ng nonemployee staff), with aced on carrying out the ary to protect patients and entation of all emergency ng. y preparedness policies and ifficantly updated, the hospice ng on the updated policies and 1.184(d):] (1) Training f must do all of the following: ures to all new and existing yiding services under	E OS		ion, nd staff's sss s ngs to hly. audit nce nt dings
	arrangement, and vexpected roles.	olunteers, consistent with their		VDH.	

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUI A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			495255	B, WING	·_		02/08/2022		
i	NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			_
	SKYVIE	W SPRINGS REHAB A	ND 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)			IX.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLÉTION DATE	
		(ii) After initial training preparedness training (iii) Demonstrate at a procedures. (Iv) Maintain docume preparedness training (v) If the emergency procedures are signiful must conduct training procedures. "[For PACE at §460. organization must do (i) Initial training in elegation organization must do (ii) Initial training in elegation organization must do (ii) Provide emergency arrangement, contraivolunteers, consister (iii) Provide emergency least every 2 years. (iii) Demonstrate staff procedures, including what to do, where to case of an emergency procedures are signiful must conduct training procedures. "[For LTC Facilities at Program. The LTC facilities at Program.	ng, provide emergency and every 2 years. If knowledge of emergency entation of all emergency and preparedness policies and a lifeantly updated, the PRTF and the updated policies and self-ball of the following: mergency preparedness ares to all new and existing and and with their expected roles. The preparedness training at the work of the following and whom to contact in a life and whom to contact in a life and whom to contact in a life and a life	EC)37				
		expected role.	unteers, consistent with their						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION		ATE SURVEY OMPLETED
,		495255	B. WING	;_	<u></u>	l n	2/08/2022
1	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER	,	:	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		10012022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE 38	(X5) COMPLETION DATE
1	least annually. (iii) Maintain docume preparedness trainly (iv) Demonstrate state procedures. *[For CORFs at §48 CORF must do all or (i) Provide initial train preparedness policies and existing staff, incurder arrangement, with their expected moder arrangement, with their expected moder arrangement, (ii) Provide emergen least every 2 years. (iii) Maintain docume (iv) Demonstrate state procedures. All new and assigned specifithe CORF's emergentheir first workday. The include instruction in alarm systems and sequipment. (v) If the emergency procedures are significated.	entation of all emergency and sentation of all emergency and sentation of all emergency and sentation of all emergency of knowledge of emergency and sentation of the following: In a sentation of all emergency and procedures to all new all of the following services and volunteers, consistent	EO	137			
, () () () ()	The CAH must do all it) initial training in en policies and procedur eporting and extinguand where necessary	nergency preparedness res, including prompt ishing of fires, protection, , evacuation of patients, s, fire prevention, and					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(XQ) MUI	LTIPLE CONSTRUCTION DING		NATE SURVEY OMPLEYED
		495255	B. WING			2/08/2022
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		6TREET ADDRESS, CITY, STATE, ZIP (30 MONTVUE DRIVE LURAY, VA 22835		
(XA) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
	authorities, to all new individuals providing and volunteers, constroles. (ii) Provide emergent least every 2 years. (iii) Maintain docume (Iv) Demonstrate state procedures. (v) If the emergence procedures are significant conduct training procedures. *[For CMHCs at §488 CMHC must provide preparedness policies and existing staff, includer arrangement, with their expected redocumentation of the demonstrate staff know procedures. Thereaf emergency prepared years. This REQUIREMENT by: Based on staff intervity review, it was determined to have a componence of the preparedness plan. Facility staff failed to procedure training the procedures training the preparedness training the prepa	w and existing staff, services under arrangement, sistent with their expected cy preparedness training at entation of the training. If knowledge of emergency y preparedness policies and ficantly updated, the CAH g on the updated policies and g on the updated policies and initial training in emergency and procedures to all new lividuals providing services and volunteers, consistent ples, and maintain training. The CMHC must provide the company at least every 2 is not met as evidenced liew and facility document lied that the facility staff late emergency and annual emergency and annual emergency	EO			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		LE CONSTRUCTION		E SURVEY PLETED
		495256	B. WING	١		02/	08/2022
NAME OF	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			TREET ADDRESS, CITY, STATE, ZIP CODE O MONTVUE DRIVE		_
SKYVIE	W SPRINGS REHAB A	ND NURSING CENTER		ı	URAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	Continued From page	ge 14	Ed	037			
1	review and interview preparedness plant (other staff member Review of the facility plan failed to eviden facility's initial emergand annual emerger offerings, and docur have received initial preparedness training were not able to pro On 02/08/2022 at application (administrative staff ASM # 2, director of	pproximately 10:40 a.m. a or of the facility's emergency was conducted with OSM () # 1, maintenance director. If a maintenance director, was emergency preparedness are documentation of the gency preparedness training mentation that facility staff & annual emergency and OSM # 1 stated that they wide evidence of training. Approximately 1:50 p.m., ASM member) # 1, administrator, nursing, and ASM # 4, vice services, were made aware of					
SS=C	Hospital CAH and LTCFR(s): 483.73(e) §482.15(e) Condition (e) Emergency and shospital must implement bases forth in paragraph (a policles and procedu paragraphs (b)(1)(i) §483.73(e), §485.62 (e) Emergency and selection of the paragraphs (b)(1)(i)	standby power systems. The nent emergency and standby and on the emergency plan set of this section and in the lines plan set forth in and (ii) of this section.	E 0	41	E-041 1. To complete a full load bank test full load test has been scheduled be performed by a certified electrician. In addition, the police entitled "Emergency Power" has been updated to include how to the generator operational during emergency. 2. The updated policy entitled "Emergency Power" has been act to the Emergency Preparedness Manual under section E-041 to	d to	

	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l''		CONSTRUCTION		TE SURVEY MPLETED
1		495255	B. WING			02	/08/2022
1	PROVIDER OR SUPPLIER N SPRINGS REHAB A	ND NURSING CENTER		30 (REET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE DRAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X9) COMPLETION DATE
E 041	the emergency planthis section. §482.15(e)(1), §483 Emergency general must be located in a requirements found Code (NFPA 99 and Amendments TIA 12-12-12-12-13, and Tentative Interir 12-12-12-13, and when a new structure or building 482.15(e)(2), §483. Emergency generat [hospital, CAH and Ithe emergency pow and [maintenance] in Health Care Facilities Safety Code. 482.15(e)(3), §483. Emergency generate LTC facilities] that in to power emergency for how it will keep experational during the evacuates. *[For hospitals at §4 and CAHs §485.625 The standards incorrection are approvereference by the Din Federal Register In Section 13 and 12 and 13 and 13 and 14 and 14 and 15 and	set forth in paragraph (a) of 3.73(e)(1), §485.625(e)(1) or location. The generator accordance with the location in the Health Care Facilities 1. Tentative Interim 2-2, TIA 12-3, TIA 12-4, TIA 1. Life Safety Code (NFPA 101 in Amendments TIA 12-1, TIA TIA 12-4), and NFPA 110, re is built or when an existing is renovated. 73(e)(2). §485.625(e)(2) or inspection and testing. The LTC facility] must implement er system inspection, testing, equirements found in the es Code, NFPA 110, and Life 73(e)(3), §485.625(e)(3) or fuel. [Hospitals, CAHs and haintain an onsite fuel source of generators must have a plan imergency power systems are emergency, unless it	EO	41	ensure the process can be efound during an emergency addition, a copy of the gene contracts has been copied ato this section for easy acces. The Administrator will in-se Director of Maintenance, the Olrector of Nursing, Assistant Director of Nursing, and the supervisors on the updated entitled "Emergency Power addition, they will be shown locate the policy and contrast manual. The Administrator will report QAPI Committee quarterly if the use and needs of the general during an emergency to fact further improvements that developed under E-041. Corrective Action will be comby 3/18/2022.	y, in erator and added ass. rvice the act and acts in the act added ass. rerator allitate any can be	

	T OF DÉFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495255	8. WING		- 02/08/2022		
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		9TREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D 8E	(X5) COMPLETION DATE	
1	material from the so inspect a copy at the Center, 7500 Secur or at the National Ar Administration (NAF availability of this magazinability of this magazinabili	purces listed below. You may a CMS Information Resource ity Boulevard, Baltimore, MD chives and Records (A). For information on the alerial at NARA, call to to: gov/federal_register/code_of (A)	EO	RE	CEI B 2 5 OH/C		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION		TE SURVEY
]		495255	B. WING	·		02	2/08/2022
1	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER	•	30	REET ADDRESS, CITY, STATE, ZIP CODE DIMONTVUE DRIVE URAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	This REQUIREMENT by: Based on staff interreview, it was deterrefailed to have a compreparedness plan. Facility staff falled to that the facility has it standby power system of the facility's emergicities and proceduplan for how to keep during an emergency evacuate. The findings include: On 02/08/2022 at appreview and interview preparedness plan we (other staff member) Review of the facility plan falled to evidency has the required emergency, and comprocedures and document of the generator of the generator of the stated, "We don't have a staff in ASM # 2, director of the president of clinical state findings.	IT is not met as evidenced view and facility document mined that the facility staff splete emergency evidence documentation he required emergency may to meet the requirements gency, and corresponding ares and documentation of a the generator operational y unless they plan to	E	141			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:			NSTRUCTION		E SURVEY PLETED
1		495255	B. WING		· · · · · ·	02/08/2022	
NAME OF I	PROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE		
SKYVIEV	V SPRINGS REHAB A	ND NURSING CENTER			NTVUE DRIVE Y, VA 22835	•••	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X3) COMPLETION DATE
F 000	INITIAL COMMENT	s	FO	00			
F 577 SS=C	survey was conduct Corrections are requirements. The survey/report will foll Corrections are requirements. The survey/report will foll Corrections are requirement(s). The census in this 1 105, Of the 105 curresidents were currected COVID-19 virus. The 48 current residents reviews. Right to Survey Res CFR(s): 483.10(g)(10) The (i) Examine the result of the facility conduction aurveyors and any prespect to the facility (ii) Receive information contact these age \$483.10(g)(11) The fill (i) Post in a place recand family members residents, the results the facility.	Life Safety Code low. Jired for compliance with lift 483 Federal Long Term Journal Long	F 5		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 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	In	
	certifications, and co	mplaint investigations made during the 3 preceding			avallability of survey results for the past 3 years in the Main Lobby	r 	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		SURVEY PLETED
		495255	B. WING	·	02/0	8/2022
	PROVIDER OR SUPPLIER N SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI) TAG		DBE	(X5) COMPLETION DATE
F 577	respect to the facility to review upon requirements of the facility accessible to the purity. The facility shall information about on this REQUIREMENT by: Based on observation document review, it staff failed to make most recent survey, include the results of ending 12/29/2021 if in the lobby. The findings include the include observation was malocated in the lobby 2:00 p.m. and on 2/2 recent survey results 2021. The results from the include of the in	of correction in effect with y, available for any individual lest; and le availability of such reports in that are prominent and liblic. I not make available identifying emplainants or residents. IT is not met as evidenced lon, staff interview, and facility was determined the facility available the results of the The facility staff falled to of the abbreviated survey in the survey results notebook of the facility on 2/6/2022 at 7/2022 at 8:05 a.m. The most in the book were dated June om the most recent survey, 21, were not in the book. Inducted with ASM member) #1, the 8/2022 at 10:29 a.m. When on was shared with ASM #1, ad just gotten to the facility a M #1 stated he really had not at. When asked the process by results available for the ant representatives, ASM #1 ent survey results should be	F 5	3. The Administrator or the Administrative Assistant and/designee will assure that 3 ye of survey results with plans or correction will be made availate all residents and guests, in Main Lobby, immediately uporeceipt 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 asses 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 made immediately available. Completion Date: 3/18/2022	ars ble the on n.	

	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		LE CONSTRUCTION		OMPLETED	
		495255	B, WING			0	2/08/2022	
1	PROVIDER OR SUPPLIER N SPRINGS REHAB A	ND NURSING CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		V2/40/3042	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULO BE	(X5) COMPLETION DATE	
F 585 SS=D	The facility policy, "In part, "18. The Rethe results of the mire acility conducted by and any plan of contribute facility." ASM #1, ASM #2, the ware made aware of 2/8/2022 at 2:05 p.m. No further information of Grievances (FR(s): 483.10(j)(1) The regrievances to the fathat hears grievance reprisal and without reprisal. Such grievance facility stay. §483.10(j)(2) The refacility must make presolve grievances accordance with this §483.10(j)(3) The facility must make presolve grievances accordance with this §483.10(j)(3) The facility must make presolve grievances accordance with this §483.10(j)(3) The facility must make presolve grievances accordance with this §483.10(j)(3) The facility must make presolve grievances accordance with this §483.10(j)(3) The facility must make presolve grievances accordance with this §483.10(j)(3) The facility must make presolve grievances accordance with this §483.10(j)(3) The facility must make presolve grievances accordance with this §483.10(j)(3) The facility must make presolve grievances accordance with this §483.10(j)(3) The facility must make presolve grievances accordance with this §483.10(j)(3) The facility must make presolve grievances accordance with this §483.10(j)(3) The facility must make presolve grievances accordance with this §483.10(j)(3) The facility must make presolve grievances accordance with this §483.10(j)(3) The facility must make presolve grievances accordance with this §483.10(j)(3) The facility must make presolve grievances accordance with this §483.10(j)(3) The facility must make presolve grievances accordance with this system.	Resident Rights" documented sident has a right to examine out recent survey of the py Federal or State surveyors rection in effect with respect to the director of nursing, ASM president of clinical services, if the above concern on in. In was obtained prior to exit. In the president of clinical services, if the above concern on in. In was obtained prior to exit. In the president has the right to voice cility or other agency or entity as without discrimination or fear of staff and of other treatment which has been that which has not been with treatment which has not been with the concerns regarding their LTC resident has the right to and the rompt efforts by the facility to the resident may have, in a paragraph. In the promote of complaint available of the resident may have, in the paragraph.	F 5			21. The snee will ooking firessed or Designee a Filing to appletion		
	§483.10(j)(4) The fa	cility must establish a						

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

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
SKYVIEW SPRINGS REHAB AND NURSING CENTER 30 MONTVUE DRIVE LURAY, VA 22835		5.000	495265	B. WING)	02/	08/2022	
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 individually or through postings in prominent locations throughout the facility of the right to file grievance annoymously; 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 grievances, and the grievance official who is responsible for overseeing the grievance, and the contact promote the process,			ND NURSING CENTER		30 MONTVUE DRIVE			
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,	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	(XS) COMPLETION DATE	
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;		grievance policy to of all grievances reg contained in this par provider must give a to the resident. The include: (i) Notifying resident postings in promine facility of the right to (meaning spoken) or grievances anonymore of the grievance offican be filed, that is, address (mailing an number; a reasonate completing the reviet to obtain a written digrievance; and the condependent entities be filed, that is, the independent entities be filed, that is, the independent or protection (ii) Identifying a Grieresponsible for over receiving and tracking conclusions; leading by the facility; maintainformation associate example, the Identity grievances submitted written grievance de coordinating with stanecessary in light of (III) As necessary, taprevent further poteright while the alleger to the responsible that is the program or protection of the program of the information associated and information and i	ensure the prompt resolution garding the residents' rights ragraph. Upon request, the a copy of the grievance policy grievance policy must a individually or through a locations throughout the offile grievances or ally or in writing; the right to file ously; the contact information clal with whom a grievance his or her name, business phone of the grievance; the right ecision regarding his or her contact information of with whom grievances may pertinent State agency, at Organization, State Survey ong-Term Care Ombudsman on and advocacy system; evance Official who is seeing the grievance process, ag grievances through to their any necessary investigations aining the confidentiality of all the day of the resident for those day anonymously, Issuing cisions to the resident; and the and federal agencies as specific allegations; iking immediate action to intal violations of any resident	F	4. Social Service Dept/ Des review all grievances we weeks and then monthly grievances are identified report to QAPI weekly fo additional oversight or recommendations. 5. Corrective Action/Audits	ekly for 4 to ensure and will		

FORM CM\$-2567(02-99) Previous Varsians Obsolets

Event ID: B7L211

Facility ID: VA0166

If continuation need Rage ...
FEB 25 2022

DH/OLC

	r of Deficiencies OF Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION		'E SURVEY «PLETED
		495255	B. WING	_		02/	/08/2022
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	_
				:	30 MONTVUE DRIVE		
SKYVIEV	W SPRINGS REHAB A	ND NURSING CENTER		_ (LURAY, VA 22835		
(X4) ID		TEMENT OF DEFICIENCIES	1D		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		CROSS-REFERENCED TO THE APPROP		DATE
ing		, , , , , , , , , , , , , , , , , , , ,	"."		DEFICIENCY)		
F 585	Continued From pag	ge 22	F 5	85	s		
1 1	(iv) Consistent with	§483.12(c)(1), immediately					
		violations involving neglect,					1
	abuse, including inju	irles of unknown source,					1
		ition of resident property, by	l		Ť.		
i	anyone furnishing se	ervices on behalf of the					1 1
		inistrator of the provider; and					
	as required by State						
- 1		written grievance decisions					1
		grievance was received, a			1		
		of the resident's grievance,				!	i i
- 1		vestigate the grievance, a			}		
		tinent findings or conclusions					
İ		nt's concerns(s), a statement					
		ievance was confirmed or not					1
1		ective action taken or to be					
		as a result of the grievance, Iten decision was issued;				1	!
Í		ite corrective action in					
		te law if the alleged violation			}		
		ts is confirmed by the facility					
		having jurisdiction, such as					
		ency, Quality Improvement					
		al law enforcement agency				ļ	
		for any of these residents'					
	rights within its area				}		1
		ence demonstrating the				[J
		es for a period of no less than					
		Jance of the grievance					
•	decision.						
		T is not met as evidenced]	
	by:	adas dassina della di i					
		nterview, staff interview,					
		and facility document					
		nined that the facility staff eported grievance for					
		ns for one of 51 residents in		-]	ļ
	missing personal iter the survey sample, F			1]
	u io oui voy saiiipie, r	ASIMBIL MY 1.		Ì			
1.	The facility staff faile	d to promptly respond to a					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
1		495255	B. WING			02/08/2022	
NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER				3	TREET ADDRESS, CITY, STATE, ZIP CODE D MONTVUE DRIVE URAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	6E	(X6) COMPLETION DATE
F 585	Continued From page	ge 23	F 5	85			
107	known grievance for Resident #21.	missing clothing items for					
9.	The findings include	:					ļ
,		MDS (minlmum data set), a of the minlmum data set in the minlmum d	:				
(15 out of 15 on the E	2/9/2021, the resident scored BIMS (brief interview for					
	mental status), Indicacognitively intact for	ating the resident is making daily decisions.					
		p.m., an interview was dent #21. The resident					
	clothing from their so	received several items of on and his girlfriend for					
- 1		ent them to the laundry to be of the been returned. The					
i	sweatshirt, two pairs	of sweatpants and a pajama ken to [Name of OSM (other)				[
	staff member) #5, en director] about these	vironmental services but had not gotten any					
٠	follow up on the item:	1					
. 1	months revealed a gr	grievances for the past 12 ievance dated 1/11/2022 for ted by social services. The					
19	grievance documente	od in part, "Missing items: st seen: 12/25/21; Describe					
1	the missing item: set size small. Gray nilor	of pajamas multi colored					
' \$	sleeve shirt/v-neck, 2 pantsInitial Action T	to 3 pair of black sweat aken: I have looked for the					
8	I didn't find the Items	undry & the residents closet To my conclusion, the					
(Sthe laundry dept. [Staff signature]." The form I follow up actions taken or					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		495255	B, WING			02	/08/2022	
NAME OF	PROVIDER OR SUPPLIER			•	STREET ADDRESS, CITY, STATE, ZIP CODE			
e KVV/IE)	W SODINGS BELIAD A	ND NURSING CENTER	ľ	3	00 MONTVUE DRIVE			
SKIVIE	N SPRINGS REINAB A	HO HORSING CENTER	[I	LURAY, VA 22895			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	ER'S PLAN OF CORRECTION		
PREFIX		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE	
17.0			,,,,		DEFICIENCY)			
F 585	Continued From page	ge 24	F5	85			1	
	resolution of the grievance.							
							1	
	Review of the reside							
		ling held on 1/31/2022 which "Resident feels like they					i I	
	are being redirecting							
		esident feels that they are not						
		ry- House clothes not being						
		es documented resident						
		from Resident #21 dated]	
•		clothing not being returned.					1 1	
1		imented, "I [Name of OSM					1 1	
1		laundry dept (department) of . I also have looked for					1	
		not found them. 02/01/22.					1	
	[Signature of OSM #							
1,0	English and a second						í I	
		p.m., an interview was					l J	
		#5, the environmental					i I	
		SM #5 stated that when they		1			{	
		for missing clothing or searched the laundry for						
		sidents room. OSM #5						
		hey found them or not they		- 1			!	
		ince form and returned it to						
		epartment. OSM #5 stated		ı				
		d sent a bag of new clothes						
		o be labeled. OSM #5					1	
		abeled the clothing and		-			l	
		same bag back to the in the room. OSM #5 stated		١			1	
		been down to be washed				ļ		
		hen and returned to the		-				
		ated that if there were						
	· · · · · · · · · · · · · · · · · · ·	as not sent to the laundry						
Ji	because they had ret	urned everything. At that		- [-		
		Resident #21's room and		Ì		ĺ	ł	
		arding missing clothing.						
	Resident #21 Informe	ed OSM #5 that they were						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		NTE SURVEY IMPLETED	
ı		495255	B. WING			02	2/08/2022	
	PROVIDER OR SUPPLIER W 8PRINGS REHAB A	ND NURSING CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 0 MONTVUE DRIVE JURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFI) TAG	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
	still missing pajamas sweatshirt. OSM #5 the clothing may have by the nursing staff, facility. OSM #5 che and stated that the cowith the linen was not service. On 2/7/2022 at 4:30 conducted with OSM #6 stated that when missing items they cound forwarded it to the OSM #6 stated that is located right away the and offered replacements the items. OSM #6 swith Resident #21 the clothing items. OSM had advised her that clothing or getting the OSM #6 went to Resident #21 became clothing was a gift from the items of the clothing items. Resident #21 became clothing was a gift from the clothing items. Resident #21 became clothing was a gift from the clothing items. Resident #21 became clothing items. Resident #21 became clothing items. Resident #21 became clothing items. Resident #31 became clothing items. Resident #41 became clothing items. Resident #42 became clothing items. Resident #45 became clothing items.	s, sweatpants and a advised Resident #21 that we been mixed in the the linen which was sent outside of the ecked Resident #21's closet slothing that gets mixed in of returned by the linen. p.m., an interview was if #6, social services. OSM they received a grievance for completed the grievance for completed the grievance for me appropriate department. If missing clothing was not ey continued to look for them nent or reimbursement for stated that they had spoken at morning about the missing #6 stated that Resident #21 they did not care about the em replaced. At that time, ident #21's room and spoke the missing clothing. It they did want them back. OSM and want them back. OSM and with Resident #21's son ment or replacement of the lent #21 appeared satisfied of discuss the concern with	F 5	B5				

NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER JUMMARY STATEMENT OF DEFICIENCIES PRETY TAG SUMMARY STATEMENT OF DEFICIENCIES SOMONTIVUE DRIVE LURAY, VA 22835 FROVIDERS PLAN OF CORRECTION SCHOOL OR SHOULD BE CONSTRUCTED BY PLLL RESULATORY OR LS REMITTING INFORMATION) F 585 Continued From page 26 In part, "17. The Resident has the right to volce grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal. Such grievances without discrimination or reprisal. Such grievances include those with respect to care and treatment which have been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC (long term care) facility staff to obtain a written decision regarding his or the righet to obtain a written decision regarding his or the righet to and their representatives have the right to file 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 respondent 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 respondence of auch findings to the Administrator or 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 grievances files, investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision"		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILC		E CONSTRUCTION		TE SURVEY MPLETED
SKYVIEW SPRINGS REHAB AND NURSING CENTER 30 MONTVUE DRIVE 10			495255	B. WING	-		02	/08/ 20 22
F 585 Continued From page 28 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 reprisel. Such grievances without discrimination or reprisel. Such grievances include those with respect to care and treatment which have been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC (long term care) facility as 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 hear grievances, either orally or in writing, to the facility ataff 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 care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the respondence of the considered action on the facility will be considered. Actions on such insules will be responded to in writing, including a rationale for the respondence of the considered action on such insules will be responded to in writing, including a rationale for the respondence of the considered actions on such insules will be responded to in writing, including a rationale for the respondence of the respondence of the considered actions on such insules of all grievances files, investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance files, investigate and reported will be meintained on file for a minimum of three years from the			ND NURSING CENTER		30	MONTYUE DRIVE		
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 ireatment 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, Filling" dated April 2017 provided during survey entrance on 2/6/2022 documented in part, "Residents and their representatives have the right to fille 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 representativeAll 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 responseUpon 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 complaintThe results of all grievances files, investigated and reported will be maintained on file for a minintum of three years from the	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	
		In part, "17. The voice grievances to entity that hears gried or reprisal. Such grievances to care and furnished as well as furnished, the behavesidents; and other (long term care) facilithe right to and the fefforts to resolve griehave. The resident written decision regard the facility policy "Griedated April 2017 proton 2/6/2022 docume their representatives grievances, either on staff or to the agency grievances (e.g., the Administrator and staresolve grievances to resident and/or reprecomplaints or recomplaints or such Issue writing, Including a raresponseUpon recomplaint, the Grieva investigate the allegareport of such finding five (5) working days and/or complaintTh files, investigated and on file for a minimum	Resident has the right to the facility or other agency or evances without discrimination levances include those with treatment which have been that which have not been allor of staff and of other concerns regarding their LTC lity stay. The resident has acility must make prompt evances the resident may has the right to obtain a arding his or her grievance" rievances/Complaints, Filing vided during survey entrance anted in part, "Residents and have the right to file ally or in writing, to the facility of designated to hear State Ombudsman). The aff will make prompt efforts to be the satisfaction of the sentativeAll grievances, mendations stemming from the sentative will be considered, as will be responded to in a grievance and/or ance Officer will review and tions and submit a written as to the Administrator within of receiving the grievance are results of all grievances. I reported will be maintained of three years from the		885			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
1		495255	B. WING		02/08/2022		
,	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	DE COMPLETION		
SS≟D '	on 2/7/2022 at applithe administrator, A ASM #3, the regions ASM #4, the vice private made aware on the facility and the facility must premain in the facility must premain in the facility must premain in the facility discharge the resident's welfare are cannot be met in the (B) The transfer or consident's welfare are cannot be met in the (B) The transfer or consident's welfare are cannot be met in the (B) The transfer or consident's welfare are cannot be met in the (B) The transfer or consident's welfare are cannot be met in the (B) The transfer or consident's welfare are cannot be met in the (B) The transfer or considently so the resident sufficiently so the resident who find otherwise be endanged. (E) The resident has appropriate notice, to under Medicare or Nonpayment applies submit the necessare payment or after the Medicare or Medicairesident refuses to president who become admission to a facility.	roximately 5:00 p.m., ASM #1, SM #2, the director of nursing, all director of operations and esident of clinical services if the concern. On was presented prior to exit. arge Requirements (i)(i)(ii)(2)(i)-(iii) and discharge- y requirements- permit each resident to and not transfer or ent from the facility unless- lischarge is necessary for the end the resident's needs a facility; ilscharge is appropriate the facility; ilscharge is appropriate the facility; ilviduals in the facility is the clinical or behavioral to the facility is the clinical or behavioral the facility is the resident does not y paperwork for third party	F 62	85	ian ansfer. I staff ily be d ie 4 days on by s were ovided cord, ae will y		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		495255	B. WING _		02/08/2022	
		ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DE COMPLÉTION	
1	resident while the all § 431.230 of this chexercises his or her discharge notice fro 431.220(a)(3) of this discharge or transfe or safety of the residentiality. The facility that fallure to transfe §483.15(c)(2) Document the facility transident under any concent and communicated to the institution or provide (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of pasection, the specific be met, facility atterneeds, and the servifacility to meet the no (ii) The documentation (A) The resident's place discharge is necessing (A) or (B) of this section.	es to operate, not transfer or discharge the ppeal is pending, pursuant to apter, when a resident right to appeal a transfer or m the facility pursuant to § s chapter, unless the failure to it would endanger the health dent or other individuals in the must document the danger er or discharge would pose. Interested in the resident's appropriate information is a receiving health care receiving health care receiving health care resident need(s) that cannot in the resident meet the resident cannot in the resident need(s) that cannot in the resident receiving health care resident need(s) that cannot in the resident need(s) that the reside	F 623	4. The Director of Nursing/Designee conduct an audit of all resident transfers to ensure that appropria paperwork is filled out and sent we resident. An initial audit will be completed with a look back of 14 to ensure required documentation NP/physician regarding transfers a completed in documentation provide hospital staff is included in recommendation of Nursing will submit the results of the audit to QAPI for revand recommendations. 5. Corrective Action/Audits to be completed by 3/18/2022	days n by were vided ord The	

02/25/2022 14:18 (FAX) P.034/120

DEPARTMENT OF HEALTH AND HUMAN SERVICE	CES
CENTERS FOR MEDICARE & MEDICAID SERVICE	CES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		TE SURVEY MPLETED
		495255	B. WING	;		02	/08/2022
1	PROVIDER OR SUPPLIÈR W SPRINGS REHAB A	ND NURSING CENTER		3	STREET ADDRESS, CITY. STATE, ZIP CODE 80 MONTYUE DRIVE LURAY, VA 22835	10	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
	must Include a mini (A) Contact informatoresponsible for the contact information (B) Resident represepontact information (C) Advance Directive (D) All special instructions care, as ap (E) Comprehensive (F) All other necessory of the resident consistent with §483 any other document a safe and effective This REQUIREMEN by: Based on staff intertion and clinical record retter facility staff failed transfer requirement survey sample, Residents #96 ar	vided to the receiving provider mum of the following: tion of the practitioner care of the resident. entative information including we information actions or precautions for propriate. care plan goals; eary information, including a state of such arge summary, 3.21(c)(2) as applicable, and ation, as applicable, to ensure transition of care. It is not met as evidenced wiew, facility document review eview, it was determined that it to implement facility initiated as for 3 of 51 residents in the idents #96, #81 and #54.	F	322			
		provided to hospital staff for fers for Residents #81 and					
1	The findings include:				RE	CEI	VED
		admitted to the facility on recent MDS (minimum data					
	set), a quarterly asse	essment with an ARD			FEE	325	ZUZZ
		ce date) of 8/18/21, the t of 15 on the BIMS (brief status), indicating the			VD	H/C	DLC

	IENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	t	495255	B. WING	·		07	2/08/2022
	OF PROVIDER OR SUPPLIER VIEW SPRINGS REHAB A	ND NURSING CENTER		30	REET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE DRAY, VA 22835		
(X4) I PREF TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)) BE	(X6) COMPLETION DATE
F 6:	resident is severely making daily decision. Review of Resident the resident was tra 11/8/21 for a fever a Further review of Refalled to reveal physic documentation regal On 2/7/22 at 4:28 p. conducted with ASM member) #5 (nurse she documents a not transfers to the hospithe time of transfer to the hospithe time of transfer to the facility policy title and Discharge* documents and president of clinicals of the above concern. The facility policy title and Discharge* documents/discharges	cognitively impaired for ons. #96's clinical record revealed insferred to the hospital on and altered mental status. Esident #96's clinical record ician or nurse practitioner rding the transfer. m., an interview was I (administrative staff practitioner). ASM #5 stated ite regarding resident out does not document a note clitty at the time of transfer. m., ASM (administrative staff ministrator), ASM #2 (the and ASM #3 (the regional vice services) were made aware	F	622	DEFICIENCY)		
	a. The transfer or dis resident's welfare an cannot be met in the i. The medical record by the attending phys identification of the re cannot be met by the attempt to meet those	will contain documentation sician to include the esident's specific needs that facility and of the facility's e needs."					
•	No further information	n was presented prior to exit.					

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION		ATE SURVEY OMPLETED
		495255	B. WING		0	2/08/2022
1	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 30 MONTVUE DRIVE LURAY, VA 22835	DĒ	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFII TAG		HOULD BE	COMPLETION DATE
F 622	Continued From pag	ge 31	F6	22		
	8/10/19 On the m data set), a quarterly (assessment referer resident scored 6 ou interview for mental resident is severely of making daily decision. Review of Resident is the resident was transfer and failed to back of the head. Fir #81's clinical record nurse practitioner do transfer, and failed to provided to hospital is On 2/7/22 at 4:28 p.r. conducted with ASM member) #5 (nurse pahe documents a not irransfers to the hospital is not in the factor of the	#81's clinical record revealed asferred to the hospital or rith a deep laceration to the arther review of Resident failed to reveal physician or cumentation regarding the preveal the information staff. a., an interview was (administrative staff practitioner). ASM #5 stated the regarding resident ital if she is in the facility at just does not document a note cility at the time of transfer.				
f	acility records.					

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 87L211

Facility ID: VA0166



CENTE	TO FOIT WILDIONICE	WILDIONIS OLIVIOLE				(VOLDAT	E ELIDIVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE		LE CONSTRUCTION		E SURVEY IPLETED
		495255	B. WING			02/	08/2022
NAME OF	PROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE		
1				3	0 MONTYUE DRIVE		
SKYVIEV	v springs rehab a	ND NURSING CENTER		L	URAY, VA 22835		
		THE STATE OF THE S	1 10		PROVIDER'S PLAN OF CORRECTION	J	000
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFI	х	(EACH CORRECTIVE ACTION SHOULD	BE	(X6) COMPLETION
PREFIX TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPI	RIATE	DATE
""	90.7		[DEFICIENCY)		
							i
F 622	Continued From pa	ge 32	FE	22			
	Continued From pa.	90 02	' '				
`	On 2/0/22 at 1:52 h	.m., ASM (administrative staff			}		
•	Un 2/0/22 at 1.52 p.	Iministrator), ASM #2 (the					
'	diseases of Europea's	and ASM #3 (the regional vice					
	director of nursing)	services) were made aware					
	of the above concer						V.
	Of the above concer	111.					
	The facility policy fit	led, "Facility Initlated Transfer					
10	and Discharge" doc	umented,"4. The medical					
	record:	differred, 4: The modern			•		i .
		fy the basis or reason for					
J	transfer or discharg		ĺ				
}	h Identify Informativ	on provided to the receiving					
į	D. Idelining information	minimum will include:					
		on of the practitioner who was					
	responsible for the						
	Il Docident represen	ntative information, including					1
}	contact information;						
	iii. Advance directive]]
		ons and/or precautions for					l
- 1	ongoing care se an	propriate, which must include,				,	
	if applicable but are	not limited to treatments and					
	devices (eviden im	plants, IVs, tubes/catheters);					
	v Precentions such	as isolation or contact;					
.		h as risk for falls, elopement,					} [
,	his openial lisks suc	re injury and/or aspiration					
	precautions;	a night direct debugger					
'	vil The resident's	omprehensive care plan					
	goals; and	Striptorionals a care plant		ĺ			
		ecessary to meet the					{
	socident's needs wh	nich includes, but may not be					i
	limited to:	not morace, but may not be					
		including baseline and					
	Current montal hobi	avioral, and functional status,					
	reason for transfer.						
	(2) Diagnoses and a						
	(2) Madiactions (1)	luding when last received);					
	•	inding muait isst tacaived);				1	
	and					1	
	(4) Most recent relev	vant labs, other diagnostic					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495265	8. WING	·		02	/08/2022
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835	, ,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL OF THE PROPERTY OF T	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	expected to return to No further information 3. Resident #54 was	munizations ary if the resident is not the facility.* on was provided prior to exit. admitted to the facility on	F6	22	6		
	data set), a five day an ARD (assessment the resident scored interview for mental	st recent MDS (minimum Medicare assessment with it reference date) of 1/2/22, 7 out of 15 on the BIMS (brief status), indicating the cognitively impaired for its.					
1	the resident was tran 12/27/21 for respirate of Resident #54's clin the Information provi				¥		
	LPN #2 stated that no with a care plan, face order (If applicable), I labs or x-rays, recent notes and a copy of t when residents are tr LPN #2 stated nurses the information provide	m., an interview was (licensed practical nurse) #2. urses provide hospital staff is sheet, do not resuscitate ohysician's orders, pertinent nurses notes, physician he bed hold agreement ansferred to the hospital. Is are supposed to document led to hospital staff in a ake a copy to keep in the					
r	nember) #1 (the adm director of nursing) ar	n., ASM (administrative staff hinistrator), ASM #2 (the nd ASM #3 (the regional vice prvices) were made aware					

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	IPLE CONSTRUCTION IG			E SURVEY PLETED
	495255	B. WING_			02/	08/2022
SUMMARY STA	ND NURSING CENTER TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SEC IDENTIFYING INFORMATION)	ID PREFIX	(EACH CORRECTIVI CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD TO THE APPROPE	BE	(X6) COMPLETION DATE
			DEFIC	CIENCY)		
No further Information Accuracy of Assess CFR(s): 483.20(g) §483.20(g) Accuracy The assessment more resident's status. This REQUIREMENT by: Based on staff interfacility document review, it was determined an accurate residents, Resident The facility staff failed MDS (minimum date for Resident #32. The findings included During the entrance request was made for smoking times and three residents provided 2/8/22 at 3 included on the list. On 2/7/22 at 3:00 Pl observed to go to the smoking area for So supervised by two sides.	on was provided prior to exit. ments y of Assessments. ust accurately reflect the IT is not met as evidenced view, resident interview, view and clinical record mined the facility staff falled to assessment for one of 51 #32. ad to complete an accurate a set), an annual assessment,	F 62	F 641 1. Resident #32 was correction and a 2/7/2022. 2. All residents may been affected. The audit the most a current resident be conducted to further inaccurations. 3. The MDSC will resident in the second secon	as modified for accuracy on any have potential fine MDS Nurse with the MDS of all the that smoke with the assessments, maintain an up-to ent residents that will be updated to each Quality ting. any resident MI kly x4 weeks to acy. an/Audits to be	vill - -	
distributed cigarettes cigarette. The smok	s and then lit each resident's king area contained a smoke tinguisher with inspection tag	,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495255	B. WING			02/08/2022	
NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIED TO T		BE	(XS) COMPLETION DATE
F 641	Continued From page 35 dated 2020-2021, and punch holes on months of June and September 2020.		, F6	41			
6	Resident #32 was admitted to the facility on 10/2/14 with diagnoses that included but were not limited to: nicotine dependence.						
1	quarterly assessmer reference date) of 12 15 out of 15 on the Emental status), indicating the MDS Section resident was coded a bed mobility, transfer hygiene, bathing, eat did not occur. A reviassessment with an A	ing and locomotion; walking lew of the annual MDS ARD of 8/6/21 revealed cumented has having "no"					
£	plan dated 10/15/21, "FOCUS-Resident is determined that [Resident supervision. INT educated on facility sucompliance requireme (oxygen) is to be in all assessment on admisquarterly and PRN (ascondition. Will be educated.)	a smoker and it has been ident #32] is a safe smoker ERVENTIONS-Resident moking times and ents to safely smoke. No O2 rea of smokers. Smoking sision, re-admission, a needed) with changes in cated on designated area miting smoking to that area. ing of smoking area,					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495255	B. WING			02/	08/2022
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		30	TREET ADDRESS, CITY, STATE, ZIP CODE D MONTVUE DRIVE URAY, VA 22835		
(X4) IĎ P REFI X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X6) COMPLETION DATE
F 641	' ' ' '	ge 36 king evaluation dated	F6	341			
1	10/15/21 at 4:19 PM "Evaluation: Resider vision or blindness; sitting or standing: Note that the control of the	I revealed, in part, Int utilizes tobacco. Poor No. Balance problems while No. Total or Ilmited ROM arms or hands: No. or skills needed to securely Lethargic / falls asleep easily rities: No. Burns skin, clothing, o. Orops ashes on self; No. colicy on location and time of erns: Able to light a cigarette a cigarette safely. Able to e safely. Able to use ashtray					
	3/28/21 at 10:59 AM Yesterday evening a back down onto the Resident was upset been out to smoke dimember to assist with member was unable doing rounds/med prout. Resident continuito room. This write having a member avite began to calm down.	ing progress note dated revealed, in part, "Late entry: t 3:20 PM, resident came floor from the offices. because they had not yet lue to not having a staff th taking them out. This to, and the 3-11 staff was ass and unable to take them sued to go off and he went or talked to resident about not realiable and resident finally."					
	7/14/21 at 5:37 PM r	ng progress note dated evealed, in part, "Nicotine resident for next two weeks.					
	AM with Resident #3 smoked, Resident #3	nducted on 2/7/22 at 11:00 2. When asked if he 32 stated, "Yes, I have been When asked where he					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		TE SURVEY MPLETED
		495255	B. WING		02	/08/2022
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 30 MONTVUE DRIVE LURAY, VA 22835	ACCORDING TO SECURE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	smokes, Resident #	32 stated, "I smoke outside in We go out of the doors on	F 64	11		
t	An interview was co with RN (registered coordinator. When MDS dated 8/6/21 fo	nducted on 2/7/22 at 4:00 PM				
,	as 'No'." When sho smoking evaluation stated, "The MDS is When asked what si	wn the care plan and safe for Resident #32, RN #2 incorrect. I will correct It." tandard is followed for the "We follow the RAI (resident				
1	member) #1, the addirector of nursing, A of operations, ASM a president of clinical spractical nurse) #3, the addirection of clinical spractical nurses and the additional spractical spractical nurses and the additional spractical	M, ASM (administrative staff ministrator, ASM #2, the ASM #3, the regional director #4, the regional vice services and LPN (licensed the assistant director of aware of the concern.				
1	No further informatio	n was provided prior to exit.		}		1
,	tobacco use: Steps for Assessmer 1. Ask the resident if any form during the 7 2. If the resident state	he or she used tobacco in 7-day look-back period. es that he or she used				
F 656	period, code 1, yes."	o during the 7-day look-back Comprehensive Care Plan	F 656		1	EIVED
	§483.21(b) Compreh	ensive Care Plans			VDH	2 5 2022 L/OLC

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495255	B. WING		02/08/2022
1	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 10 MONTVUE DRIVE	
SKYVIE	w springs rehab a	ND NURSING CENTER		URAY, VA 22835	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	§483.21(b)(1) The filmplement a compricare plan for each resident rights set for §483.10(c)(3), that is objectives and time medical, nursing, an needs that are identical assessment. The codescribe the following (i) The services that or maintain the residentical, mental, an required under §483.24, §483 (ii) Any services that under §483.24, §483 provided due to the under §483.10, inclutreatment under §483.10, inclutreatment under §483.10 inclutreatm	acility must develop and ehensive person-centered esident, consistent with the orth at §483.10(c)(2) and includes measurable frames to meet a resident's and mental and psychosocial diffied in the comprehensive emprehensive care plan must ang - are to be furnished to attain dent's highest practicable dipsychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights adding the right to refuse 3.10(c)(6). Services or specialized as the nursing facility will be PASARR for a facility disagrees with the ARR, it must indicate its lent's medical record. Although the resident and the active (s)-balls for admission and reference and potential for cilities must document the sessed and any referrals to ses and/or other appropriate	F 656	1. Resident # 88 failed to have documentation documenting pharmacological pain interventions. Resident # 52 ft to have documentation that a shower was refused, or a show was given. Resident # 11 obset to not have doughnut pillow to ankle to alleviate pressure. The residents care plan document be on at all times. Residents Residents #41 and Resident # care plans were immediately updated. 2. All other residents may have potentially affected. The Direct of Nursing/Designee will educate nursing staff on policy Care Planning-Comprehensive Persidents have been reviewed and care plans have interventions implemented. 3. The Director of Nursing/Design will educate nursing staff on policy Care Planning-Comprehensive Person-Centered, including built in the director of Nursing/Design will educate nursing staff on policy Care Planning-Comprehensive Person-Centered, including builtmited to importance of ensural care plans have intervention implemented and orders reviewed and care plans have intervention implemented and orders reviewed and ord	wer erved to left te ed to # 10, 74 been tor ate tor inted

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						(X3) DATE SURVEY COMPLETED	
	495255	B. WING			02/	08/2022	
PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		3	IO MONTVUE DRIVE			
SUMMARY BTATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (FAG REGULATORY OR LSC IDENTIFYING INFORMATION)				(EACH CORRECTIVE ACTION SHOUL	D 8E	(XS) COMPLETION DATE	
section. This REQUIREMENthly: Based on observation, staff in and facility documenthat the facility staff implement the composite staff implement the composite staff in the st	on, family interview, terview, clinical record review of review, it was determined failed to develop and/or prehensive care plan for six of survey sample, Residents # # 11 and # 74. : alted to implement Resident # care plan for the use of fall individual to the facility with a led but was not limited to lack individual to the BIMS (brief status), indicating the impaired of cognition for ins. proximately 2:22 p.m., an lent # 10 revealed they were lent # 10 revealed they were lent # 10 revealed they were	F 6	556	4. The Director of Nursing will complete an audit of with oxygen to ensure the concentrator is set on the appropriate liter flow per orders and comprehensing plan. This audit will be we weeks then monthly. The of Nursing will submit to committee for review and recommendations. The Diversity of Particles with mensure orders and comprehensing plans is implemented audit will be weekly for 4 then monthly. The Direct Nursing will submit to the committee for review and recommendations. The Diversity for 4 weeks. The Diversity for 5 weekly for 6 wee	residents at oxygen MD recare residents are care residents are residents for 4 pirector of mplete and rector of QAPI rector of QAPI rector of piecetor of question que transcription question que transcription que transcription que transcription que transcription que transcription question que transcription		
	PROVIDER OR SUPPLIER V SPRINGS REHAB A SUMMARY BTAT (EACH DEFICIENCY REGULATORY OR LS Continued From paysection. This REQUIREMEN by: Based on observation staff intervity and facility documentate the facility staff implement the compstance of the staff includes and facility staff in the	PROVIDER OR SUPPLIER V SPRINGS REHAB AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 falled 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 falled 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	PROVIDER OR SUPPLIER V SPRINGS REHAB AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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.	PROVIDER OR SUPPLIER V SPRINGS REHAB AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 falled to develop and/or implement the comprehensive care plan for slx of 51 residents in the survey sample, Residents # 10, # 41, # 88, # 52, # 11 and # 74. The findings include: 1. The facility staff falled 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	PROVIDER OR SUPPLIER 495255 SIMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (SACH ORSPICIENCY MINES DE PROCEDED BY PILL (REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, cilnical record review and facility document review, it was determined that the facility staff falled 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 falled to implement Resident # 10's comprehensive care plan for the use of fall mats. The facility document review and recommendations. The D Nursing /Designee will conducted 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 socred 4 (four) out of 15 on the BIMS (brief interview for mental status), indicating the resident 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 loft side. On 02/07/2022 at approximately 8:52 a.m., an observation of Resident # 10 revealed they were lying in bed with a fall mat on the floor to the resident's loft side.	## SPRINGS REHAB AND NURSING CENTER SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY WAS TO BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 ECONTINUED FROM THE PRESPRENCE OF THE APPROPRIATE DEPICEMENT WAS RECTION, STATE (ALL PROVIDERS PLAN OF CORRECTION HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICEMENT WAS RECTION, STATE (ALL PROVIDERS PLAN OF CORRECTION HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICEMENT OF THE APPROPRIATE DEPICEMENT WITH A DIFFERENCE OF THE APPROPRIATE DEPICEMENT OF THE APPROPRIATE DEPICEMENT OF THE APPROPRIATE DEPICEMENT WITH A DIFFERENCE OF THE APPROPRIATE DEPICEMENT OF THE APPROPRIATE DEPCICIENCY THE APPROPRIATE DEPCICEMENT WITH A DIFFERENCE OF THE A	

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEPLAY OF CORRECTION IDENTIFICATION NUMBER:		A. SUILDI	riple construction NG	•	COMPLETED		
		495255	B. WING			02/0	08/2022	
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CIT 30 MONTVUE DRIVE LURAY, VA 22835	Y, STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFI) TAG	(EACH CORRECTION CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPF DEFICIENCY)	BE	(X6) COMPLETION DATE	
1	On 02/07/2022 at a observation of Resilying in bed with a faresident's left side. The current POS (p Resident # 10 docuboth sides of bed Q Order Date: 02/07/2 The comprehensive documented in part, risk for falls r/t (relaiproblemsRevision at bedside on right s 06/14/2021." On 02/07/2022 at a interview was condupractical nurse) # 1. orlentation of placing side of a resident's irreferred to the reside asked what should I plan documents a p device/equipment, L implemented or in p On 02/07/2022 at apobservation Resider was conducted with describe the location LPN # 1 stated, "it's Resident # 10's] becomprehensive care # 1 was asked if the	pproximately 2:10 p.m., and dent # 10 revealed they were all mat on the floor to the hysician order sheet) for mented in part, "Floor mats to (every) shift. Every shift. 2022. Start Date: 02/07/2022." care plan for Resident # 10, "Focus: [Resident # 10] is at ted to) Galt/balance on: 10/29/2021." Floor mats side. Date Initiated: Exproximately 10:35 a.m., an acted with LPN (Ilcensed When asked to describe the grafall mat on the right or left bed, LPN # 1 stated that it ent's left or right side. When happen if a resident's care rocedure or the use of a LPN # 1 stated, "It should be	F6	5. Corre	ective Action/Audits to	o be		

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION BING		(X3) DATE SURVEY COMPLETED	
		495255	B. WING		02	2/08/2022	
į.	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BĘ	(XS) COMPLETION DATE	
	The facility's policy "Comprehensive Per in part, "2. The facilita comprehensive per each resident, that it objectives and timef medical, nursing, an needs as identified to comprehensive Resident (RAI) process." On 02/07/2022 at ap (administrative staff ASM # 2, director of vice president of clinical sthe findings. No further information 2. Facility staff falled 41's comprehensive administration of oxy. Resident # 41 was addiagnoses that including respiratory failure and pulmonary disease. On the most recent Nequarterly assessment reference date) of 12 accord 15 out of 15 or mental status), incognitively intact for mesection "O Special Treograms" coded Residents.	Care Planning - son-Centered" documented, ty will develop and Implement orson-centered care plan for includes measurable trames to meet a resident's d mental and psychosocial throughout the ident Assessment Instrument oproximately 5:00 p.m., ASM member) # 1, administrator, nursing, ASM # 3, regional trations, ASM # 4, vice services, were made aware of the was provided prior to exit. Ito implement Resident # care plan for the gen at one liter per minute. Idmitted to the facility with led but were not limited to:	F 6	56			

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	TOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	A. BUILD		LE CONSTRUCTION	(X3) DATE SURVE COMPLETED		
		495255	B. WING	·	· 	02	/08/2022	
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE O MONTVUE DRIVE LURAY, VA 22835			
(X4) IĎ PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
	observation of Residelying in bed receiving Observation of the froncentrator revealed between 0.5 and 1 limits of the froncentrator of Residelying in bed receiving Observation of the froncentrator revealed between 0.5 and 1 limits of the froncentrator revealed between 0.5 and 1 limits of the froncentrator revealed between 0.5 and 1 limits of the froncentrator revealed between 0.5 and 1 limits of the froncentrator revealed between 0.5 and 1 limits of the froncentrator revealed between 0.5 and 1 limits of the froncentrator revealed between 0.5 and 1 limits of the froncentrator revealed between 0.5 and 1 limits of the froncentrator froncentrator from froncentrator obstructive prespiratory fallure. Despiratory fallure	pproximately 3:23 p.m., an dent # 41 revealed they were g oxygen by nasal cannula. low meter on oxygen ed an oxygen flow rate liters per minute. pproximately 8:20 a.m., an dent # 41 revealed they were g oxygen by nasal cannula. low meter on oxygen ed an oxygen flow rate ters per minute. pproximately 2:15 p.m., an lent # 41 revealed they were g oxygen by nasal cannula. low meter on oxygen ed an oxygen flow rate ters per minute. pproximately 2:15 p.m., an lent # 41 revealed they were g oxygen by nasal cannula. low meter on oxygen eters per minute. for Resident #41 (one liter per (nasal cannula) every shift. 20." care plan for Resident # 41 cumented in part, "Focus: lered respiratory hing r/t (related to) COPD outmonary disease), ate Initiated: N as ordered. Date Initiated: proximately 2:30 p.m., an ext 41's flow meter on their and interview was	F	656				
0	conducted with LPN ((licensed practical nurse) #						

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE C		(X3) DATE SURVEY COMPLETED		
		495255	B. WING				2/08/2022	
	PROVIDER OR SUPPLIER ** SPRINGS REHAB A	ND NURSING CENTER		30 M	ET ADDRESS, CITY, STATE, ZIP CODE ONTVUE DRIVE AY, VA 22835		ZI OUI AUAL	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	K	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	1
Foo Commander Street	1. When asked the Resident # 41 who we cannula LPN # 1 rea "One and a half liters reviewing the compre Resident # 41's resp asked if the care plant 1 stated no. On 02/07/2022 at application of the care plant 1 stated no. On 02/07/2022 at application of the president of clinical state findings. No further information of further information of the findings. No further information of Norchydrocodone-acetam Resident # 88 was addiagnosis that include thronic pain. On the most recent Mularterly assessment reference date) of 01/2 cored 15 out of 15 or mental status), indiagnitively intact for mection J0400 "Pain F 88 as "Frequently." Intensity," it documenticale (00-10) Ask resident (00-10) Ask	oxygen flow rate was for yas receiving oxygen by nasal d the flow meter and stated, a per minute." After shensive care plan for iratory care, LPN # 1 was now as being followed. LPN # 1 proximately 5:00 p.m., ASM member) # 1, administrator, nursing, ASM # 3, regional rations, ASM # 4, vice ervices, were made aware of now as provided prior to exit. Itel to implement Resident care plan for implementing interventions prior to the continophen) (1). Intervention of the facility with a d but was not limited to the facility with a d but was not limited to the BIMS (brief interview cating the resident is aking daily decisions. requency" coded Resident	F6	56				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,		495255	B. WING		02	2/08/2022	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
SKYVIE	W 8PRINGS REHAB A	ND NURSING CENTER		30 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	·	HOULD BE	(X6) COMPLETION DATE	
F 656	Continued From page	ge 44	F6	356			
1	worst pain you can i 00-10 pain scale). E	ng no pain and ten as the magine." (Show resident inter two-digit response. Enter er." Resident # 88 was coded	Ot.				
	88 documented in pi to 325) MG (HYDRO Give 1 (one) tablet be needed for Pain. For	's order sheet) for Resident # art, "Norco Tablet 5-325 (five OcodoneAcetaminophen). by mouth every 4 hours as r pain 1-5 Tyl 6-10 Norco. 020. Start Date: 08/04/2020,"		±.			
ı	dated 08/12/2021 do [Resident # 88] has to pain/discomfort. Date"Offer non-pharm (care plan for Resident # 88 cumented in part, "Focus: the potential for a Initiated: 08/12/2021 (non-pharmacological) n. Date Initiated: 10/27/2021."					
	record) for Resident documented the physabove. Further revie Resident # 88 receive the following dates at non-pharmacological attempted: 01/01/202 at 4:00 a.m., and at 7 p.m.; 01/04/2022 at 1:30 a. 01/07/2022 at 1:30 a. 01/07/2022 at 7:14 p.m. and at 7:46 p.m.; 01/1/2022 at 1:00 a. and at7:24 p.m.; 01/1/3:14 p.m.; 01/14/2022	22 at 2:06 a.m.; 01/02/2022 2:23 p.m.; 01/03/2022 at 7:33 2:00 a.m., and at 7:22 p.m.; m.; 01/06/2022 at 1:00 a.m.; a.m., and at 7:30 p.m.; n.; 01/09/2022 at 1:30 a.m., 10/2022 at 1:00 a.m.; m.; 01/12/2022 at 2:24 a.m., 3/2022 at12:30 a.m., and at 2 at 8:33 p.m.; 01/18/2022 at 2 at 2:34 a.m.; 01/2/1/2022	_				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA (DENTIFICATION NUMBER:	(X2) MU A. BUIL(PLE CONSTRUCTION		NTE SURVEY IMPLETED
		495255	B. WING	_		02	2/08/2022
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER] 3	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(XB) COMPLETION DATE
F 656	01/23/2022 at 9:43 ; 01/25/2022 at 2:00 a a.m., and at 7:40 p.r 01/28/2022 at 2:00 a 01/29/2022 at 1:45 a 7:25 a.m. The eMAR for Resid 2022 documented th above. Further revie Resident # 88 receiv	o.m.; 01/24/2022 at 2:00 a.m.; a.m.; 01/26/2022 at 12:25 m.; 01/27/2022 at 1:00 a.m.; a.m., and at 7:46 p.m.; a.m.; and on 01/31/2022 at lent # 88 dated February se physician's order as stated ow of the eMAR revealed red 5-325 mgs of Norco on	F€	\$56			
	the following dates a evidence of non-phabeing attempted: 02/7:58 p.m.; 02/04/202	nd times, without no macological interventions 02/2022 at 1:45 a.m., and at 2 at 2:10 a.m.; 02/05/2022 at 2 at 1:30 a.m., and at 7:42					
	Resident # 88 dated 02/07/2022 falled evi non-pharmacological	s nursing progress notes for 12/01/2021 through dence documentation interventions attempted for 88 received 5-325 mgs of					
(conducted with Resident # 88 to pain. Resident # 88 to pain in their hand and they receive pain medication Resident:	c.m., an interview was lent # 88 regarding their stated that they have arthritis it left knee. When asked if dication as needed, Resident en asked if nursing staff try before administering their # 88 stated, "No, they just lication and say I hope it					
l l		roximately 11:04 a.m., an led with LPN # 1. LPN # 1 s documentation that					

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AND PLAN	ND PLAN OF CORRECTION (X1) PROVIDENSUPPLIENCES (X1) PROVIDENSUPPLIENCES (X1) PROVIDENSUPPLIENCES (X1) PROVIDENSUPPLIENCES (X1) PROVIDENSUPPLIENCES		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495255	B. WING		02/08/2022			
	PROVIDER OR SUPPLIER W SPRINGS REHAB	ND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTYUE DRIVE LURAY, VA 22835					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES If MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE		
	non-pharmacologicattempted prior to F physician ordered p # 1 stated no. After Resident # 88, LPN plan was implement non-pharmacological administration for the dates listed above. On 02/08/2022 at a (administrative staff ASM # 2, director of president of clinical the findings. No further information References: (1) Hydrocodone is a opioid is sometimes Acetaminophen is a increases the effects combination of aceta is used to relieve mo information was obta https://www.rxlist.com mages-side-effects.th 4. The facility staff facomprehensive care #52. Resident #52 was ad 11/22/2021. On the mo data set), a quarterly (assessment reference)	al Interventions were Resident # 88 receiving the rain medication of Norco. LPN reviewing the care plan for # 1 was asked if the care ted for the use of al Interventions prior to the e pain medication on the LPN # 1 stated no. **Opproximately 1:50 p.m., ASM member) # 1, administrator, nursing and ASM # 4, vice services, were made aware of the majority of the medication. An called a narcotic. **Jess potent pain reliever that is of hydrocodone. The minophen and hydrocodone derate to severe pain. This sined from the website: m/norco-5-325-drug/patient-latm. **Jest to implement the plan for bathing for Resident mitted to the facility on nost recent MDS (minimum assessment, with an ARD ce date) of 12/30/2021, the of 15 on the BIMS (brief tatus), indicating the	F 656	D: VA0168 If conti	Nuation sheet Page WHOL	47 of the		

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495255	B. WING		··-	02	/08/2022
SKYVİE		ND NURSING CENTER		30	REET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE RAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	resident is severely making dally decision Status, the resident a shower or bath during the comprehensive documented, in part, ADL self-care perfor Dementia, Limited MBATHING/SHOWE when a full bath or significant the resident has refur the resident has refur the resident has refur the resident has refur the resident has refur the staff is telling refusing them. The ADL (activities of following months documentation of the telling refusing them. The ADL (activities of following months documentation of the telling refusing them). The ADL (activities of following months documentation of the telling refusing them). For November 2021 and 11/26/2021, 11/28/2021. On the telling refusing the reside to the telling.	cognitively impaired for ms. In Section G - Functional was coded as not having had ring the lookback period. care plan dated 11/29/2021, "Focus: The resident has an mance deficit r/t (related to) lobility ERING - Provide sponge bath hower cannot be tolerated." mentation in the care plan that sed baths/showers. Inducted with the resident's 6/2022 at 3:11p.m. When concerns, the family is she is concerned that her baths/showers. She stated her that the resident is If daily living) records for the umented: In the resident received a 21. The activity (bathing) 3/2021, 11/25/2021, 21, 11/28/2021, 11/29/2021 the following dates, bathing air Only" was documented: 21, and 11/29/2021. There were only six days of	F6	56			

1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495255	B. WING			02	2/08/2022	
11	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		3	BTREET ADDRESS, CITY, STATE, ZIP CODE BO MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 656	Continued From pag	ge 48	F6	56				
1	12/4/2021 - there wa bathing. 12/5/2021 - the resk night shift.	d a bed bath on night shift, as no documentation of any dent received a bed bath on dent received a bed bath on			2.			
1	scheduled on the ev Friday. There was no 1/14/2022. On 1/14/2 1/25/2022, and 1/28/	the resident's showers were enling shift on Tuesday and o documentation until 2022, 1/18/2022, 1/21/2022, 1/2022, it was documented vity did not occur; however, alted for each date.						
		on 2/1/2022 and 2/4/2022 ld not occur. For both of ented "hair only."						
	The nurse's notes from 2/7/2022 were review documentation of the baths/showers.							
	nursing assistant) #7 The above ADL recor #7. CNA #7 was info had expressed conce receiving baths/show resident refuses them staff are to document bath/shower, CNA #7 nowhere to document were told to document completed, and then the nave been given. She	t the refusal. She stated they						

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 #3 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 if is 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		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
SKYVIEW SPRINGS REHAB AND NURSING CENTER SKYVIEW SPRINGS REHAB AND NURSING CENTER SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LISC IDENTIFYING INFORMATION) 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, "We have to tell the nurse." CNA #7 stated she has not seen the ADL records princtical nurse) #1, no 2/8/2022 at 11:07 a.m. When asked the purpose of the care plan, LPN #1 stated if is a guide to paken 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 #1. 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 recort MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference delet) of 11/17/2021, the recident was cooled as having			495255	B. WING		02	02/08/2022	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 princted 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 if it should be followed, LPN #1 stated; span with 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			ND NURSING CENTER		30 MONTVUE DRIVE	· · · · · · ·		
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 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 11/11/2021, the resident was coded as having	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFI	X (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR	LD 8E	COMPLETION	
short and long term memory problems and severely cognitively impaired for making daily decisions. In Section M - Skin Conditions, the		bath/shower did not should have been giresident refuses what take, CNA #7 stated CNA #7 stated CNA #7 stated in this manner practical nurse) #3 will documentation that it bath/shower on the additional tracked in the state of the state of the should be asked if it should be asked if it should be asked if it should be administrator, ASM #3, the regional services, were made on 2/8/2022 at 2:05 p. No further information for the facility staff to comprehensive care pressure relieving decional pillow was not be comprehensive care in the services. On the modulate set) assessment with an ARD (assessment with an ARD (assessment and long term mereverely cognitively in the resident and long term mereverely cognitively in the state of	occur, but that a shower ven. When asked If a at action should the CNA, "We have to tell the nurse." has not seen the ADL records or. At this time, LPN (licensed was asked to provide any Resident #52 had received a above referenced dates. Inducted with LPN (licensed on 2/8/2022 at 11:07 a.m. pose of the care plan, LPN to patient care. When followed, LPN #1 stated, yes. Istaff member) #1, the P2, the director of nursing, I vice president of clinical aware of the above concernion. In was obtained prior to exit. Implement the plan for the placement of a vice for Resident #11. The n place per the plan. In place per the plan, assessment, ment reference date) of ont was coded as having the plained for making daily	F 6		9		

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FORM	APPROVED
OMB NO.	0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495255	B. WING	·		02	/08/2022
NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
SKYVİE	W SPRINGS REHAB A	ND NURSING CENTER		1	30 MONTVUE DRIVE LURAY, VA 22835		
(XA) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRÉCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) GOMPLETION DATE
	pressure Injury. "Prinjury is localized da underlying soft tissu prominence or related device. The Injury capen ulcer and may as a result of Intension pressure in comb Pressure Injury. Full-thickness loss of is visible in the ulcer epibole (rolled wound Slough and/or eschall "Focus: The resident shoulder"Donut plipressure." Observation was mad 2/7/2022 at 8:11 a.m. a reclining chair with There was not donut	essure Injury: A pressure image to the skin and the usually over a bony sed to a medical or other an present as intact skin or an be painful. The injury occurs a and/or prolonged pressure ination with shear. Stage 3 -thickness skin loss of skin, in which adipose (fat) and granulation tissue and diedges) are often present. Ar may be visible." (1). care plan dated 11/9/2021, 022, documented in part, thas a pressure ulcer of left liow to left ankle to alleviate de of Resident #11 on . The resident was seated in her legs bent at her knees. pillow around the resident's	F	356			
	left ankle. A second of 2/7/2022 at 3:31 p.m with her covers over noted on the top of himursing assistant) #8 asked if the resident on her left ankle, CN/puts it on her. It's sup CNA #6 confirmed that he nightstand and not the physician orders documented in part, "	observation was made on . The resident was in her bed her. The donut pillow was er nightstand. CNA (certified came into the room. When was to have the donut pillow A #6 stated that she always posed to be on all the time. e donut pillow was sitting on of on the resident.					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495255	B. WING			02/08/2022	
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE SO MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
F 656	Continued From pag	ge 51	F	56		 .	
ı	practical nurse) #8 of above observation we When asked if the p should be in place a yes. When asked if it	nducted with LPN (licensed on 2/7/2022 at 3:32 p.m. The was shared with LPN #8. hysician ordered donut pillow is prescribed, LPN #8 stated, the resident's care plan ow should be in place is #8 stated, no.		S.			
ľ	administrator, ASM # ASM #3, the regiona	staff member) #1, the #2, the director of nursing, I vice president of clinical aware of the above concern o.m.					
=	No further informatio	n was obtained prior to exit.					
9	following website: https://cdn.ymaws.co	vas obtained from the m/npuap.site-ym.com/resour essure_injury_stages.pdf					
	6. The facility staff fa	iled to develop a care plan for Resident #74.					
	quarterly assessment reference date) of 1/1 coded as being sever daily declalons. Secti	IDS (minimum data set), a with an ARD (assessment 9/2022, the resident was ely impaired for making on O documented the gen at the facility during the					
1	#74 was observed in I nasal cannula with a i 2/4/22; the equipment	ximately 2:15 p.m., Resident bed wearing an oxygen numidifier bottle dated was attached to an oxygen nt #74 was observed to be					

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P.057/120

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495256	B. WING	·		02/08/2022		
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		30	TREET ADDRESS, CITY, STATE, ZIP CODE DIMONTVUE DRIVE URAY, VA 22835			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	OULD BE COMPLÉTION		
F 656	Continued From pag alert, awake and no	·	F6	556				
	2/6/2022 at approximately 8:1	ons of Resident #74 on nately 4:15 p.m. and 2/7/2022 5 a.m. revealed oxygen being al cannula as described						
		care plan for Resident #74 cumentation of oxygen						
		s for Resident #74 "Oxygen therapy at 2 (two) nasal cannula. Start Date:						
	interview was conduct practical nurse) #1. If purpose of the care patient. LPN #1 is included on the care Resident #74's oxyge 1.5 liters per minute,	eximately 2:35 p.m., an exted with LPN (licensed LPN #1 stated that the plan was to guide the care of stated that oxygen should be plan. LPN #1 observed on and stated it was set at and that she would verify the plan and correct this as						
	part, "2. The facility	re planning" documented in will develop and implement son-centered care plan for cludes measurable						
'	bjectives and timefra nedical, nursing, and	ames to meet a resident's mental and psychosocial			RECE	CIVE	D	
1 7	needs as identified the comprehensive Resid				FEB 2	5 202	2	
	RAI) process" On 2/7/2022 at 5:00 p	.m., ASM #1, the			VDH/	OL(C	

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AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	1 1 11 11 11	3	COMPLETED	
	495255	B. WING		02/08/2022	
PREFIX (EACH DEFICIENCY	IND NURSING CENTER TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
ASM #3, the regions ASM #4, the vice provided aware of the No further Information ADL Care Provided CFR(s): 483.24(a)(2) A resion activities of dally services to maintain personal and oral hy This REQUIREMEN by: Based on family into review, and clinical determined the facilic (activities of dally liveresidents in the surve Resident #52, a dependent #52, a dependent #52, a dependent #52, a dependent #52 was an 11/22/2021. On the data set), a quarterly (assessment referencesident scored and Interview for mental resident is severely making daily decision Status, the resident a shower or bath dute. The comprehensive	#2, the director of nursing, all director of operations and resident of clinical services of the findings. on was provided prior to exit. for Dependent Residents ident who is unable to carry (living receives the necessary good nutrition, grooming, and yglene; it is not met as evidenced erview, facility document record review, it was lity staff falled to provide ADL ing) care for one of 51 rey sample, Resident #52. pendent resident, was not	F 656		wer was given. ve been taff Educator nursing staff itation. ee will n ADL Care esignee will iled showers irector of I committee ations.	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495255	6. WING	i		02	/08/2022
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 30 MONTVUE DRIVE LURAY, VA 22835	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD I	BE	COMPLETION DATE
F 677	 Continued From page	ge 54	F 6	377			
t I	Dementia, Limited M BATHING/SHOW! when a full bath or s	ERING - Provide sponge bath hower cannot be tolerated." nentation in the care plan that	Æ.				
	family member on 2/ asked if she had any representative stated mother is not getting	nducted with the resident's 6/2022 at 3:11p.m. When concerns, the family she is concerned that her baths/showers. She stated her that the resident is					
	The ADL (activities o following months doc	f daily living) records for the cumented:		15			
	bed bath on 11/24/20 did not occur on 11/2 11/26/2021, 11/27/20 and 11/30/2021, On t	21, 11/28/2021, 11/29/2021 he following dates, bathing air Only" was documented:					
E	documentation of bat 12/1/2021 - the reside 12/2/2021 - the reside bathing. 12/3/2021 - the reside bath on day shift and 12/4/2021 - there was bathing. 12/5/2021 - the reside hight shift.	there were only six days of hing. ent received a bed bath. ent did not receive any ent received a partial bed a bed bath on night shift. ent documentation of any ent received a bed bath on ent received a bed bath on ent received a bed bath on					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LTIPLE CONSTRUCTION DING	(X3	(X3) DATE SURVEY COMPLETED	
		495255	B. WING	B. WING		02/08/2022	
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 30 MONTVUE DRIVE LURAY, VA 22835	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUSY BE PRECEDED BY FULL BC (DENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	COMPLETION E DATE	
F 677	Continued From page	ge 55	F 6	377			
	scheduled on the ever Friday. There was not 1/14/2022. On 1/14/1/25/2022, and 1/28 that the bathing activity of the bathing activity of these, it was document the bathing activity of these, it was document the nurse's notes for 2/7/2022 were review documentation of the baths/showers. An Interview was consument above ADL reconsument at the above ADL reconsument	non 2/1/2022 and 2/4/2022 Ild not occur. For both of ented "hair only." om 11/22/2021 through wed. There was no e resident's refusal of a resident's refusal of a resident at the resident not yers. CNA #7 stated the m. When asked how facility to a resident's refusal of a resident's refusal of a resident's refusal of a resident's refusal of a resident not yers. CNA #7 stated the m. When asked how facility to a resident's refusal of a resident's refusal of a resident's refusal of a resident was not to document what should be stated the January 2022 anced above shows that the occur, but that a shower					

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION DING		DATE SURVEY COMPLETED
23	e	495255	B. WING)		02/08/2022
l .	F PROVIDER OR SUPPLIER EW SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZI 30 MONTYUE DRIVE LURAY, VA 22835		VK, 0012022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT)	ION SHOULD BE HE APPROPRIATE	(XII) COMPLETION DATE
F 677	documentation that bath/shower on the On 2/8/2022 at 9:59 documentation that baths/showers. The 2/3/2022 and 2/7/20 could not find any ot resident received an	Resident #52 had received a above referenced dates. a.m. LPN #3 provided Resident #52 received three dates were 1/28/2022, 22. LPN #3 stated the facility her documentation that the y other showers/baths.	F 6	577		
11 00 00 00 00 00 00 00 00 00 00 00 00 0	administrator, ASM # ASM #3, the regiona	staff member) #1, the #2, the director of nursing, I vice president of clinical aware of the above concern o.m.				
1	(ADLs)" documented unable to carry out a independently will recto maintain good nutrand oral hygiene2. services will be proviousable to carry out Alconsent of the reside	ceive the services necessary rition, grooming and personal Appropriate care and ded for residents who are DLs independently, with the nt and in accordance with iding appropriate support a. hygiene (bathing,				
	ASM #3, the regional	2, the director of nursing, vice president of clinical aware of the above concern				
F 686 SS=D		was obtained prior to exit. event/Heal Pressure Ulcer i)(ii)	F 686	6		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		495255	B. WING	B. WING			08/2022
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE SO MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL BC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE	(XB) COMPLETION DATE
F 686	Continued From pa	ge 57	F 6	86	F 686		
	resident, the facility (i) A resident receive professional standal pressure ulcers and ulcers unless the in- demonstrates that ti (ii) A resident with p necessary treatment with professional stap promote healing, prinew ulcers from dev This REQUIREMENT by: Based on observati document review and was determined the implement the physic	rehensive assessment of a must ensure that- es care, consistent with rds of practice, to prevent idoes not develop pressure dividual's clinical condition hey were unavoidable; and ressure ulcers receives t and services, consistent andards of practice, to event infection and prevent			1. Resident # 11 recommendation relative to wound have been implemented and dough nut applied as per physician order. 2. All residents have the potent be affected by this alleged deficient practice of ensuring necessary pressure relieving devices are provided to proming and or prevent decling pressure ulcers. The Staff Edu /Designee will educate nursing staff on the Policy Pressure in Prevention and management facility audit was completed. Wound Nurse through obserto ensure that residents with pressure relieving devices are	pillower. tial to note ne in ucator ng njury . A by the vation	
,	residents in the surv	vey sample, Resident # 11. ed to place a donut pillow on kle.			place and implemented per physician order. 3. The Staff Educator /Designee educate nursing staff on the Pressure injury Prevention as	Policy	
ı	Resident #11 was an 7/11/2015. On the m data set) assessment with an ARD (assess 11/17/2021, the resistant and long term being severely cognitive daily decisions. In Sthe resident was coopressure injury. "Property of the resident was coopressure injury."	dmitted to the facility nost recent MDS (minimum nt, a quarterly assessment sment reference date) of dent was coded as having memory problems and as litively impaired for making section M - Skin Conditions, ded as having one stage III essure Injury: A pressure mage to the skin and			management. A Mandatory Nursing Inservice has been scheduled with the Wound Physician and Wound Nurse. 4. The Director of Nursing/Desi will complete an audit of resi with pressure relieving device weekly x 4weeks. The Directo Nursing will submit to QAPI if review and recommendation	gnee Idents ees or of for	

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

STATEMENT AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495255	B. WING		02/08/2022	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
8KYVIE\	W SPRINGS REHAB A	AND NURSING CENTER		30 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
	underlying soft tisst prominence or relation device. The injury copen ulcer and may as a result of intensor pressure in comb Pressure Injury: Fulf-thickness loss is visible in the ulce epibole (rolled wour Slough and/or eschibole) (rolled wour Slough and/or eschibole) (rolled wour Slough and/or eschibole) (rolled wour Slough and/or eschibole) (rolled wour Slough and/or eschibole) (rolled wour Slough and/or eschibole) (rolled wour Slough and/or eschibole) (rolled wour Slough and/or eschibole) (rolled wour Slough and/or eschibole) (rolled wour sitter was no donut left ankle. A second 2/7/2022 at 3:31 p.n. with her covers over noted on the top of nursing assistant) # asked if the resident donut pillow on her I she always puts it of "It's supposed to be confirmed the donut nightstand and not pillow on the documented in part, times, every shift for The February 2022 record) documented pillow was documented pillow was documented pillow was documented in part, the comprehensive	tige 58 The usually over a bony ted to a medical or other can present as intact skin or any be painful. The injury occurs to and/or prolonged pressure conation with shear. Stage 3 in-thickness skin loss of skin, in which adipose (fat) or and granulation tissue and and edges) are often present, ar may be visible." (1) ade of Resident #11 on any the resident was seated in the registent was made on any the resident was in her bed or her. The donut pillow was ther nightstand. CNA (certified 6 came into the room. When the was supposed to have the left ankle, CNA #6 stated that in the resident. She added: on all the time." CNA #6 stated that in the resident. She added: on all the time." CNA #6 stated that in the resident. She added: on all the time." CNA #6 stated that in the resident. She added: on all the time." CNA #6 stated that in the resident. She added: on all the time." CNA #6 stated that in the resident. She added: on the resident. TAR (treatment administration the above order. The donut ted as being in place for day care plan dated 11/9/2021, 2022, documented in part, 2022, documented in part,	F 8	5. Corrective Action/Audits to be completed by 3/18/2022		

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

1

Event ID: B7L211

Facility ID: VA0168

If continuation sheet Page 59 of 1.

FEB 25 2022

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,		CONSTRUCTION		'É BURVEY MPLETED
*:		495255	B. WING			02/	08/2022
	PROVIDER OR SUPPLIER W SPRINGS REHAB	AND NURSING CENTER		30 1	REET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE RAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRÉCEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X6) COMPLETION DATE
F 686	Continued From pa	ge 59	F 6	86			
SI.		nt has a pressure ulcer of left illow to left ankle to alleviate					
· · · · · · · · · · · · · · · · · · ·	ball of the foot. It was suspected deep tiss Pressure Injury: Per red, maroon or purp non-intact skin with non-blanchable deed discoloration or epic dark wound bed or wound measurement in length, by 1.6 cm wound consultant not documented the woold has healed. The woold suspected the suspected deep tissues and	nsultant note dated ented a new wound on the left ras described as a pressure sue injury (Deep Tissue raistent non-blanchable deep ple discoloration intact or localized area of persistent ep red, maroon, purple dermal separation revealing a blood filled blister.) (1). The ints were 2.3 centimeters (cm) in width, and no depth. The other dated 1/11/2022, and on the ball of the left foot bound consultant note dated occument anything about the					
į	practical nurse) #8 of above observation with the part of the part	inducted with LPN (licensed on 2/7/2022 at 3:32 p.m. The was shared with LPN #8. hysician-ordered donut pillow is prescribed, LPN #8 stated the resident currently has a er left foot, LPN #8 stated she d.					
- 40%	And Management" of "Preventative Meast interventions will be pressure ulcer/injury related factors, and interventions may in						

	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		RUCTION		E SURVEY PLETED
		495255	8. WING			02/	08/2022
NAME OF	PROVIDER OR SUPPLIER			l	DDRESS, CITY, STATE, ZIP CODE		
SKYVIEV		ND NURSING CENTER		"	 VUE DRIVE VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD OSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X6) COMPLETION DATE
F 886	loadTreatment Proordered by the physicand interventions metric c. Use of supportable ASM (administrative	ssure redistribution and tissue otocols:1. Treatments will be cician / practitioner. Treatment ay include but are not limited t devices."	F	386			
1	and ASM #3, the reservices, were mad on 2/8/2022 at 2:05 No further information	#2, the director of nursing, gional vice president of clinical e aware of the above concern p.m. on was obtained prior to exit.		1			
F 689 SS≓D	following website: https://cdn.ymaws.c ce/resmgr/npuap_pi	was obtained from the om/npuap.site-ym.com/resour ressure_injury_stages.pdf zards/Supervision/Devices	F 6	689	F 689	ál-að	
	supervision and ass accidents. This REQUIREMEN by: Based on observati Interview and clinica determined that the implement interventi	sure that - esident environment remains hazards as is possible; and resident receives adequate istance devices to prevent IT is not met as evidenced on, resident interview, staff if record review, it was facility staff failed to ions to prevent an accident hits in the survey sample,			The facility failed to make sure the environment remained free accident of hazard for resident 32, resident # 10 fall matts wer placed bilaterally immediately. The fire Extinguisher in the outdoor smoking area for resid 32 was immediately provided was current inspection tag. All other residents may have be potentially affected. Unit Managers will perform an audit all residents who use the outdoor smoking area.	e of # ent with	

	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100		PLE CONSTRUCTION		ATE SURVEY PMPLETED
		495255	B. WING			0:	2/08/2022
NAME OF	PROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE		
SKYVIEV	W SPRINGS REHAB A	ND NURSING CENTER			30 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(XS) COMPLETION DATE
F 689	Continued From pa	ge 61	F€	389			
:	and place one fall m side of the bed.	ailed to provide two fall mats nat on Resident # 10's right admitted to the facility with a			3. The Director of Nursing /Design will reviewall residents with formats and physicians' orders, a ensure implementation is per physician orders. The Mainten Director will inspect the design	all nd ance nated	
1	diagnosis that include of coordination. On the most recent quarterly assessment reference date) of 1 scored 4 out of 15 or mental status), indicates	MDS (minimum data set), a nt with an ARD (assessment 1/16/2021, the resident in the BIMS (brief interview for eating the resident is severely in for making dally decisions.			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 aud all residents with fall mats weeks. The Director of Nurswill submit to QAPI for review	it of kly ing	
	observation of Residelying in bed with a faresident's left side. On 02/07/2022 at apobservation of Residelying in bed with a faresident's left side. On 02/07/2022 at apobservation of Residelying in bed with a faresident's left side.	oproximately 2:22 p.m., an lent # 10 revealed they were all mat on the floor to the oproximately 9:52 a.m., an lent # 10 revealed they were all mat on the floor to the oproximately 2:10 p.m., an lent # 10 revealed they were all mat on the floor to the			recommendations. The Maintenance Director will complete an audit of the designated smoking area for 4 weeks to assure compliance. Findings will be presented at Q meetings with recommendatio 5. Corrective Action/Audit to be completed by 3/18/2022		
e Č	Resident # 10 docur both sides of bed Q Order Date: 02/07/20	nysician order sheet) for nented in part, "Floor mats to (every) shift. Every shift. 022. Start Date: 02/07/2022."					

		AND HUMAN SERVICES			FO	ED: 02/16/2022 RMAPPROVED
		& MEDICAID SERVICES			OMB	NO. 0938-0391
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
•		495255	B. WING			02/08/2022
NAME O	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
SKYVİ	W SPRINGS REHAB A	ND NURSING CENTER		30 MONTVUE DRIVE LURAY, VA 22835		
(X4) IQ PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X6) COMPLETION DATE
F 688	with a revision date part, "Focus: [Reside (related to) Galt/bala	of 10/29/2021 documented in ent # 10] is at risk for falls r/t ince problemsRevision on: nats at bedside on right alde.	F 60	69		
	Interview was condu practical nurse) # 1. orientation of placing	proximately 10:35 a.m., an cted with LPN (licensed When asked to describe the a fall mat on the right or left ed LPN # 1 stated that it ent's left or right side.				
e E	observation of Resid- Interview was conduct asked to describe the fall mat LPN # 1 state [Name of Resident # the physician's order, interpret the order. L to be plural so there s	proximately 2:20 p.m., an ent # 10's fall mat and cled with LPN # 1. When a location of Resident # 10's ed, "It's on the left side of 10's] bed." After reviewing LPN # 1 was asked to PN # 1 stated, "I take 'mats' should be two mats, but I it with the unit manager and				
1	On 02/07/2022 at app 1 stated, "There shou both sides of Residen	proximately 3:20 p.m., LPN # ld have been a fall mat on at # 10's bed."				
	(administrative staff m ASM # 2, director of n vice president of oper	proximately 5:00 p.m., ASM nember) # 1, administrator, ursing, ASM # 3, regional ations, and ASM # 4, vice ervices, were made aware of				
.	No further information	was provided prior to exit.				

PRINTED: 02/16/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495255 B. WING 02/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE SKYVIEW SPRINGS REHAB AND NURSING CENTER **LURAY, VA 22835** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PREFIX PROVIDER'S PLAN OF CORRECTION (XS) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) F 689 Continued From page 63 F 689 2. The facility staff falled 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.

FORM CMS-2567(02-99) Previous Varsions Obsolute

A review of Resident #32's comprehensive care

*FOCUS-Resident is a smoker and it has been determined that [name of Resident #32] is a safe smoker with supervision ...Resident educated on

requirements to safely smoke. No O2 (oxygen) is to be in area of smokers. Smoking assessment

plan dated 10/15/21, revealed, in part.

facility smoking times and compliance

Event ID: B7L211

Facility ID: VA0168

The continuation short page 64 of 118

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:	02/16/2022
FORM/	APPROVED
G145 116	

CENTE	RO FOR MEDICARE	& MEDICAID SERVICES				MB MK	0.0938-0391
STATEMEN	T OF DEFICIÊNCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		LE CONSTRUCTION	(X3) D/	ATE SURVEY OMPLETED
1		495255	B. WING	·			2/22/2222
NAME OF	PROVIDER OR SUPPLIER		4	8	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0,	2/08/2022
SKYVIEV	N SPRINGS REHAB A	ND NURSING CENTER			0 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	DBE	(X5) COMPLETION DATE
	with changes in con- designated area and smoking to that area smoking area, smok related to smoking."	mission, quarterly and PRN dition. Will be educated on I will comply with limiting a. Will voice understanding of ing times and facility policy	F6	89			
	vision or blindness: No sitting or standing: No arms or hands: No, needed to securely he falls asleep easily du. Burns skin, clothing, ashes on self: No. Fo location and time of a Able to light a cigaretoigarette safely. Able	revealed, in part, it utilizes tobacco. Poor No. Balance problems while o. Total or limited ROM in Insufficient fine motor skills old cigarette: No. Lethargic / ring tasks or activities: No. furniture or other: No. Drops ollow the facility's policy on smoking: Yes. Concerns; te safely. Able to hold a to extinguish a cigarette shtray to extinguish a					
S S S S S	AM with Resident #32 moked, Resident #33 moking for years." V mokes, Resident #32	2 stated, "Yes, I have been Vhen asked where he 2 stated, "I smoke outside in 'e go out of the doors on					
l O Si Si Ci Ci	moking area for Soul upervised by two stat moking. LPN (licens istributed cigarettes a igarette. The smokin	side smoking area. The think wing residents was					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURV COMPLETER 495255 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835 (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 65 F 689 Continued From page 65 F 689). 0938-039 i
NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 65 STREET ADDRESS, CITY. STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835 ID PROVIDER'S PLAN OF CORRECTION (X (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DATE OF COMPLETED TO THE APPROPRIATE DATE OF CONTINUED TO THE APPROPRIATE DAT	TE SURVEY
NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 65 STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DAY) F 689 Continued From page 65	/NR/2022
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) F 689 Continued From page 65 30 MONTVUE DRIVE LURAY, VA 22835 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 689	10012022
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, 603	COMPLETION DATE
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, "It have been current, OSM #6 stated, "It means the year." 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 if 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 director of operations, ASM #4, the regional director of nursing, ASM #3, the regional director of nursing, ASM #3, the regional director of nursing were made aware of the concern. According to the facility's "Smoking Permitted"	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 30 MONTVUE DRIVE LURAY, VA 22835			
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SS≓D	policy, "Residents, vin designated areas a. Smoking area will. Smoking times or c. Oxygen will not d. The area will be from smoking activitie. The area will be ashtrays f. The area will be blanket(s) g. The facility will pa call system h. A fire extinguished proximity." No further information Respiratory/Tracheo CFR(s): 483.25(i) § 483.25(i) Respiratory care and trached sure care, consistent with practice, the compresioned and 483.65 of this sure This REQUIREMENT by: Based on observation staff interview and face determined that the farespiratory services as the compresion of the c	visitors, and staff may smoke only: vill be clearly identified; will be identified: be used in the smoking area kept clean and free of liter fies equipped with self-containing equipped with smoking equipped with smoking erovide reasonable access to ar will be kept in close on was provided prior to exit. estomy Care and Suctioning ery care, including not tracheal suctioning. ure that a resident who re, including tracheostomy ctioning, is provided such professional standards of nensive person-centered into goals and preferences, bpart. T is not met as evidenced In, clinical record review, cility document review it was accility staff failed to provide is ordered, and in a sanitary of residents in the survey	F 69		flow rate tely per signee will residents rs to ensure the resident for the re, so that listent with of practice		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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1 10 10 10	The findings included 1. The facility staff of the ordered flow rate on the ordered flow rate on the most recent quarterly assessment reference date) of 1. Coded as being severally decisions. See resident receiving or facility. On 2/6/2022 at appr#74 was observed in nasal cannula with a 2/4/22; this equipme concentrator. The oconcentrator was obtined in part, awake and Additional observational approximately 8:1 flow rate to be set at The physician order documented in part,	failed to administer oxygen at e to Realdent #74. MDS (minimum data set), a nt with an ARD (assessment /19/2022, the realdent was erely impaired for making stion O documented the kygen while a resident at the oximately 2:15 p.m., Realdent a bed wearing an oxygen in humidifier bottle dated int was attached to an oxygen xygen flow rate on the served to be set at 1.5 lpm Realdent #74 was observed to non-verbal. Ons of Realdent #74 on mately 4:15 p.m. and 2/7/2022 5 a.m. revealed the oxygen 1.5 lpm.	F 68	95	 The Director of Nursing/Designation will complete an audit of all residents with oxygen concentrators to ensure that the oxygen concentrator is set on the appropriate liter flow per physic order weekly x 4 weeks. The Director of Nursing will report to QAPI for review and recommendations. Corrective Action/Audits to be completed by 3/18/2022. 	at he cian	
, }	The comprehensive	care plan for Resident #74 cumentation of oxygen			RECEIVI FEB 2 5 207	22	
	conducted with LPN	p.m., an interview was (licensed practical nurse) #1. laff checked the oxygen			VDH/OL	C	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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100	PROVIDER OR SUPPLIER N SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		
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F 695	oxygen rate was set the flowmeter on the oxygen flow rate on observed Resident; it was set at 1.5 lpm orders and correct to the correct to the correct to the correct to the facility policy "Consumented in part, the number of liters physician/practitions oxygen device on the cannula and/or nass oxygen delivery devithe resident and the being administered.	LPN #1 stated that the to by centering the metal ball of a line showing the ordered the concentrator. LPN #1 #74's oxygen and stated that and she would verify the his if needed. Toximately 3:30 p.m., LPN #1 confirmed the ordered for Resident #74. Doxygen Administration The oxygen at minute as ordered by the eresident (i.e., mask, nasel al catheter). 7. Adjust the ice so that it is comfortable for proper flow of oxygen is ""."	F6	95		
	staff member) #1, the director of nursing, A of operations, and A clinical services were No further information. 2. The facility staff faculipment in a sanite Resident #28 was as 4/28/2016 with diagrams.	p.m., ASM (administrative the administrator, ASM #2, the ASM #3, the regional director SM #4, the vice president of the made aware of the findings. In was provided prior to exit. Alled to store respiratory ary manner for Realdent #28. Idmitted to the facility on hoses that include, but were		REC. FEB 2. VDH/C	EIVED 2022 PLC	
	disease (COPD). O	c obstructive pulmonary n the most recent MDS assessment, an annual	,			

STATEMENT AND PLAN (r of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION		PLETED
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F 69 5	assessment, with a date) of 12/13/2021 15 on the BIMS (Bri score, indicating the impaired for making - Special Treatment	n ARD (assessment reference, the resident scored 13 out of lef interview for mental status) are resident is not cognitively gradity decisions. In Section O is, Procedures and Programs, ded as using oxygen while a	F€	395			
•	2/6/2022 at 2:59 p.r. She was not using it oxygen tubing and rover the oxygen conclean plastic bag. The floor that was dated observed on 2/7/202 her oxygen in use viobservation was matter resident was in oxygen at the time. cannula were drape	ade of Resident #28 on m. The resident was in bed. her oxygen at that time. The hasal cannula were draped here was a plastic bag on the 1/13/2022. The resident was 22 at 7:41 a.m. In her bed with it the hasal cannula. A third ade on 2/7/2022 at 3:23 p.m. her bed, not using her The oxygen tubing with hasal ad over the oxygen were not in a clean plastic					
J	The physician order documented, "Oxyg minute) via nasal catolerates every shift	en at 2L/min (liters per Innula continuous as resident					
1	documented, in part COPD, left middle in respiratory alteration On 2/7/2022 at 3:24 nurse) #8 was broug and asked to observe	care plan dated 1/6/2022 t, "Focus: [Resident #28] has ung malignancy, at risk for nsOxygen as ordered." p.m., LPN (licensed practical ght into Resident #28's room we the oxygen tubing. When in tubing should be stored					

STATEMENT AND PLAN (FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '				E SURVEY IPLETED
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	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 0 MONTVUE DRIVE .URAY, VA 22835		
(X4) IB PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDÉNTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(XS) COMPLETION DATE
1	when not in use, LP be stored in a plasti #3 went to get a bag ASM (administrative administrator, ASM ASM #2, the director president of clinical assistant director of the above concern of 4:45 p.m. A review of the facility Administration faile to the storage of oxyuse. No further information. The facility staff factor of the facility staff factor of the facility staff factor of the facility staff factor of the facility staff factor of the storage of oxyuse. No further information. The facility staff factor of the facility staff factor of the facility staff factor of the facility staff factor of the facility staff factor of the facility staff factor of the facility staff factor of the facility staff factor of the facto	N #8 stated, it's supposed to c bag, when not in use. LPN g. staff member) #1, the #2, the director of nursing, r of nursing, ASM #4, the vice operations, and LPN #3, the nursing, were made aware of on 2/7/2022 at approximately ty policy "Oxygen d to reveal information related ygen equipment when not in on was obtained prior to exit. siled to maintain Resident # a t one liter per minutet, resician's orders. Idmitted to the facility with ded but were not limited to: and chronic obstructive MDS (minimum data set), a not with an ARD (assessment 2/10/2021, the resident is making daily decisions. Treatments, Procedures and esident # 41 for "Oxygen"	F6	\$95			
		* * *					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
1		495255	B. WING		<u></u> _	02/08/2022		
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE		· · · · ·	
SKYVIEW 8PRINGS REHAB AND NURSING CENTER				LURAY, VA 22835				
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F 695	observation of Resilying In bed receivin Observation of the Concentrator reveal between 0.5 and 1.6 On 02/07/2022 at a observation of Resilying in bed receivin Observation of the froncentrator reveal between 0.5 and 1.6 On 02/07/2022 at a observation of Resilying in bed receivin Observation of Resilying in bed receivin Observation of the froncentrator reveal between 0.5 and 1.6 The physician order documented, "O2 (ominute) via (by) NC Order Date: 12/01/2 The comprehensive dated 11/02/2021 do The resident has alt status/difficulty brea (chronic obstructive	dent # 41 revealed they were g oxygen by nasal cannula. flow meter on the oxygen ed an oxygen flow rate D liters per minute. pproximately 8:20 a.m., an dent # 41 revealed they were g oxygen by nasal cannula. flow meter on the oxygen ed an oxygen flow rate D liters per minute. pproximately 2:15 p.m., an dent # 41 revealed they were g oxygen by nasal cannula. flow meter on the oxygen ed an oxygen flow rate D liters per minute. for Resident #41 oxygen) at 1 LPM (one liter per (nasal cannula) every shift. 020." care plan for Resident # 41 oxumented, in part, "Focus:	F6	695				
1	observation of Resid oxygen concentrator conducted with LPN	oproximately 2:30 p.m., an lent # 41's flow meter on their						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER IDENTIFICA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	for Resident # 41, L and stated, "One an After reviewing the # 41's oxygen, LPN liter per minute." W important to maintai according to the phystated, "They could it." On 02/07/2022 at ap (administrative staff ASM # 2, director of vice president of oppresident of clinical the findings.	ge 72 PN # 1 read the flow meter id a half liters per minute." physician's order for Resident # 1 stated, "It should be one hen asked why It was in the oxygen flow rate valcian's orders LPN # 1 become more dependent on peroximately 5:00 p.m., ASM member) # 1, administrator, nursing, ASM # 3, regional prations, and ASM # 4, vice services, were made aware of the provided prior to exit.	F 6		
· ·	provided to residents consistent with profethe comprehensive pand the residents' go This REQUIREMEN by: Based on resident in clinical record review review, it was determined to implement a program by document resident's pain and in non-pharmacological administration of pm	sure that pain management is swho require such services, issional standards of practice, berson-centered care plan, pals and preferences. T is not met as evidenced interview, and facility document inlined that the facility staff in complete pain management inting the location of the inplementing.		1. Non- pharmacological interven for resident#25 and # 88 have updated. 2. All residents may have been potentially affected. An audit wide done of all residents receiving medications. A Pain Intervention Order will be utilized for non-pharmacological Interventions. 3. The Staff Educator/Designee wideducate Nursing staff on the Potential Management and Implementation/documentation.	been Will be pain on Ill Dicy

AMAE OF PROVIDER OR SUPPLIER SKYVEW SPRINGS REHAB AND NURSING CENTER SUMMANY STATEMENT OF DEPOSITORS SUMMANY STATEMENT OF DEPOSITORS SUMMANY STATEMENT OF DEPOSITORS PROVIDERS PLAN OF CORRECTION PRETX RESULATORY OR LSC IDENTIFYING INFORMATION) PRETX PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDER PROVIDERS PLAN OF CORRECTION PROVIDER PROVIDERS PLAN OF CORRECTION PROVIDER PROVIDER PROVIDERS PLAN OF CORRECTION PROVIDER PROVIDERS PLAN OF CORRECTION PROVIDER PROVIDERS PLAN OF CORRECTION PROVIDER PROVIDER PROVIDERS PLAN OF CORRECTION PROVIDER PROVIDERS PLAN OF CORRECTION PROVIDER PROVIDERS PLAN OF CORRECTION PROVIDER PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDER			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY
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sample, Residents # 25 and # 88. The findings include: 1. The facility staff falled 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 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 HCI (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."	PREFIX	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	
The comprehensive care plant for it resident the control of th		sample, Residents of The findings included an Included to the Resident of the Resident of the Resident of the Resident of the Administ Resident #25 was addingnosis that included osteoarthritis. On the most recent of the Resident of the Resident of the Administ Resident #25 was addingnosis that include osteoarthritis. On the most recent of the Resident of the Res	failed to document the dent #25's pain and harmacological interventions ration of Tramadol (1). Idmitted to the facility with a led by not limited to MDS (minimum data set), a not with an ARD (assessment 2/10/2021, the resident on the BIMS (brief interview adicating the resident is making daily decisions. Frequency" coded Resident stantly." Under "J0600. Pain ated, "A. Numeric Rating isident: "Please rate your ast 5 days on a zero to ten g no pain and ten as the magine." (Show resident ter two-digit response. Enter er." Resident #25 was I sheet for Resident #25 documented in part: ogen chloride) Tablet. Give y mouth every 6 (six) hours rate to severe pain. Will its (tablets). Order Date: ate: 06/17/2021."	F6	397	4. The Director of Nursing/Design review medical records of 10 residents weekly for 4 weeks to ensure non-pharmacological interventions are offered. The Director of Nursing will submit QAPI for review and recommendations. S. Corrective Action/Audit to be	to e	

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		(X3) DATE SURVEY COMPLETED		
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(X4) II PREFI TAG	K EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		OULD BE	(X5) COMPLETION DATE	
F 69	dated 06/01/2021 do # 25] has the potent resident is able to: c pain, reposition self, how much pain is ex	ge 74 coumented in part, "[Resident ial for pain/discomfortThe all for assistance when in ask for medication, tell you operienced, tell you what s pain. Date Initiated:	F6	97			
,	record) for Resident documented the phyabove. Further revie Resident # 25 receiv Tramadol on 12/08/2 level of eight, 12/15/2 level of four, 12/25/20 level of four and on 1 pain level of ten. Fur failed to evidence documents	ic medication administration # 25 dated December 2021 sician's order as stated w of the eMAR revealed ed 25 mgs (milligrams) of 021 at 9:33 p.m. with pain 2021 at 9:33 p.m. with pain 221 at 4:06 a.m. with pain 2/28/2021 at 8:43 a.m. with ther review of the eMAR cumentation of the location in and non-pharmacological ed.					
a f	record) for Resident & documented the phys above. Further review Resident # 25 receive 01/09/2022 at 1:26 p.i 01/12/2022 at 3:12 a.i 01/23/2022 at 10:31 a 01/24/2022 at 4:30 a.i 01/26/2022 at 11:55 a 01/28/2022 at 4:30 a.i on 01/31/2022 at 2:21 Further review of the	c medication administration #25 dated January 2022 dician's order as stated wof the eMAR revealed at 25 mgs of Tramadol on m. With pain level of eight, with pain level of four, m. with pain level of four, m. with pain level of eight, m. with pain level of six, m. with pain level of five, m. with pain level of five, m. with pain level of five, m. with pain level of six and a.m. with pain level of one, eMAR failed to evidence location of Resident #25's cological interventions					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				TE SURVEY MPLETED
1		495255	B. WING	3		02	/08/2022
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 30 MONTVUE DRIVE LURAY, VA 22835	DE	<u> </u>	10012422
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		HOULD B	DE ATE	(XS) COMPLETION DATE
F 697	record) for Resident documented the phy above. Further revie Resident # 25 receiv	ic medication administration # 25 dated February 2022 sician's order as stated by of the eMAR revealed ed 25 mgs of Tramadol on	F6	697			
	Further review of the documentation of the	.m. with pain level of seven. eMAR falled to evidence location of Resident # 25's acological interventions					æ
	Resident # 25 dated 02/07/2022 falled evident # non-pharmacological the dates Resident #	dence documentation of the					
	When asked if they extheir pain is located Repain in my stomach." pain medication as neyes. When asked if ne	ent # 25 regarding pain. kperience pain and where esident # 25 stated, "I have When asked if they receive eded Resident # 25 stated ursing staff try to alleviate nistering their medication					
, F	nterview was conduct practical nurse) # 1 reg administering prn pain locumentation of non- nterventions. LPN # 1	garding the procedure for medication and pharmacological					24

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
,		495255	B. WING		02	/08/2022	
•		ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835			
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	88	(X5) COMPLETION DATE	
scale Attentit documed resideses the med the med attention giving about and a Interview Dece 2022, 12/01 25, La document Trama The fa document modal achieve modal Non-p appropress medic interve the roce	mpt other techniesn't work checkication and admident 30 minutes if it was effective non-pharmacolompted LPN # 1 matempts of non-ventions LPN # comments section instration recording the physician process of the nurses' process of the nurses' process of the nurses' process of the nurses' process of the nurses' process of the nurses' process of the nurses' process of the nurses' process of the nurses' process of the nurses' process of the nurses' process of the nurses' process of the nurses' process of the nurses' process of the nurses' process of the nurses' process of the nurses' process of the nurses' policy "Process of the nurse	th ten being the worse pain. iques to alleviate their pain, if it the order for prn pain inister it. Recheck the after giving the medication to e." When asked how often gloal interventions should be stated, "Every time when hedication." When asked ocation of the resident's pain pharmacological 1 stated, "It's documented on of the MARs (medication of the MARs (medication of the nurses' notes." proximately 11:04 a.m., an octed with LPN # 1. After an's orders, eMARs dated ary 2022 and February ogress notes dated 02/07/2022 for Resident # 25's armacological interventions to Resident # 25 receiving pain medication of	F 6	97			

1

		AND HUMAN SERVICES					:D: 02/16/202 :MAPPROVEI	
		& MEDICAID SERVICES			***		0.0938-039	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		PLE CONSTRUCTION		ATE SURVEY OMPLÊTED	
		495255	B. WING	3		1 0	<u>2</u> /08/2022	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			7
SKYVIE	W SPRINGS REHAB A			1	30 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X6) COMPLETION DATE	
	repositioning, etc.; ii. warm compresses, i electrical nerve stimula acupuncture, etc.; iii. exercises to prevent contractures; iv. Cog relaxation, music, div. On 02/08/2022 at ap. (administrative staff if ASM # 2, director of president of clinical at the findings. No further information References: (1) Tramadol is used moderately severe paredications called opworks by changing the system respond to paredication of the well-https://medlineplus.goml.	Physical - Ice packs, cool or paths, transcutaneous ulation (TENS), massage, Exercise - range of motion muscle stiffness and initive or Behavioral - versions, activities, etc." proximately 1:50 p.m., ASM member) # 1, administrator, nursing and ASM # 4, vice services, were made aware of the was provided prior to exit. Ito relieve moderate to ain. Tramadol is in a class of plate (narcotic) analgesics. It is eway the brain and nervous lin. This information was besite: Devidruginfo/meds/a695011.ht ed to by documenting the armacological interventions tion of Norco inophen) (1). mitted to the facility with a dibut was not limited to	F	697				
	On the most recent Mi	DS (minimum data set), a		Ì			- 1	

quarterly assessment with an ARD (assessment

ST. AN	ATEME D PLAN	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
_			495255	B. WING	3		02	/08/2022
s	KYVIE	F PROVIDER OR SUPPLIER EW SPRINGS REHAB A		25	STREET ADDRESS, CITY, STATE, ZIP (30 MONTVUE DRIVE LURAY, VA 22835			
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFI TAG		4 SHOULD	BE	(X5) COMPLETION DATE
	1	reference date) of 0'scored 15 out of 15 for mental status), in cognitively intact for Section J0400 "Pain #88 as "Frequently.' Intensity" It documer Scale (00-10) Ask re worst pain over the lascale, with zero being worst pain you can in 00-10 pain scale). En 99 if unable to answer a "6 (six)." The current POS (ph: Resident #88 docum 5-325 (five to 325) Mi (HYDROcodoneAcett tablet by mouth every For pain 1-5 Tyl 6-10 08/04/2020. Start Da The comprehensive of dated 08/12/2021 doc [Resident #88] has the pain/discomfort r/t Arti (non-pharmacological initiated: 10/27/2021." The eMAR (electronic record) for Resident #80 received 1/01/2022 at 2:06 a. no 1/02/2022 at 4:00 a. no and at 7:23 p.m. with pain and at 7:23 p.m.	1/26/2022, the resident on the BIMS (brief interview dicating the resident is making daily decisions. Frequency" coded Resident 'Under "J0800. Paln sted, "A. Numeric Rating sident: "Please rate your ast 5 days on a zero to ten g no pain and ten as the nagine." (Show resident ter two-digit response. Enter er." Resident # 88 was coded ysician's order sheet) for tented in part, "Norco Tablet G aminophen). Give 1 (one) 4 hours as needed for Pain. Norco. Order Date: te: 08/04/2020." Fare plan for Resident # 88 sumented in part, "Focus: te: 08/04/2020." Fare plan for Resident # 88 sumented in part, "Focus: te: 08/04/2020." Fare plan for Resident # 88 sumented in part, "Focus: te: 08/04/2020." Fare plan for Resident # 88 sumented in part, "Focus: te: 08/04/2020." Fare plan for Resident # 88 sumented in part, "Focus: te: 08/04/2020." Fare plan for Resident # 88 sumented in part, "Focus: te: 08/04/2020." Fare plan for Resident # 88 sumented in part, "Focus: te: 08/04/2020." Fare plan for Resident # 88 sumented in part, "Focus: te: 08/04/2020." Fare plan for Resident # 88 sumented in part, "Focus: te: 08/04/2020." Fare plan for Resident # 88 sumented in part, "Focus: te: 08/04/2020." Fare plan for Resident # 88 sumented in part, "Focus: te: 08/04/2020."	F 6	397			

NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER B. WING GTREET ADDRESS, CITY, STATE, 30 MONTYUE DRIVE LURAY, VA. 22835	ZIP CODE	/08/2022
SKYVIEW SPRINGS REHAB AND NURSING CENTER 30 MONTYUE DRIVE	ZIP CODE	
LURAY, VA 22835		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTUAL TAG CROSS-REFERENCED TO DEFICIENCY DEFICIENCY OR LSC IDENTIFYING INFORMATION)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 697 Ontinued From page 79 O1/04/2022 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, 01/05/2022 at 1:00 a.m. pain level of six, 01/07/2022 at 1:00 a.m. pain level of six, 01/07/2022 at 1:200 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 seven, 01/08/2022 at 1:30 a.m. with pain level of six, 01/10/2022 at 1:00 a.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 1:00 a.m. with pain level of seven, 01/12/2022 at 1:20 a.m. with pain level of seven and at 8:14 p.m. with pain level of seven and at 8:14 p.m. with pain level of six, 01/18/2022 at 7:34 p.m. with pain level of six, 01/18/2022 at 7:34 p.m. with pain level of six, 01/29/2022 at 2:34 a.m. with pain level of six, 01/29/2022 at 7:23 p.m. with pain level of six, 01/21/2022 at 7:23 p.m. with pain level of six, 01/22/2022 at 7:23 p.m. with pain level of six, 01/22/2022 at 2:00 a.m. with pain level of seven, 01/25/2022 at 2:00 a.m. with pain level of seven, 01/25/2022 at 2:00 a.m. with pain level of seven, 01/26/2022 at 2:00 a.m. with pain level of six, 01/27/2022 at 1:00 a.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, 01/28/2022 at 1:00 a.m. with pain level of six, 01/28/2022 at 1:00 a.m. with pain level of six, 01/28/2022 at 1:00 a.m. with pain level of six, 01/28/2022 at 1:00 a.m. with pain level of six, 01/28/2022 at 1:00 a.m. with pain level of six, 01/28/2022 at 2:00 a.m. with pain level of six, 01/28/2022 at 2:00 a.m. with pain level of six, 01/28/2022 at 1:45 a.m. with pain level of six, 01/28/2022 at 1:45 a.m. with pain level of six, 01/28/2022 at 1:45 a.m. with pain level of six at 1:00 a.m. with pain level of six at 1:00 a.m. with pain level of six at 1:00 a.m. with pain level of six at 1:00 a.m. with pain level of six at 1:00 a.m. with pain l		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		(X3) DATE SURVEY COMPLETED		
1		495255	B. WING	·		0.	2/08/2022
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		30	TREET ADDRESS, CITY, STATE, ZIP CODE O MONTVUE DRIVE URAY, VA 22835	<u> </u>	0/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) BY PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODUCTION DEFICIENCY)				BE	(X5) COMPLETION DATE
F 697	at 2:10 a.m. with pair 7:22 p.m. with pain It 1:30 a.m. with pain It pain level of six and with pain level of six. falled to evidence do	n pain level of six, 02/04/2022 on level of six, 02/05/2022 at evel of six, 02/06/2022 at evel of six and at 7:42 with on 07/07/2022 at 1:30 a.m. Further review of the eMAR cumentation of the location and non-pharmacological	F 6	97			
ķ	Resident # 88 dated 02/07/2022 failed to ethe location of Residenon-pharmacological the dates Resident #	evidence documentation of					
·	conducted with Resid pain. Resident # 88 s pain in their hand and hey receive pain med # 88 stated yes. Whe o alleviate their pain i nedication Resident #	e.m., an interview was ent # 88 regarding their stated that they have arthritis left knee. When asked if lication as needed Resident in asked if nursing staff try pefore administering their # 88 stated, "No, they just ication and say I hope it					
C in p a a a ir re	nterview was conduct ractical nurse) # 1 re- idministering prn (as ind documentation of aterventions. LPN # 1 psident's pain, where cale one to ten, with t	roximately 10:35 a.m., an ed with LPN (licensed garding the procedure for needed) pain medication non-pharmacological stated, "Assess the the pain is and using a en being the worse pain.					×

		OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BURLDING			(X3) DATE SURVEY COMPLETED		
			495255	a. WING			no	/08/ 2 022	
I	NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	, CODE	<u> </u>	00/2022	_
	SKYVIE	W SPRINGS REHAB A			30 MONTYUE DRIVE LURAY, VA 22835				
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD I	BE	COMPLETION DATE	1
	i.	it doesn't work check medication and admiresident 30 minutes see if it was effective the non-pharmacolog attempted LPN # 1 signing the prin pain mabout documenting is and attempts of non-interventions LPN # 1 the comments section administration record On 02/08/2022 at application of the pain and that non-pharmacological properties was conducted by the comments of the pain and that non-pharmacological properties was asked to the pain and that non-pharmacological properties were attempted prior in the pain and that non-pharmacological properties were attempted prior in the pain and that non-pharmacological properties were attempted prior in the pain and that non-pharmacological properties in the pain and that non-pharmacological prior in the pain and that non-pharmacological properties in the pain and that non-pharmacological properties in the pain and that non-pharmacological properties in the pain and that non-pharmacological properties in the pain and that non-pharmacological properties in the pain and that non-pharmacological properties in the pain and that non-pharmacological properties in the pain and that non-pharmacological properties in the pain and the pain and that non-pharmacological properties in the pain and	the order for prn pain inister it. Recheck the after giving the medication to after giving the medication to a when asked how often gical interventions should be tated, "Every time when edication." When asked ocation of the resident's pain pharmacological stated, "it's documented on n of the MARs (medication) or the nurses' notes." Proximately 11:04 a.m., an eted with LPN # 1. After an's orders, eMARs dated any 2022 and February gress notes dated 2/07/2022 for Resident #	F 6	97				
	, F	On 02/08/2022 at app (administrative staff m ASM # 2, director of no president of clinical se he findings. No further information References; 1) Hydrocodone is an apploid is sometimes ca	ss potent pain reliever that						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION	(X3) DATE SURVEY COMPLETED	
		495255	B. WING	-	· · · · · · · · · · · · · · · · · · ·	02/	08/2022
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		30 MON	ADDRESS, CITY, STATE, ZIP CODE TVUE DRIVE , VA 22835		á
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD PROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X3) COMPLETION DATE
1	Is used to relieve minformation was obthittps://www.rxllst.comages-side-effects. Bedrails CFR(s): 483.25(n)(1) §483.25(n) Bed Rail The facility must attail atternatives prior to a bed or side rail is correct installation, rails, including but nelements. §483.25(n)(1) Assess entrapment from be sentrapment from sentrapment for the sentrapment from sentrapment from sentrapment for the sentrapment from se	aminophen and hydrocodone oderate to severe pain. This ained from the website: m/Norco-5-325-drug/patient-i htm. 1)-(4) Is. empt to use appropriate installing a side or bed rail. If used, the facility must ensure use, and maintenance of bed ot limited to the following as the resident for risk of drails prior to installation. We the risks and benefits of sident or resident betain informed consent prior that the bed's dimensions he resident's size and weight. If the manufacturers and specifications for installing and specifications for instal	F 6	700 F 700 1. 2. 3.	Consent has been obtained for bedrails for Residents # 11, #40 #28. All other residents may have potentially been affected. A fact audit was completed by the Dirtof Nursing/Designee for all residents who have bed rails to ensure informed consent has been completed. The Director of Nursing/Designee ducate all nursing staff on the documentation for Bedrail consand assessments.	ee will UDA ents ee wily eks sare ed,	
	failed to have conse	ne use of side rails and/or nt, after discussion of the r the use of the bed rails, for					

_	-DEPAR	TMENT OF HEALTH	AND HUMAN-SERVICES			F		
	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			C		NTED: 02/16/2022 FORM APPROVED B NO. 0938-0391 COMPLETED 02/08/2022 (X6) COMPLETION OATE
		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		
	1		495255	B. WING	_	· · · · · · · · · · · · · · · · · · ·	0	2/08/2022
	NAME OF	PROVIDER OR SUPPLIER			- 4	STREET ADDRESS, CITY, STATE, ZIP CODE		
	SKYVIE	W SPRINGS REHAB A	ND NURSING CENTER			30 MONTVUE DRIVE LURAY, VA 22835		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BY IDENTIFYING INFORMATION	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	
	F 700	Continued From pag	ne 83	F 7	'n			
			s in the survey sample,					
	1	The findings include	:					
	i	discussion of the risl	alled to obtain consent, after a ks and benefits for the use of ne responsible party, for					
	1	data set) assessmen with an ARD (assess 11/17/2021, the residence of the residence of the residence of the resident was coded as with a section of the resident was coded as with a section of the resident was coded as with a section of the resident was coded as with a section of the resident was coded as with a section of the resident was coded as with a section of the resident was coded as with a section of the resident was coded as with a section of the resident was coded as with a section of the resident was coded as with a section of the residence of the res	Imitted to the facility ost recent MDS (minimum at, a quarterly assessment, ament reference date) of lent was coded as having memory problems and impaired for making daily of G - Functional Status, the as requiring extensive aff members for moving in the					
	· · · · · · · · · · · · · · · · · · ·		de of Resident #11 on The resident observed to oth side rails up.					
	' · t 1	1:31 p.m., failed to evi the discussion of the use of the bed rails, v The nurse who comp	sment" dated, 2/4/2022 at vidence documentation of risks and benefits for the vith the responsible party. leted this assessment was view during the survey.					
	t	locumentation of the	notes failed to evidence discussion and consent for ils with the responsible					
	т	he physician orders	dated, 5/29/2019,					

-DEPAR	TMENT OF HEALT	HAND HUMAN SERVICES				: 02/16/202
		E & MEDICAID SERVICES				TAPPROVE 0. 0938-039
TATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
1		495255	B. WING_		02	/08/2022
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO		00/2022
SKYVIE	W SPRINGS REHAB	AND NURSING CENTER	- 1	30 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 700	documented, "1/4	age 84 (quarter) side rails to aid with oaltioning as needed."	F 700			
	documented in par an ADL (activities of performance deficit Dementia." The "In	e care plan dated, 11/17/2021, t, "Focus: [Resident #11] has of daily living) self-care t r/t (related to) Alzheimer's terventions" documented in to aid with bed mobility and				
-	practical nurse) #2 above side rail assi LPN #2. When ask complete the side rail associated the side rate of	onducted with LPN (licensed on 2/8/2021 at 11:52 a.m. The essment was reviewed with ed how does the nurse ail assessment, LPN #2 stated had done one like the form lerapy assesses for side rails lything has changed with the lit we do them with the lost along with the fall on asked if the facility should be use of side rails, after a resident and/or responsible d, yes, we document it in the				
	manager, #7 on 2/8 asked the process fralls, LPN #7 stated used for bed mobilitiand discussion with responsible party is side rails, LPN #7 standard upon admissigned upon admiss	onducted with LPN, the unit /2022 at 1:17 p.m. When or a resident to have side for most residents they are y. When asked if a consent the resident and/or required for the use of the lated there once was a form ission paperwork that was alon. When asked if that erisks and benefits for the				

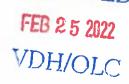
ORM CMS-2687(02-99) Provious Versions Obsolete

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Event ID: B7L211

Facility ID: VA0166

RE contigued on sheet Page 85 of 118



	HTJABH-70F-HEALTH	AND HUMAN SERVICES			Р		D: 02/16/202	
		& MEDICAID SERVICES			0	TORMAPPROVED MB NO. 0938-0391		
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495255	B. WING	_		02/08/20		
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			٦
SKYVIE	W SPRINGS REHAB A	ND NURSING CENTER			30 MONTYUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	8E	(X6) COMPLETION DATE	
F 700	Continued From pag	ne 85	F7	70 0				7
		ve bed rail assessment was	' '	UU	']			
		f7. When asked who the						Ī
		e assessment documents the resident and/or responsible						ı
į	party and the conser	nt to use them, LPN #7 asked						1
·		d page to this assessment, is what was received. LPN #7						1
	requested to look int	o the matter and get back						1
	with this writer.	,			*]	
	On 2/8/2022 at 1:50	p.m., LPN #7 returned and						ı
	stated that when the	new company took over this						l
		are part of the admission urther stated they have						l
15	nothing for [Resident	#11] as she has been here					}	l
	for a long time.							
	The facility policy, "Be	ed Inspection and Safety*						ľ
	documented in part, '	1. The resident's sleeping						
	environment shall be interdisciplinary team	evaluated by the considering the resident's		1				
1	safety, medical condi	tions, comfort, and freedom				j		l
		as input from the resident		1				
	bed environment."	previous sleeping habits and						
	ASM (administrative a	staff member) #1. the						
- 1	administrator, ASM #	2, the director of nursing.						
1	ASM #3, the regional	vice president of clinical aware of the above concern				[
	on 2/8/2022 at 2:05 p	.m.						
	No further information	n was obtained prior to exit.	60					
	2. The facility staff fail							į
	assessment and obtained							
		s and benefits for the use of resident and/or responsible						
	earty, for Resident #4	0.						

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			Р			
_		& MEDICAID SERVICES			0			
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	(X3) DA	ITE SURVEY	
'		495255	B. WING	-		02	2/08/2022	
NAME OF	PROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE			
SKYVIE	W 8PRINGS REHAB A	ND NURSING CENTER	ID SERVICES OMB NO. 0938-0939 (22) MULTIPLE CONSTRUCTION A BUILDING A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTYUE DRIVE LURAY, VA 22835 G CENTER OPERATOR THE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 700 The facility on It with an ARD of a 12 out of 15 mental status) altely cognitively one. In Section G was coded as of one staff ent #40 on ent was in her ed to evidence sesment. Id to evidence of the resident fisks and benefits O/2019, d to promote turn pendence." Intell #417/2021, sident #40] has reformance deficit; The It, "1/4 side rails positioning."					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRÉCEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION 9HOULD CROSS-REFERENCED TO THE APPROPR	BE	(XS) COMPLETION DATE	
F 700	Continued From pag	ge 86	F7	'00				
	11/19/2019. On the data set), a quarterly 12/17/2021, the resident the BIMS (brief indicating the resident impaired for making - Functional Status,	dmitted to the facility on most recent MDS (minimum / assessment with an ARD of dent scored a 12 out of 15 nterview for mental status) nt is moderately cognitively daily decisions. In Section Githe resident was coded as assistance of one staff in the bed.			¥2			
'		de of Resident #40 on . The resident was in her alls up.						
1	Review of the clinica documentation of a b	record failed to evidence ed rail assessment.						
.	documentation of a d	s notes failed to evidence liscussion with the resident arty for the risks and benefits lls.						
- 0		dated 11/20/2019, r rails to bed to promote turn well as independence."						
t c	documented in part, " he potential for ADL : /t depression, dizzine Interventions" docum	care plan dated, 8/17/2021, Focus: [Resident #40] has self-care performance deficit ess, anxiety." The nented in part, "1/4 side rails ence with repositioning."					c.	
ı s	taff member) #2, the	director of nursing, stated state assessments or the residents.						

DEPAR	TMENT-OF-HEALTH	AND HUMAN SERVICES					D: 02/18/2022 M-ABBBAVER	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM APPROVED MB NO. 0938-0391		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
1		495255	B. WING	_		0:	2/08/2022	
NAME OF	PROVIDER OR SUPPLIER			ł .	STREET ADDRESS, CITY, STATE, ZIP CODE			
SKYVIEW SPRINGS REHAB AND NURSING CENTER				'	30 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 700	700 Continued From page 87		F7	'00	·			
	On 2/7/2022 at 4:57 had no side rail asse Resident #40.	p.m., ASM #2 stated they essments or consents for						
.		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.							
1	No further information	n was obtained prior to exit.						
		ain consent, after a is and benefits for the use of e resident and/or responsible					4.7	
i i	4/28/2016. On the midata set) assessment with an ARD of 12/13 13 out of 15 on the Bis not cognitively imposed size on the section resident was coded a	G - Functional Status, the						
. 2		le of Resident #28 on The resident was observed both side rails up.						
		record failed to evidence de bed rail assessment.						
	Review of the nurse's	notes failed to evidence						

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		RETRUCTION	(X3) DAT COA	E SURVEY APLETED
		495255	B. WING	_		02/	08/2022
	PROVIDER OR SUPPLIËR W SPRINGS REHAB A	ND NURSING CENTER		30 MON	ADDRESS, CITY, STATE, ZIP CODE VIVUE DRIVE 7, VA 22635		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFID TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(Xs) COMPLETION DATE
F 700	documentation of a and/or responsible processible for the use of side responsible processible for the use of side responsible processible for the use of side responsible for the part, (both sides) for indemobility." The comprehensive documented in part, potential for ADL sell hx (history) of CVA (weakness." The "Int part, "1/4 side rails to	discussion with the resident party for the risks and benefits ails. dated, 5/20/2019, "Quarter side rails up x2 pendence in position and bed care plan dated, 7/22/2021, "Focus: [Resident #28] has a if-care performance deficit r/t stroke) with right sided erventions" documented in o promote independence with	F 7	00	Ų		
1	staff member) #2, the the facility doesn't had consents for most of the	p.m. ASM (administrative be director of nursing, stated ave side rails assessments or of the residents. p.m., ASM #2 stated they essments or consents for	iv.				
1	administrator, ASM a ASM #3, the regiona services, were made on 2/8/2022 at 2:05	staff member) #1, the #2, the director of nursing, I vice president of clinical aware of the above concern p.m.			24		
F 730 99=D	Nurse Alde Peform F CFR(s): 483.35(d)(7) §483.35(d)(7) Regula	Review-12 hr/yr In-Service		1.	. CNA # 3 has had a documented performance review completed	•	

FORM CM8-2587(02-99) Previous Versions Obsolete

Event ID: B7L211

Facility ID: VA0166

continuation sheet Page 89 of 116



(FAX)

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTR ING	(X3) DATE SURVEY COMPLETED		
1		495255	B. WING			02/	08/2022
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		STREET ADD 30 MONTVU LURAY, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X6) COMPLETION DATE
1	of every nurse aide months, and must p education based on reviews. In-service requirements of §48 This REQUIREMEN by: Based on staff inter and employee record that the facility staff documentation for onursing assistant) er CNA#3. For CNA#3 evidence documents performance review. The findings include A review was conducted a review was conducted as a request was made 2/7/2022 at the end approximately 4:45 p. On 2/8/2022 at approximately 4:45 p. On 2/8/2022 at approximately 4:45 p. On 2/8/2022 at approximately 4:45 p. On 2/8/2022 at approximately 4:45 p. On 2/8/2022 at approximately 4:45 p. On 2/8/2022 at approximately 4:45 p. On 2/8/2022 at approximately 4:45 p. On 2/8/2022 at approximately 4:45 p. On 2/8/2022 at approximately 4:45 p. On 2/8/2022 at approximately 4:45 p. On 2/8/2022 at approximately 4:45 p. On 2/8/2022 at approximately 4:45 p. On 2/8/2022 at approximately 4:45 p.	at least once every 12 rovide regular in-service the outcome of these training must comply with the i3.95(g). IT is not met as evidenced view, facility document review d review, it was determined failed to evidence ne of four CNA (certified imployee records reviewed, is, the facility staff failed to ation of an annual cted of four CNA employee mentation of an annual CNA#3 failed to have se of a performance review. for the above records on of day meeting at it. cximately 9:00 a.m., OSM # 3, human resources, ited documents with this she'd return with answers la.m., OSM #3 presented a list" dated 7/8/2021. OSM	F7	2. Ab P Store	All employees' files will be audity Human Resources for yearly erformance Review due dates. Chedule and a tracking—sheet e developed and implemented ach employee. The Human Resource Dept will isperse to Department Heads, appropriate to complete evaluation a time frame for completion yearly performance reviews. It was the Department Heads of a limportance of completing an evaluations timely. The Human Resource Department ill do an audit of all employees issure yearly review has been impleted timely. The procedure Action/Audits to be impleted by 3/18/2022	A will for as tions lon The ill on annual	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		riple construction NG			E SURVEY (PLETED
ı		495255	B. WING			02/	08/2022
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE 30 MONTVUE DRIVE LURAY, VA 22835	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD TO THE APPROPE	BE	(X8) COMPLETION DATE
SS⊒C	The facility policy, "I Training," document completes a performat least annually." ASM (administrative administrator, ASM and ASM #3, the registered, were made on 2/8/2022 at 2:05 No further informatic Posted Nurse Staffin CFR(s): 483.35(g)(1) Data in must post the following basis: (i) Facility name. (ii) The current date. (iii) The total number by the following cate unlicensed nursing sizes ident care per shid. (A) Registered nurses (B) Licensed practice vocational nurses (a: (C) Certified nurse a (IV) Resident census §483.35(g)(2) Postin (i) The facility must person and the process of the following cate unlicensed practice vocational nurses (a: (C) Certified nurse a (IV) Resident census	Nurse Aide In-service and In part, 2: "The facility nance review of nurse aides at staff member) #1, the #2, the director of nursing, glonal vice president of clinical e aware of the above concerning. In was obtained prior to exit. In a Information (and inform	F 73		it to post the data for the publicated to reflect to deception is and every arm and ry shift. If data, if data, if data, if data, if data, if the reflect to the public staffing to each of the public staffing to each deception if data, if the reflect to the public staffing to each data will all the reflect to the public staffing to each data weeks all the reflect to the public staffing to each data weeks all the reflect to the public staffing to each data weeks all the reflect to th	n will be the the Charge ducate donists posting adit the ensure the ff and	
, ,	(B) In a prominent pl	ace readily accessible to			 		

	T OF DEFICIÊNCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED
		495255	B. WING _		02	2/08/2022
	PROVIDER OR SUPPLIER N SPRINGS REHAB A	ND NURSING CENTER	- 1	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERÊNCED TO THE APPRO DEFICIENCY)	D BE	(X6) COMPLETION DATE
1	staffing data. The fivilten request, male available to the public exceed the community of the property of the	c access to posted nurse acility must, upon oral or see nurse staffing data lic for review at a cost not to nity standard. Ity data retention facility must maintain the taffing data for a minimum of quired by State law, whichever it is not met as evidenced on, staff interview and facility was determined the facility e daily nursing staff posting	F 732			
	at 11:44 a.m. When a posting sheets, OSM #9].	asked who does the staff #8 stated, [name of OSM ducted with OSM #9, the	i			
	AT ITTEL AICAN AAGS COL	MUCCOU WILL CONTRO, LICE				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		ITE SURVEY
1		495255	B. WING			02	2/08/2022
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		30	TREET ADDRESS, CITY, STATE, ZIP CODE D MONTVUE DRIVE URAY, VA 22835	, ,	
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE API DEFICIENCY)			(X6) COMPLETION DATE
F 732	11:45 a.m. When as posting, OSM #9 sta	ceptionist, on 2/7/2022 at ked the process for the staff ited she gets the information	F7	32			
	her the staff and tim- puts the paper in the stated she arrives at her rounds and then changes the staff po the schedules, OSM #3]. When asked wi	omputer program] that gives es. When asked when she frame in the lobby, OSM #9 the around 7:30 a.m., does posts it. When asked who sting based on changes in #9 stated, [name of OSM no posts the document on the stated there is no one to put					
1	not have access to the continuation of the con	me of computer program]			12		
	When asked who do weekends, OSM #3 s receptionist is respor	stated the part-time isible for putting it up.					
	Staffing* documented Dur facility will post, of shift, the number of name esponsible for provide SPECIFIC PROCEDI I. At the beginning of icensed nurses (RNs number of unilcensed lirectly responsible for	on a daily basis for each sursing personnel ling direct care to residents. URES / GUIDANCE: feach shift, the number of LPNs, and LVNs) and the Inursing personnel (CNAs) or resident care will be a location (accessible to and in a clear and					

STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		(X3) DATE SURVEY COMPLETED		
ſ		495255	B. WING			02/08/2022	
NAME OF PROVIDER OR	CHODI IED	433230	3, 11, 13	STREET ADDRESS, CITY, STATE, ZIP CODE			08/2022
NAME OF PROVIDER OR	SUPPLIER				MONTVUE DRIVE		
SKYVIEW SPRINGS	REHAB A	ND NURSING CENTER			URAY, VA 22635		
PREFIX (EACH	DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	8E	(XB) COMPLETION DATE
The shift's record the Information administra ASM (admadministra and ASM & services, won 2/8/202 No further Nutritive V: CFR(s): 48 \$483.60(d) Each resid \$483.60(d) attractive, a temperatur This REQUIPY: Based on interview and determined food at a paservice on of 54 reside tray. The finding	omplete upervisor census, in the lotor. Inistrative tor, ASM 13, the revere mad 2 at 2:05 informatical ue/Apper 13.60(d)(1). Food an ent receive via (2) Food and at a second clinical that the alatable to 2/7/2022 ents on the sinclude include he facility designated form. If /designee will date the form, and post the staffing cation(s) designated by the staff member) #1, the #2, the director of nursing, glonal vice president of clinical e aware of the above concern p.m. In was obtained prior to exit. ear, Palatable/Prefer Temp (1)(2) If d drink was and the facility providesprepared by methods that alue, flavor, and appearance; and drink that is palatable, eafe and appetizing If is not met as evidenced on, resident interview, staff if record review, it was facility staff falled to provide emperature during lunch, with the potential to affect 53 he North unit receiving a meal	F 8	732	 F 804 Food will be served at a safe and appetizing temperature. The meal Resident 88, 25, 28, 8 will be monifor temperature and taste at time service. All residents may potentially be affiby this finding. Upon inspection, it was found the sided plate warmer heating unit or side, had a malfunctioning heating The heating unit has been ordered plates are additionally being warm heated cart to help plates aid in ke plates and food at temperature. 	fected dual n one unit. dand		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495255	B. WING		02	/08/2022	
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22838			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES (PROSS-REFERENCE)	ULD BE	(X\$) COMPLETION DATE	
F 804	"1. Food- not being food- Getting trays I hot" A resident control of the food in part, "Resident control of the food is at temp (temperature we do not have any The coffee Is served insulated mug. We nursing). Tough food We are working on the food is at temp (temperature we do not have any The coffee Is served insulated mug. We nursing). Tough food We are working on the find a way to tender OSM (other staff med CSM (other staff med CSM), a quarterly ass (assessment referent the resident as being 2/6/2022 at 2:06 p.m. conducted with Resident #25's most assessment with an the resident as being 2/6/2022 at 2:40 p.m. conducted with Resident #28's most assessment with an the resident as being 2/6/2022 at 3:23 p.m. conducted with Resident #28's most assessment with an the resident as being 2/6/2022 at 3:23 p.m. conducted with Resident with Re	in 1/2022. The minutes stated: ing cooked/too tough. Cold ate. Resident requested imments/concerns form dated the minutes documented in the complains of) food being t. 2. They want hot coffee. 3. too tough to eat The food is the when it leaves the kitchen- control of when it is delivered. If at 160 (degrees) in an will speak to DON (director of the most likely pork chops. That as we speak. Trying to the tecent MDS (minimum data the essment with an ARD the condition of 1/26/2022, coded to cognitively intact. On the in, an interview was the death was sometimes cold. The resident the death was not the complete of the condition of the cold the condition of the cold the condition of the cold the condition of the cold the condition of the cold the condition of the cold the condition of the cold t	F 8	4. A test tray on each food delive be created and food componer temperatures taken at the time leaves the kitchen and at the titray is served. Variances will be on an Audit Tool to monitor per This will occur for 4 weeks to as meals are served at a safe and temperature. The results will be immediately and reported at the QAPI Meeting. 5. Completion Date: 3/18/2022	the cart me the last recorded rformance. ssure appetizing acted on		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
1		495255	B, WING	B. WING			08/2022
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SKYVIEV	V SPRINGS REHAB A	ND NURSING CENTER			0 MONTVUE DRIVE URAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	38	(X3) COMPLETION DATE
F 804	Continued From pareceived it.	ge 95	F 8	04			
1	assessment with an resident as being m 2/6/2022 at 3:07 p.n conducted with Res	recent MDS, an admission ARD of 11/9/2021, coded the oderately impaired. On n., an interview was ident #8. The resident stated bland and sometimes cold.					
Ė		ch food items were obtained e in the kitchen and were (in):					
1	plates were prepare in food carts and tak 12:28 p.m., a test tra North unit in the food 2/7/2022 at 12:44 p. served on the North food on the test tray	08					
,	The food on the test	tray was sampled by two mined the pot roast, peas,					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
1		495255	B. WING			02/0	08/2022
(PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		30	TREET ADDRESS, CITY, STATE, ZIP CODE DI MONTVUE DRIVE URAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR OEFICIENCY)	BE	(XS) COMPLETION DATE
F 804	enough to be palata and stated these for On 2/8/2022 at apprequest was made to member) #1, the adpolicy on serving for The facility policy, "I documented in part, with a nourishing, pathat meets his or he dietary needs, taking preferences of each On 2/7/2022 at 5:00 administrator, ASM #3, the regions	ttered noodles were not warm able. OSM #4 confirmed this ad items could be warmer. Toximately 1:50 p.m., a so ASM (administrative staff ministrator for the facility and at a palatable temperature. Tood and Nutrition Services "Each resident is provided alatable, well-balanced diet or daily nutritional and special ginto consideration the resident" p.m., ASM #1, the #2, the director of nursing, all director of operations, and seldent of clinical services,	Fe	304			
F 842 SS=D	Resident Records - CFR(s): 483.20(f)(5) §483.20(f)(5) Reside (I) A facility may not resident-identifiable (II) The facility may resident-identifiable accordance with a cagrees not to use or except to the extent to do so.	ent-identifiable information. release information that is to the public. elease information that is to an agent only in ontract under which the agent disclose the information the facility itself is permitted	F 8	42 6	 Level II PASARR information was obtained for #83 and scanned in medical records on 2/22/2022. 100 0/0 audit will be completed Social Worker to identify any por residents that could have been a regarding the need for Level II Passes and review PASARR's of all new admit for completions of PASARRs and recommendations are followed through. 	by the tential offected ASARR	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495255	B. WING_		02/	08/2022
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22836		
(X4) ID PREFIX TAG ¹	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PRÉFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X8) COMPLETION DATE
	must maintain medithat are- (i) Complete; (ii) Accurately docur (iii) Readily accessif (iv) Systematically of §483.70(i)(2) The feall information contergardless of the forrecords, except wher (ii) To the individual, representative wher (ii) Required by Law (iii) For treatment, poperations, as permith 45 CFR 164.50 (iv) For public health neglect, or domestic activities, judicial an law enforcement purposes, research medical examiners, a serious threat to help and in compliance §483.70(i)(3) The farecord information a unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from there is no requirem	rds and practices, the facility leal records on each resident mented; ble; and organized reliable in the resident's records, rm or storage method of the en release isor their resident e permitted by applicable law; it ayment, or health care eitted by and in compliance 6; or activities, reporting of abuse, eviolence, health oversight d'administrative proceedings, reposes, organ donation purposes, or to coroners, funeral directors, and to avert ealth or safety as permitted e with 45 CFR 164.512. cility must safeguard medical gainst loss, destruction, or eal records must be retained erequired by State law; or he date of discharge when ent in State law; or ears after a resident reaches	F 84	4. Admissions Director/Designed all new admission PASARRs we 4 weeks then monthly on an obasis to ensure PASARRs are cand scanned into medical recorreport will be given monthly a meeting. 5. Corrective Action/Audit to be completed by 3/18/2022	eekly for ongoing omplete ords. A	

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED		
î.		495255	B. WING			0	2/08/2022	
	PROVIDER OR SUPPLIER W SPRINGS REHAB	AND NURSING CENTER		30	REET ADDRESS, CITY, STATE, ZIP CODE) MONTVUE DRIVE URAY, VA 22836			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X6) COMPLETION DATE	
F 842	Continued From pa	ge 98	F8	42				
	(i) Sufficient information (ii) A record of the reliable of the provided; (iv) The results of a and resident review determinations condition (v) Physician's, nursiprofessional's progressional's ucted by the State; se's, and other licensed ess notes; and ology and other diagnostic required under §483.50. IT is not met as evidenced view, facility document			11				
	(Pre-admission Scre	eening and Resident Review) s available on the clinical						
	Resident #83 was as 3/13/18 and had the to stroke, bipolar, an recent MDS (minimulassessment with an date) of 1/25/22, the on the BIMS (brief in ndicating the resider making was coded as requiri	dmitted to the facility on diagnoses of but not limited d depression. On the most im data set), a quarterly ARD (assessment reference resident scored 15 out of 15 terview for mental status), in twas not cognitively daily decisions. The resident ing extensive assistance for lion for all other areas of						

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

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495255	B. WING	B. WING			08/2022
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 0 MONTVUE DRIVE JURAY, VA 22835		
(XA) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	activities of dally livi A review of the clinic level 1 screening da	~	F 8	142			
*	Further review of the	e clinical record falled to that the level 2 screening d.					
1	Staff Member, the E "We do not have the resident came from current ownership d	AM, ASM #2 (Administrative Director of Nursing) stated, e level 2 at this time. The another facility, plus the loes not have access to ecords. We are making calls in get."				ļ	
9	conducted with OSM Director of Social So "was not in this departypically, a level 2 is This is the first time when the Level 1 was recommended the L	done before admission. I ever ran Into this. Typically					
1	surveyor a copy of the screening had a fax PM, indicating the feelsewhere and that he record. A review of was dated 3/2/18, do services are not indit the company that pe	PM, OSM #2 provided this he level 2 screening. This date stamp of 2/8/22 at 12:39 acility received it from it had not been on the clinical the level 2 screening, which occumented, "Specialized cated." OSM #2 stated that prformed the level 2 screening aving provided the level 2					

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495255	B. WING		02/08/2022
NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER				STREET ADDRESS, CITY. STATE, 2IP CODE 30 MONTVUE DRIVE LURAY, VA 22835	
(X4) ID PREFIX TAG ¹	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTS (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLÉTION
F 842	on 2/08/22 at 2:08 meeting, ASM #1 (twere made aware of	ge 100 ne facility at the time of the PM, at the "End of Day" he Administrator) and ASM #2 of the findings. No further vided by the end of the	F 84	2	
F 883 SS=D	Documentation" revito the resident, proggoals, or any chang physical, functional, be documented in the medical record between the interdistresident's condition. No further information influency and Pneuroper (1) 483.80(d) (1) 1.5483.80(d) 1.5483.	a and pneumococcal nza. The facility must develop ures to ensure that- e influenza immunization, resident's representative regarding the benefits and a of the immunization;	F 88	1. Resident #91 was administed the pneumococcal vaccine. 2. All other residents may have potentially been affected. The Educator/Designee will educate nursing staff on policy Pneumococcal Vaccine and documentation requirement. 3. The Staff Educator/Designee educate all nursing staff on policy Pneumococcal Vaccine and	e staff sate all ss. will policy
3	immunized during the (III) The resident or the control of the cont			documentation requirement importance of implementation facility audit was completed	on. A

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

Event ID; B7L211

Facility ID: VA0166

FEB 2 5 2022



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

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		STRUCTION	COMPLETED	
ı		495255	B. WING		38	02/	08/2022
NAME OF PROVIDER OR SKYVIEW SPRINGS		AND NURSING CENTER		30 MON	ADDRESS, CITY, STATE, ZIP CODE TVUE DRIVE , VA 22835		
PREFIX (EACH)	DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	C	N D SE PRIATE	(XB) COMPLETION DATE	
documents following: (A) That the was provide and potents immunizate immunizate immunizate refusal. §483.80(d) must deverthate immunizate representate benefits and immunizate immunizate immunizate representate benefits and immunizate (ii) Each refumunizate medically defined and potents immunizate (N) That the was provide and potents immunizate (B) That the pneumocount immunizate (B) That the pneumocount immunicate contraindictions and potents immunicate (B) That the pneumocount immunicate contraindictions and potents immunicate (B) That the pneumocount immunicate contraindictions and potents immunicate (B) That the pneumocount immunicate contraindictions and potents immunicated (B) That the pneumocount (sident's mation that the resider deducatial side ellon; and the resider don or did ton due to the resident ion; and the resident or portunity aldent's mation that the resident eresident call in moococal limitation or resident call in moococal limitation or resident or resident call in moococal limitation or resident call in moococal limitation or resident call in moococal limitation or resident call in moococal limitation or resident call in moococal limitation or resident call in moococcal limitation or resident call in the reside	Indicates, at a minimum, the Indicates, at a minimum, the Int or resident's representative ation regarding the benefits iffects of influenza intellher received the influenza intellher received the influenza intersective the influenza intersective the influenza intersective the influenza intersection contraindications or improved in mococcal disease. The facility is and procedures to ensure it is pneumococcal resident or the resident's lives education regarding the all side effects of the influenza indicated or the resident has indicated or the resident has indicated includes indicates, at a minimum, the intersection regarding the benefits iffects of pneumococcal indicates in the received the unization or did not receive inmunization due to medical indicates.	F8:	4.	residents who consented to a pneumococcal vaccine to ensuadministration was complete. The ADON/Designee will compan audit of all residents. The Director of Nursing will submit QAPI for review and recommendations. Corrective Action/Audits to be completed by 3/18/2022	olete	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
,		495255	B. WING			02/08/2022	
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		30 N	EET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE RAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
•	and clinical record rethe facility staff faile pneumococcal immeresident immunization. Resident #91's RR (provided consent for immunization on 12 to evidence the immeresident. The findings include Resident #91 was an 7/11/14. On the moset), a quarterly asse (assessment referencesident scored 5 out interview for mental resident is severely making dally decision. Review of Resident: a consent for the preform dated 12/29/21 mark beside, "I here permission to admin VACCINATION, unlecontraindicated." The obtained from Resid two nurses. Further clinical record, include the sident record, include the sident record, include the sident record, include the sident record.	rview, facility document review evlew, It was determined that do administer the unization for one of five on record reviews, Resident (resident representative) or the pneumococcal /29/21. The facility staff falled nunization was administered distributed to the facility on st recent MDS (minimum data essment with an ARD noce date) of 1/27/22, the status), indicating the cognitively impaired for status), indicating the cognitively impaired for ins. #91's clinical record revealed eumococcal immunization that documented a check by GIVE the facility lister a pneumonia ess medically se verbal consent was ent #91's RR via phone by review of Resident #91's ding the immunization record, mentation regarding the	F	83			
	On 2/8/22 at 11:52 a	.m., an Interview was				ł	

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONST		(X3) DATE SURVEY COMPLETED	
		495255	B. WING				02/08/2022	
•	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER	ē.	3(MONT	DDRESS, CITY, STATE, ZIP CODE VUE DRIVE VA 22836		
(X4) ID PREFIX TAGI	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE DEFICIENCY)			DBE	(X5) COMPLETION DATE
F 883	conducted with LPN LPN #2 stated nurse pneumococcal imm family members if the representative, and ordered by the physical pharmacy and usual days. On 2/8/22 at 1:52 p. member) #1 (the addirector of nursing) president of clinical of the above concertion the facility policy "P documented, "6. Conthe pneumococcal with the president and prior to administration of the will be documented Administration Recothe month/hear give	I (Ilcensed practical nurse) #2. es obtain consent for the unization from residents' ne residents are not their own then the immunization is iclan, obtained from the illy administered within a few m., ASM (administrative staff lministrator), ASM #2 (the end ASM #3 (the regional vice services) were made aware n. Incumococcal Vaccine" nsent for the administration of recination will be obtained ad/or resident's representative on of the vaccine7. es pneumococcal vaccination on the Medication on the Medication and and/or Vaccination Log for and name of person	F8	83		DEPICIENCY		
	COVID-19 Vaccinati CFR(s): 483.80(l)(1) §483.80(l) COVID-19 Vaccinati must develop and in procedures to ensur vaccinated for COVI section, staff are con		F 8	88	1.	F 888 A list was obtained from the fact hospice care provider (the fact had 1 hospice patient served by said company) documenting the hospice company's employee proof of vaccination per facility policy and procedure. Proof of	ility by ne	
,		<u></u>				vaccination was obtained for t	he _	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	' '	TIPLE CONSTRUCTION ING	-	(X3) DATE SURVEY COMPLETED	
1		495255	B. WING			02/08/2022	
	-	ND NURSING CENTER		STREET ADDRESS, CITY, STA 30 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION ZE ACTION SHOULD D TO THE APPROPR CIENCY)	BE COMPLETION	
1	a primary vaccination completion of a primary vaccination completion of a primary completion of a primary completion of a primary completion of a primary contact, and a single-dose vaccinary required doses of a single-dose vaccinary and contact, must apply to the foliprovide any care, treather facility and/or its (i) Facility employed (ii) Licensed practiti (iii) Students, trained (iv) Individuals who other services for the under contract or by \$483.80(i)(2) The present of the provide facility who exclusive telemedicine service and who do not have residents and other and who provide facility that are performed the facility setting an contact with resident paragraph (i)(1) of the \$483.80(l)(3) The princlude, at a minimum (i) A process for ensparagraph (i)(1) of the staff who have pendibeen granted, exemple single contact with resident paragraph (i)(1) of the staff who have pendibeen granted, exemple contact with resident paragraph (i)(1) of the staff who have pendibeen granted, exemple contact with resident paragraph (i)(1) of the staff who have pendibeen granted, exemple contact with resident paragraph (i)(1) of the staff who have pendibeen granted, exemple contact with resident paragraph (i)(1) of the staff who have pendibeen granted, exemple contact with resident paragraph (i)(1) of the staff who have pendibeen granted, exemple contact with resident paragraph (i)(1) of the staff who have pendibeen granted, exemple contact with resident paragraph (i)(1) of the staff who have pendibeen granted, exemple contact with resident paragraph (i)(1) of the staff who have pendibeen granted, exemple contact with resident paragraph (i)(1) of the staff who have pendibeen granted, exemple contact with resident paragraph (i)(1) of the staff who have pendibeen granted, exemple contact with resident paragraph (i)(1) of the staff who have pendibeen granted, exemple contact with resident paragraph (i)(1) of the staff who have pendibeen granted.	on series for COVID-19. The nary vaccination series for dhere as the administration of the nary vaccination series for the administration of the administration of all multi-dose vaccine. Indicate the administration of all multi-dose vaccine. Indicate the policies and procedures illowing facility staff, who eatment, or other services for residents: It is an advolunteers; and provide care, treatment, or a facility and/or its residents, other arrangement. Indicate and procedures of this to the following facility staff: rely provide telehealth or a outside of the facility setting any direct contact with staff specified in paragraph (I) and a support services for the remed exclusively outside of the who do not have any direct is and other staff specified in	F8	various hospice employees who facility. 2. Communication the hospice con regarding immed the facility when occur, i.e., a ne retained and se resident. 3. A sign-in log has assure identification for the years screen the requirement vaccinated or expectation for to always including the weekly testing the serious whose the property including the serious whose the serious was included the seriou	o entered the as were provided impany(les) ediate updates to an a change may ew employee is erved the facility s been added to ation of any inter the facility, and and reminded at to be fully empted from use of special PPI de the use of an e facility and proof g with negative s communicated if vider. Introl Prevention gn-in log for tched to e vaccination lity.	l of E of	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ULTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
<u>.</u> .		495255	B. WING	G		02	/08/2022
NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER				8TREET ADDRESS, CITY, STATE, ZIP 30 MONTVUE DRIVE LURAY, VA 22835	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	TIX (EACH CORRECTIVE ACTIO	N SHOULD	BE	(XS) COMPLETION DATE
	delayed, as recommodinical precautions a received, at a minima vaccine, or the first of vaccine prior to staff treatment, or other sits residents; (iii) A process for enadditional precaution transmission and spusho are not fully vaccinenting the CO all staff specified in precion; (v) A process for tradocumenting the CO all staff specified in precion; (v) A process for tradocumenting the CO any staff who have of as recommended by (vi) A process by white exemption from the strequirements based (vii) A process for tradocumenting Information who have requested, has granted, an exemption from the strequirements of tradocumentation, which clinical contraindication and which supports sexemptions from vaccinations recination must be temporarily hended by the CDC, due to and considerations) have hum, a single-dose COVID-19 dose of the primary or a multi-dose COVID-19 providing any care, services for the facility and/or assuring the implementation of as, intended to mitigate the read of COVID-19, for all staff clinated for COVID-19; cking and securely evid-19 vaccination status of paragraph (i)(1) of this exign and securely evid-19 vaccination status of balaned any booster doses the CDC; ch staff may request an exaff COVID-19 vaccination on an applicable Federal law; cking and securely and for whom the facility into provided by those staff and for whom the facility into provided by those staff in requirements; suring that all a confirms recognized ons to COVID-19 vaccines taff requests for medical cination, has been signed	F&	888				
t	he Individual request	ed practitioner, who is not ing the exemption, and who espective scope of practice accordance with, all					

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	ULTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495255	B. WING	S	0	2/08/2022	
	PROVIDER OR SUPPLIËR W SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 30 MONTVUE DRIVE LURAY, VA 22835	DE		
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	applicable State and ensuring that such of (A) All information state authorized COVID-1 contraindicated for the and the recognized contraindications; are (B) A statement by the recommending that the exempted from the form the fo	I local laws, and for further locumentation contains: pecifying which of the 9 vaccines are clinically the staff member to receive clinical reasons for the 1 dd 1 dd 1 dd 1 dd 1 dd 1 dd 1 dd 1	F	888			
		ned that the facility staff					

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 A. BUILDING			(X3) DATE SURVEY COMPLETED	
495256		B. WING			02/08/2022		
. 100	PROVIDER OR SUPPLIER N SPRINGS REHAB A	ND NURSING CENTER		3(TREET ADDRESS, CITY, STATE, ZIP CODE D MONTVUE DRIVE URAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
	failed to track all emvaccination status, a facility policy for employed staff member) #10, it is facility staff failed for COVID-19 employed tracking, and failed to vaccination status for #14, and #15, all em Company). The findings included the facility policy titled (SARS-CoV-2) Vaccing documented, "4. Procompany] requires a volunteers and contribution of the following: CDC (SARS-CoVID-19 vaccination of the following: CDC	poloyees' COVID-19 and failed to Implement the ployee vaccination tracking per sampled, OSM (other #11, #12, #13, #14, and #15. Indicate to implement their policy page vaccination status to track COVID-19 In OSM #10, #11, #12, #13, Inployees of [name of Hospice Indicate to the policy of facility In employees, and all actors working on-site, to be inst COVID-19. Employees If full vaccination status either in via the Vaccination establish they have received ine, employees must [sic] one Incommended);	F8	88			
	reren fitatile ot U02	pice Company] can only give			WEC SELVIEU	9	

FORM CM8-2587(02-99) Previous Versions Obsolete

Event ID:87L211

Facility ID: VA0166

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/16/2022 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING _ B. WING 495255 02/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTYUE DRIVE SKYVIEW SPRINGS REHAB AND NURSING CENTER **LURAY, VA 22835** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X6) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST SE PRECEDED BY FULL PRÉFIX DATE REGULATORY OR LSC (DENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 888 Continued From page 108 F 888 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 909 F 909 F 909 Resident Bed CFR(s): 483.90(d)(3) SS=D 1. The bed inspection for residents 11, 40 and 28 will be completed to §483.90(d)(3) Conduct Regular inspection of all assure bed safety; to Include the bed frames, mattresses, and bed ralls, if any, as part of a regular maintenance program to identify bed rails. Monthly bed checks are areas of possible entrapment. When bed rails performed as part of our bed

and mattresses are used and purchased

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495255	B. WING		02/08/2022
	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835	
(X4) ID PREFIX TAG)	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE COMPLETION
1	separately from the ensure that the bed frame are compatible. This REQUIREMENT by: Based on observation document review, as was determined the annual inspection of beds in the survey sand #28. The findings include 1. For Resident #11, complete an annual Resident #11 was ac 7/11/2015. On the material data set) assessment with an ARD (assess 11/17/2021, the resident and long term is severely cognitively indecisions. In Section resident was coded assistance of two stabed. Observation was mad 2/6/2022 at 2:10 p.m. be in her bed, with bed The physician orders documented, "1/4 (quickled mobility and pos The comprehensive in the comprehensive in the section in the section in the comprehensive in th	bed frame, the facility must ralis, mattress, and bed le. IT is not met as evidenced on, staff interview, facility and clinical record review, it facility staff failed to have an ithree resident beds of 52 ample, Resident #11, #40, the facility staff failed to bed inspection. Imitted to the facility ost recent MDS (minimum and, a quarterly assessment, ament reference date) of the dent was coded as having memory problems and impaired for making daily and G - Functional Status, the as requiring extensive aff members for moving in the de of Resident #11 on . The resident observed to oth side rails up.	F9	safety quality assurance with annual inspection through a contract service. 2. The potential for missed bed inspections can affect all resi A comprehensive bed inspect will be completed to assure a beds have been inspected. 3. Ongoing bed inspections will place monthly, with an annual inspection completed by a conservice. Findings will be reviewed ally 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 a reviewed at the monthly QAPI meeting. 5. Completion date: 3/18/2022	dents. Il take I ntract wed

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	: 02/16/2022 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTI		MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		495255	B. WING				02/	08/2022
NAME OF	PROVIDER OR SUPPLIER			STREET AD	DRESS, CITY, STATE	E, ZIP CODE		VOI LOZZ
SKYVIE	W SPRINGS REHAB A	ND NURSING CENTER		30 MONTV				
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F 909	Continued From pag	ge 110	. F90	9				
	performance deficit	dally living) self-care r/t (related to) Alzhelmer's rails to aid with bed mobility						
,		on 2/7/2022 at 10:30 a.m. of the bed inspections.						
1	member) #1, the ma that the beds that we inspected when othe reviewed at the time OSM #1 further state inspection, 2/24/2021 outbreak of COVID a	p.m. OSM (other staff intenance director, stated are requested had not been r beds in the facility were of the previous inspection. It is the facility was in an and the inspectors would not barrier walls to do the						
	documented in part, 'deaths/injuries from tequipment (including rails, headboard, foot accessories), the fact safety inspections an approaches: a) Inspection by main related equipment as	he beds and related the frame, mattress, side board, and bed lity shall conduct regular bed d will promote the following tenance staff of all beds and part of our regular bed ntify risks and problems						
8	and ASM #3, the region	2, the director of nursing, onal vice president of clinical aware of the above concern				RECE	VE	
<u> </u>	lo further information	was obtained prior to exit.				FEB 25	2022	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
	495255					02/08/2022		
SKYVIE		ND NURSING CENTER		3	STREET ADDRESS, CITY. STATE, ZIP CODE SO MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			,
F 909	Continued From pag	ge 111	F9	09				
	2. For Resident #40, complete an annual	the facility staff failed to bed inspection.						
i i	11/19/2019. On the r data set), a quarterly 12/17/2021, the resident om the BIMS (brief in Indicating the resider impaired for making - Functional Status, to requiring extensive a member for moving in Observation was made	dmitted to the facility on most recent MDS (minimum assessment with an ARD of dent scored a 12 out of 15 nterview for mental status) on is moderately cognitively daily decisions. In Section Ghe resident was coded as ssistance of one staff on the bed. de of Resident #40 on The resident was in her						
	bed, with both side re The physician orders documented, "quar turn and repositioning The comprehensive of documented in part, " the potential for ADL a	nils up.						
. f	or the documentation On 2/7/2022 at 3:09 p nember) #1, the main hat the beds that wer nspected when other eviewed at the time o	tenance director, stated e requested had not been beds in the facility were f the previous inspection, that at the time of the last						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILI		(X3) DATE SURVEY COMPLETED			
495255			B. WING	;		02/08/2022		
]	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 0 MONTVUE DRIVE .URAY, VA 22835			
(X4) ID PREFIX TAG ₁	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 909	outbreak of COVID	ge 112 and the inspectors would not barrier walls to do the	F 9	09				
1	administrator, ASM and ASM #3, the reg	staff member) #1, the #2, the director of nursing, ional vice president of clinical aware of the above concern o.m.						
		n was obtained prior to exit. the facility staff failed to ped inspection.						
1 to	4/28/2016. On the m data set) assessmen with an ARD of 12/13 13 out of 15 on the B is not cognitively Improdecisions. In Section resident was coded a	G - Functional Status, the			₩			
	Observation was mad 2/6/2022 at 2:12 p.m. to be in her bed, with	The resident was observed						
	The physician order d documented in part, "o both sides) for independently."	ated, 5/20/2019, Quarter side rails up x2 endence in position and bed			FEB 25 2002			
d	locumented in part, "f ectential for ADL self-c	are plan dated, 7/22/2021, Focus: [Resident #28] has a care performance o promote independence			IDHIOLC			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495255	B. WING		02/08/2022			
NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
SKYVIE	W SPRINGS REHAB A	ND NURSING CENTER			ONTVUE DRIVE AY, VA 22835			
(X4) ID PREFIX TAG			(D PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X4) COMPLETION DATE	
F 909	Continued From pay	•	F 9	09				
	with positioning and	ded mobility."]					
ł		e on 2/7/2022 at 10:30 a.m. on of the bed inspections.						
1	member) #1, the me that the beds that we inspected when other	p.m. OSM (other staff alintenance director, stated are requested had not been ar beds in the facility were						
	OSM #1 further state inspection, 2/24/202 outbreak of COVID:	of the previous inspection. ed that at the time of the last 1, the facility was in an and the inspectors would not barrier walls to do the						
'	Inspection.	staff member) #1, the						
	administrator, ASM and ASM #3, the reg	#2, the director of nursing, ional vice president of clinical aware of the above concern						
F 947		n was obtained prior to exit. Training for Nurse Aides	F 94	7	F 947			
	§483.95(g) Required	in-service training for nurse		1.	CNA # 2 received the required Dementia training.			
	aldes. In-service training m	ust-		2.	A facility wide audit was conducted determine staff that have met the			
	§483.95(g)(1) Be suf continuing competen be no less than 12 ho	ce of nurse aides, but must			required Dementia training. Any sidentified not meeting requirement have been provided Dementia training.	nts		
	training and resident	e dementia management abuse prevention training.		3.	The staff Educator/Designee will conduct inservice training, Health Academy Training completion and			
	§483.95(g)(3) Addres	ss areas of weakness as		1	report before yearly review date.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495255	8. WING	8. WING			08/2022
	PROVIDER OR SUPPLIER V SPRINGS REHAB A	ND NURSING CENTER		30	REET ADDRESS, CITY, STATE, ZIP CODE MONTVUE DRIVE JRAY, VA. 22835		
(X4) ID PREFIX TAG				×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
1	Continued From pay determined in nurse and facility assessme address the special determined by the factorial form of the factorial form of the factorial form of the factorial form of the factorial form of the factorial form of the factorial form of the factorial form of the factorial form of the factorial form of the factorial form of the factorial form of the factorial form of the factorial form of the factorial form of the factorial form of the factorial form of the factorial form of the factorial form of the factorial factorial form of the factorial factori	ge 114 e aides' performance reviews nent at § 483.70(e) and may needs of residents as acility staff. urse aides providing services ognitive impairments, also the cognitively impaired. IT is not met as evidenced eview, facility document the record review, it was ity staff failed to ensure one of aursing assistants) had NA#2. The facility failed to ning in dementia care. cation records of four CNAs as noted that CNA#2 failed to ad dementia training. e for CNA #2's dementia et/7/2022 at the end of day	F 9	l		rvices ce Care	
⇒ . *	(other staff member) reviewed the reques surveyor and stated information. On 2/8/2022 at 11:00	oximately 9:00 a.m. OSM # 3, human resources, ted documents with this she would return with further 0 a.m., OSM #3 stated she cumentation of any dementia			•9	4	
		urse Aide in-service Training" "4. Annual in-services: e.					

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OMB NO	0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		i -		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
495255		B. WING			02/08/2022		
l	PROVIDER OR SUPPLIER W SPRINGS REHAB A	ND NURSING CENTER		30	TREET ADDRESS, CITY, STATE, ZIP CODE 0 MONTVUE DRIVE URAY, VA 22835		
(X4) ID PREFIX TAG ₁	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	9E	(X6) COMPLETION DATE
F 947	residents with cognitraining in demential control, and abuse passed (administrative administrator, ASM and ASM #3, the regiservices, were made on 2/8/2022 at 2:05	addresses the care of litive impairment; and f. include management, infection prevention." a staff member) #1, the #2, the director of nursing, gional vice president of clinical a aware of the above concern	F	347	DEPOLETO!)		

FORM CM3-2557(02-99) Previous Versions Obsolete

Event ID: 87L211

Facility ID: VA0165

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