	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495226	B. WING		07/	28/2022
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW		
(XA) ID	SIMMARYS	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COR	BEATION	
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
E 000	An unannounced Er survey was conducte 07/28/2022. The fac	mergency Preparedness ed 07/26/2022 through ility was in substantial	E 000	Deficiencies and proposes this Correction to the extent that th findings is factually correct and maintain compliance with appl provisions of quality of care of	tatement of Plan of e summary of I in order to icable rules and residents. The	
	compliance with 42 (Requirement for Lor	CFR Part 483.73, ng-Term Care Facilities.		Plan of Correction is submitted allegation of compliance.	l as a written	
F 000 F 622 SS=D	An unannounced Mi survey was conducte No complaints were survey. Corrections with 42 CFR Part 48 requirements. The L survey/report will foll The census in this 9 facility was 50 at the survey sample include reviews and 4 closed Transfer and Discha CFR(s): 483.15(c)(1)	edicare/Medicaid standard ed 7/26/22 through 7/28/22. investigated during the are required for compliance 3 Federal Long Term Care Life Safety Code low. 0 bed Medicare certified time of the survey. The ded 25 current resident d record reviews. rge Requirements)(i)(ii)(2)(i)-(iii)	F 000	response to this Statement of does not denote agreement w Statement of Deficiencies nor constitute an admission that a accurate. Further, Wayland N Rehabilitation Center reserver refute any of the deficiencies Statement of Deficiencies thro Dispute Resolution, formal ap and/or any other administrativ proceeding. On 7-26-22 the Director of Nurs the record of resident # 12 to er issues occurred r/t improper tra documentation	Deficiencies rith the does it any deficiency is ursing and s the right to on this bugh Informal peal procedure e or legal	
	remain in the facility, discharge the reside (A) The transfer or d resident's welfare an cannot be met in the (B) The transfer or d because the residen sufficiently so the residen sufficiently so the residen services provided by (C) The safety of ind	y requirements- permit each resident to , and not transfer or nt from the facility unless- ischarge is necessary for the d the resident's needs facility; ischarge is appropriate t's health has improved sident no longer needs the the facility; ividuals in the facility is he clinical or behavioral		On 7-26 the Director of Nursing record of resident #29 to ensure occurred r/t improper transfer d On 8-2-22, the Director of Nursi an audit of resident transfers/dia the past 30 days This audit is to the transfer or discharge is doct the resident's medical record ar information is communicated to health care institution or provide but not limited to a copy of resid goals. The DON addressed all a concern identified during the au providing required written inform receiving health care institution The audit will be completed by	e no issues ocumentation ng initiated scharges for e ensure that umented in nd appropriate the receiving er to include lent care plan areas of dit to include nation to the or provider.	

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

		MEDICAID SERVICES			OMB NO. (
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SU COMPLE	
		495226	B. WING		07/28	/2022
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODI		
WAYLANI	D NURSING AND REHAE	BILITATION CENTER		30 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 622	 (D) The health of indiotherwise be endang (E) The resident has appropriate notice, to under Medicare or Selfent only allowab or (F) The facility cease (ii) The facility may norresident while the app § 431.230 of this chare exercises his or her r discharge notice from 431.220(a)(3) of this discharge or transfer or safety of the resider facility. The facility methat failure to transfer or safety of the resider facility. The facility methat failure to transfer §483.15(c)(2) Docum When the facility transfer in paragraphs (c)(1)(i section, the facility methat facility methat facility methat facility or discharge is docun medical record and a communicated to the institution or provider. (i) Documentation in to must include: 	ividuals in the facility would ered; failed, after reasonable and o pay for (or to have paid edicaid) a stay at the facility. if the resident does not of paperwork for third party third party, including d, denies the claim and the ay for his or her stay. For a ese eligible for Medicaid after of, the facility may charge a le charges under Medicaid; s to operate. of transfer or discharge the peal is pending, pursuant to pter, when a resident ight to appeal a transfer or of the facility pursuant to § chapter, unless the failure to would endanger the health ent or other individuals in the foust document the danger or discharge would pose. entation. sfers or discharges a i the circumstances specified 0(A) through (F) of this ust ensure that the transfer mented in the resident's ppropriate information is receiving health care	F 622	On 8-11-22 the Director of Nurse a transfer document checklist to documentation is being sent wi On 8-11-22, the ADON(Assista Nursing) initiated an in-service Social Workers, Admission Coor Director of Nursing and Admini regarding Required Notification Documentation Upon Discharg emphasis on documentation of discharge in the resident's med appropriate information is comment the receiving health care institu- to include but not limited to a pro- of resident care plan goals. In-second and/or Administrator who has no received the in-service will rece- scheduled work shift. All newly social worker, admission coord and/or Administrator who has no received the in-service will rece- scheduled work shift. All newly social worker, admission coord and/or Administrator will be in-second and/or Administrator will be and and/or Administrator will be and and/or Administrator will be and and/or Administrator and and required infor communicated to the receiving institution or provider to include to a copy of resident care plant documentation in the electronic Director of Nursing will address identified during the audit to include to a copy of res	o ensure proper th the patient ant Director of with all nurses, ordinator, strator // e/Transfers with transfer/ lical record and municated to tion or provider roviding a copy services will be -22, any nurses, inator, DON to tworked or eive upon next hired nurses, inator, DON serviced by the ation regarding tation Upon Assurance) e an audit of ges utilizing the t weeks then to ensure the transfer/ mation is health care but not limited goals with record. The all concerns dude education Transfer/Bed dministrator will ol weekly x 4 to ensure all	

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

Facility ID: VA0050

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
			A. BUILDIN	G		-LETED
		495226	B. WING			/28/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
WAYLANI	D NURSING AND REHA	BILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) iD	SUMMARY S	TATEMENT OF DEFICIENCIES		· · · · · · · · · · · · · · · · · · ·		T
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 622	 (i) of this section. (B) In the case of pasection, the specific be met, facility attern needs, and the servifacility to meet the needs, and the servifacility to meet the needs, and the servifacility to meet the needs. (ii) The documentati (2)(i) of this section (A) The resident's pl discharge is necessar (A) or (B) of this section. (iii) A physician when necessary under part this section. (iii) Information provimust include a minin (A) Contact information provimust include a minin (C) Advance Directive (D) All special instruction (C) Advance Directive (C) All other necessary of the resident? consistent with §483 any other documenta a safe and effective to This REQUIREMENT by: Based on staff internant facility staff failed required clinical information for a control of the facility staff failed required clinical information for a control of the safe for 2 or control of the safe	aragraph (c)(1)(i)(A) of this resident need(s) that cannot hpts to meet the resident ice available at the receiving eed(s). On required by paragraph (c) must be made by- hysician when transfer or ary under paragraph (c) (1) tion; and in transfer or discharge is ragraph (c)(1)(i)(C) or (D) of ided to the receiving provider mum of the following: ion of the practitioner are of the resident. entative information including re information ctions or precautions for bropriate. care plan goals; ary information, including a is discharge summary, .21(c)(2) as applicable, and ation, as applicable, to ensure transition of care. T is not met as evidenced view, clinical record review t review, it was determined I to provide evidence that all mation was provided to the trof 29 residents in the vere transferred to the	F 6:	22 The Administrator will forwar Notification Audit Tools to the QAPI Committee monthly x Executive QAPI Committee Tools monthly x 2 months to trends and / or issues that n interventions put into place a the need for further and / or monitoring.	the Executive 2 months. The will review the b determine may need further and to determine	

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

Facility ID: VA0050

If continuation sheet Page 3 of 60

CENTER		ID HUMAN SERVICES MEDICAID SERVICES				RM APPROVE NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED 07/28/2022	
		495226	B. WING	1000 AM (0017-510-4		
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	Description of the second s	
WAYLAND	NURSING AND REHAB	ILITATION CENTER	1	LUNENBURG HIGHW YSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 622	Continued From page	• 3	F 622			
	The findings include:					
	required resident clini receiving facility at the Resident #29. Reside the hospital on 6/21/2 Resident #29 was add 3/19/20 with diagnosis limited to: end stage r and discitis. The most recent MDS assessment, a quarte ARD (assessment ref coded the resident as the BIMS (brief intervi indicating the resident impaired. A review of status coded the resident impaired for transfe totally dependent for the bathing; supervision for procedures/treatments dialysis "yes".	e time of discharge for ent #29 was transferred to 2. mitted to the facility on s that included but were not enal disease, heart failure 6 (minimum data set) rly assessment, with an erence date) of 6/8/22, scoring a 07 out of 15 on ew for mental status) score, t was severely cognitively the Section G-functional dent as requiring extensive r, dressing and hygiene; bed mobility, locomotion and or eating. Section O-special s coded the resident as ehensive care plan dated ed, "FOCUS: End Stage esident is at risk for				
	Saturday). Diet as ord Restriction." A review of the nursing 6/21/22 at 11:55 AM, r Returned from Dialysis	revealed, "Time Resident				

Facility ID: VA0050

If continuation sheet Page 4 of 60

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/03/2022 MAPPROVED
E Contraction of the second se		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI		E CONSTRUCTION	OMB NC	D. 0938-0391
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI				PLETED
		495226	B. WING			07	28/2022
NAME OF P	ROVIDER OR SUPPLIER	1		s	STREET ADDRESS, CITY, STATE, ZIP CODE	077	28/2022
WAYI ΔΝΓ	NURSING AND REHAB			7	30 LUNENBURG HIGHW		
		IEITATION CENTER		۲	KEYSVILLE, VA 23947		
(X4) ID		JMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
					DEFICIENCY)		
	_						
F 622	Continued From page		F	622			
	etc.): intact. Bruit & T Mental Status upon re	Thrill: =/- Site: +. Condition &					
	confusion, lethargy, o						
		s &/or Communication from					
	Dialysis Center (pre/p	oost weights, order changes,					
		ent complained of upset					
	pressure within norma	of not feeling well. Blood					
	•	. Patient coughed and heart					
	rate dropped within no	ormal limits. 20 min later					
	heart rate up to 129.						
		Additional Comments (time					
	changes/verified, etc.	D notification & orders					
		pain and left arm pain with					
	nausea. Physician in						
		2 saturations at 85%. O2					
		nula at 2 liters per minute.					
	called. 13:10 county r	rgency room. 12:43 911 escue squad arrived					
		a stretcher and 2 attendants					
	at 13:15. 13:20 report	called to emergency room."					
	Thora is no ouidenee	of transfer documentation in					
	the medical record. A						
		nsfer of Resident #29 on					
	6/21/22 was made on	7/26/22 at 4:40 PM.					
	On 7/27/22 of 7:25 AB	A ASM (administrative staff					
		M, ASM (administrative staff ctor of nursing stated, there					
		clinical documentation for					
	this resident for this tr						
	An intenview was con-	ductod on 7/27/22 -+ 0.20					
		ducted on 7/27/22 at 8:30 d practical nurse) #1. When					
		in is provided to the hospital					
		ident, LPN #1 stated, there					
		at we send. When asked if					
	there is a checklist, LF	PN #1 stated, "We do not					

Facility ID: VA0050

If continuation sheet Page 5 of 60

AME OF PI	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. E				
			A. BUILDIN	G	CON	MPLETED
		495226	B. WING		0	7/28/2022
VAYLAND	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
WAYLAND NURSING AND REHABILITATION CENTER		ILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 622	F 622 Continued From page 5 F have a checklist."		F 62	22		
	(administrative staff n administrator, ASM #	2, the director of nursing and ector of nursing, were made				
	A review of the facility's "Discharge and Transfer" policy dated 8/12, reveals, "Discharge and/or transfer to other medical facilities will be effected only when medically appropriate as indicated by the attending physician. When a resident is transferred or discharged to a hospital or to a					
	nursing home, a copy and referral record ar medical information, a	of an approved transfer ad a copy of any additional as required by the facility will accompany him/her."				
	2. The facility staff fail #12's (R12) comprehe	a was provided prior to exit. led to provide Resident ensive care plan goals to the 12 was transferred to the				
	On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/9/22, the resident's cognitive skills for daily decision making were coded as severely impaired.					
	resident was transferr 6/20/22 for abdominal bowel sounds. Further	l distention and hypoactive er review of R12's clinical evidence of the clinical				

		ND HUMAN SERVICES			FOR	D: 08/03/202 M APPROVE D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		495226	B. WING		07	/28/2022
NAME OF P	ROVIDER OR SUPPLIER		S'	TREET ADDRESS, CITY, STATE, ZIP COL		
WAYLAN	NURSING AND REHAE	ILITATION CENTER		30 LUNENBURG HIGHW		
				EYSVILLE, VA 23947		·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 622	conducted with RN (r nurse who sent R12 stated she provides h residents' face sheets a copy of telephone of the monthly orders an physician's order to s hospital, a copy of the resuscitate form if ap sometimes she provid care plans that is rela did not provide any p comprehensive care transferred to the hose On 7/27/22 at 4:35 p. staff member) #1 (the	registered nurse) #1 (the to the hospital). RN #1 hospital staff with a copy of s, a copy of monthly orders, orders that are received after re signed, a copy of the end the residents to the e bed hold and a do not plicable. RN #1 stated des a piece of residents' ated to the problem but she ortion of the care plan or the plan goals when R12 was	F 622			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1): §483.21 Comprehens Planning §483.21(a) Baseline (§483.21(a)(1) The fac implement a baseline that includes the instr effective and person- that meet professiona The baseline care pla (i) Be developed withi admission.	sive Person-Centered Care Care Plans cility must develop and care plan for each resident uctions needed to provide centered care of the resident al standards of quality care. in must- in 48 hours of a resident's um healthcare information care for a resident	F 655	On 7-26-22, the MDS nurse plan for resident #149 for us urinary catheter and provide resident/resident representa On 8-2-22 the Director of nu audit of all admissions and/o for the past 30 days to includ This audit is to ensure all add readmissions had a baseline developed and implemented of admission to the facility th instructions needed to provid person-centered care of the meet professional standards include but not limited to use urinary catheters and that the resident representative was of the care plan. All areas of immediately addressed by th Nursing. Audit will be completed	e of indwelling d a copy to the tive. rsing initiated an r readmissions de resident #149. missions or care plan within 48 hours at includes the de effective and resident that of quality care to of indwelling e resident and/or provided a copy concerns were de Director of	9/01/202

Facility ID: VA0050

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	D. 0938-03 SURVEY PLETED
		495226	B. WING		*******	07	/28/2022
	ROVIDER OR SUPPLIER D NURSING AND REHAB	ILITATION CENTER		7:	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947		20/2022
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 655	 (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recomm §483.21(a)(2) The fact comprehensive care plan if the section (exit this section). §483.21(a)(3) The faresident and their rep of the baseline care plimited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the facilit (iv) Any updated infor of the comprehensive This REQUIREMENT by: Based on observation document review and facility staff failed to d care plan for one of 20 sample, Resident #14 	endation, if applicable. cility may develop a blan in place of the baseline rehensive care plan- in 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary lan that includes but is not the resident. resident's medications and treatments to be acility and personnel acting y. mation based on the details care plan, as necessary. is not met as evidenced h, staff interview, facility clinical record review, the evelop a complete baseline D residents in the survey 9. to include Resident #149's ary catheter on the	F	655	On 8-11-22 100% in-service was in the ADON (Assistant Director of Ne with all nurses, MDS Coordinator, in nurse regarding Baseline Care Pla Emphasis includes guidelines to de implement a baseline care plan for admission and/or readmission with that includes instructions needed to effective and person-centered care resident, minimum healthcare infor necessary to properly care for a re- include but not limited to use of ind catheter, and that the facility must resident and their resident represe with a summary of the baseline car service will be completed by 9-1-22 9-1-22 all nurses, MDS Coordinato MDS who has not completed the in will complete in-service upon next work shift. All newly hired nurses w serviced during orientation regardin newly hired all nurses, MDS Coord MDS will be in-serviced regarding I Care Plans during orientation. 10% audit of all admissions and/or readmissions to include resident # completed by the DON, ADON, QA designees utilizing the Baseline Car Audit Tool weekly x 4 weeks then r month. This audit is to ensure all ar or readmissions had a baseline car developed and implemented within of admission to the facility that inclu- instructions needed to provide effe- person-centered care of the resider meet professional standards of qua- and that the resident and/or resider representative was provided a cop- care plan. All areas of concerns wil immediately addressed by the Dire Nursing to include retraining of staf- indicated. The DON will review and Baseline Care Plan Audit Tool wee	ursing) and MDS ns. evelop and each new in 48hrs o provide of the mation sident to welling provide the ntative re plan. In- 2. After r, and e-service scheduled rill be in- ng All inator, and Baseline 149 will be nurse or re Plan nonthly x 1 dmissions re plan 48 hours udes the ctive and nt that lity care of t be ctor of f as initial the	

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

Facility ID: VA0050

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION		<u>O. 0938-03</u>
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		G		e survey Pleted
		495226	B. WING		- 07	//28/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA		
18/AVI A NI	NURSING AND REHAE	ILITATION OFNERS		730 LUNENBURG HIGHW		
WAT LAN	NURSING AND REHAD	SILITATION CENTER		KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETIC DATE
F 655		e 8	F 6	55 areas of concerns l	y x 1 month to ensure any nave been addressed.The ird the results of Baseline	
	The findings include:			Care Plan Audit To		
	lying in bed with an indwelling urinary catheter.	Committee monthly Executive QAPI Co monthly x 2 months				
	physician's order date	inical record revealed a ed 7/19/22 for a urinary		Care Plan Audit To and / or issues that	ol to determine trends	
		eline care plan initiated on ument information regarding catheter.			and / or frequency of	
	conducted with RN (r stated the purpose of resident's plan of car a resident's baseline admitting nurse and a should be included on	p.m., an interview was registered nurse) #1. RN #1 f a care plan is to drive the e. RN #1 stated she initiates care plan if she is the an indwelling urinary catheter n the baseline care plan eceives specialized care rr.				
	On 7/27/22 at 4:35 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.					
	PLAN" documented, ' care plan will begin up designated RN. Base the instructions needed	eline care plans will include ed to provide effective and for residents that meet				
F 657 SS=D	No further informatior Care Plan Timing and CFR(s): 483.21(b)(2)(F 6	Nursing) updated t	OON(Assistant Director of the care plan for resident rately safety interventions risk for wandering.	9/01/202

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

Facility ID: VA0050

		ND HUMAN SERVICES	2		FORM): 08/03/202 APPROVE 0.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495226	B. WING		07/	28/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				730 LUNENBURG HIGHW		
WAILANL	NURSING AND REHAE	BILITATION CENTER		KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 657	 §483.21(b) Compreh §483.21(b)(2) A com be- (i) Developed within 1 the comprehensive at (ii) Prepared by an in includes but is not lin (A) The attending ph (B) A registered nurs resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prather the resident and the An explanation must medical record if the and their resident reg not practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and revite am after each asse comprehensive and a assessments. This REQUIREMENT by: Based on clinical record the survey sample, F (R29). 	ensive Care Plans prehensive care plan must 7 days after completion of issessment. iterdisciplinary team, that nited to ysician. e with responsibility for the a responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident oresentative is determined e development of the e staff or professionals in nined by the resident's needs he resident. vised by the interdisciplinary essment, including both the quarterly review T is not met as evidenced cord review, staff interview t review, it was determined d to review or revise the plan for 2 of 29 residents in Residents #22 (R22) and	F 657	On 7-28-22, the DON (Director (Assistant clarified the order an the care plan for resident #29 for restrictions and monitoring. On 8-2-22, the DON completed falls for the past 30 days. This a ensure the resident is care plar reflects all safety interventions following a fall and that safety in are in place. The Director of Nu designee will address all conce during the audit to include upda when indicated. Audit will be co 9-1-22 On 7-29-22, the ADON initiated residents for at risk for wanderi care plan accurately reflect resi wandering to include interventio The Director of Nursing or desig address all concerns identified audit to include assessment of initiating interventions and upda when indicated with changes in wandering status. Audit will be 9-1-22 On 8-3-22 the Director of Nursii audit of all residents with fluid re orders. This audit is to ensure r plan accurately reflects fluid rest resident monitoring. The Direct or designee will address all con- identified during the audit to inc care plan when indicated. Audit completed by 9-1-22. On 8-11-2 initiated an in-service with all nur regarding Care Plans. Emphas ensuring care plan is updated t accurately with all aspects of re- include but not limited to safety following a fall and fluid restrictit will be completed by 9-1-22. Af	d updated or fluid an audit of audit is to accurately initiated hereventions rsing or rns identified ting care plan mpleted by an audit of all ng to ensure dents' risk for ons in place. gnee will during the the resident, ating care plan resident's completed by ng initiated an estriction esident care striction and or of Nursing cerns dude updating twill be 22, the ADON urses is is on imely and esident care to interventions on. In-service ter 9-1-22 any	
	The findings include:			nurse who has not completed th will complete in-service upon ne work shift		

Facility ID VA0050

If continuation sheet Page 10 of 60

TATEMENT	DF DEFICIENCIES CORRECTION	KANNERSPICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
		495226	B. WING _			07	28/2022
NAME OF P	ROVIDER OR SUPPLIER		I	ST	REET ADDRESS, CITY, STATE, ZIP CODE		20/2022
				73	0 LUNENBURG HIGHW		
WATLAN	NURSING AND REP	ABILITATION CENTER		KI	EYSVILLE, VA 23947		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN O		CTION	(X5)
PREFIX TAG		ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETIC
F 657		•	Fe	657	All newly hired nurses will be in- during orientation regarding Car		
	comprehensive ca	. The facility staff failed to update (R22) comprehensive care plan following (R22's) fall on 17/07/2022.			Nurse Supervisor and MDS nurs care plans for 10% of residents	e will review to include	
	(R22) was admitte			resident #22 and #29 weekly x 4 monthly x 1 month utilizing the C	are Plan		
	that included but v			Audit Tool. This audit is to ensur updated timely and accurately for			
	falls.	· · · · · · · · · · · · · · · · · · ·			interventions following a fall, res	idents on	
					fluid restrictions and residents at		
		nt MDS (minimum data set), a			wandering or who have had cha wandering status. The assigned		
		ent with an ARD (assessment 06/02/2022, coded (R22) as			Nursing or designee will address		
		e brief interview for mental			identified during the audit to inclu	ude updating	
		ch indicated the resident was			care plans and/or re-training of s		
	cognitively intact for making daily decisions. The facility's progress note dated 07/07/2022				Director of Nursing will review an Care Plan Audit Tool weekly x 4	weeks then	
					monthly x 1 month to ensure all identified.	concerns	
		rt, "Called to resident's			The Director of Nursing will forw	ard the	
		305 (1:35 p.m.). Resident on bottom on bathroom floor			results of the Care Plan Audit To	ol to the	
		wall. Assessed for injury, none			Executive Quality Assurance Pe		
		d what happened, she stated			Improvement (QAPI) Committee months. The Executive QA Com		
	that she got dizzy	and lost her balance. Assisted			meet monthly x 2 months and re		
	back into room int	o bed x2 assist. VS obtained"			Care Plan Audit Tool to determin		
	The facility's fall in	vestigation for (R22) dated			and / or issues that may need fu interventions put into place and t		
		mented in part, "Incident			the need for further and / or frequencies		
		ng Description: Called to			monitoring.		
		m @ (at) 1305 (1:35 p.m.).		ŀ			
		be sitting on bottom on					
		h back against wall. Resident					
		t that she got dizzy and lost her Injury: No injuries observed at					
	time of incident."	njury. No injunes observed at					
		ve care plan for (R22) dated nented, "Focus: Problematic					
		esident acts characterized by					
:	ineffective coping:	Wandering and/or at risk for					
	unsupervised exits	from facility related to:					

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-0	
	CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495226	B. WING		07/28/2022	
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CO		
WAYLAN	NURSING AND REHAB	ILITATION CENTER		LUNENBURG HIGHW 'SVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETI DE APPROPRIATE DATE	
	02/10/2022." Under " documented, "At Risk Initiated: 02/10/2022, wandering per facility 02/10/2022, Wander g Initiated: 02/10/2022." plan failed to evidence was reviewed or revise 07/07/2022. On 07/28/22 at appro- interview was conduct staff member) #2, direct the revision or review	Wandering Protocol Date Document episodes of protocol Date Initiated: guard alarm bracelet Date ' Further review of the care e documentation that that it red regarding (R22's) fall on ximately 8:00 a.m., an ted with ASM (administrative ector of nursing, regarding of (R22's) care plan				
	that the care plan was 07/27/2022. They fur medications were rev by the physician but ti plan at that time. Whi procedure for revising plan ASM #2 stated th reviewed/revised at th intervention. When as	ther stated that (R22's) iewed at the time of the fall hey failed to update the care en asked to describe the / reviewing a resident's care hat the care is he time of the new				
	that the care plan mal of care for the residen The facility's policy "R documented in part, " be an ongoing proces problems and/or need assessment including (MDS) and Care Asse the resident's respons	kes a continuous continuity It.				

Facility ID: VA0050

If continuation sheet Page 12 of 60

		MEDICAID SERVICES			OMB NC	<u>). 0938-03</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE COMF	SURVEY	
		495226	B. WING		07/28/2022		
AME OF PI	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>	
AYLAND	NURSING AND REHAE	BILITATION CENTER		LUNENBURG HIGHW SVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 657	Continued From pag	e 12	F 657				
		care plan by the appropriate					
		ht to the next scheduled care					
		m the ICP team of its					
		proximately 11:35 a.m., ASM d ASM #2, were made aware					
	No further informatio	n was provided prior to exit.					
	2. The facility failed to care plan to include of Resident #29.	o revise the comprehensive correct fluid restriction for					
	3/19/20 with diagnos	lmitted to the facility on is that included but were not renal disease and heart					
	assessment, a quarte	S (minimum data set) erly assessment, with an ference date) of 6/8/22,					
	the BIMS (brief intervindicating the resider	s scoring a 07 out of 15 on view for mental status) score, it was severely cognitively the Section G-functional					
	status coded the resi assistance for transfe totally dependent for	dent as requiring extensive ar, dressing and hygiene; bed mobility, locomotion and					
		for eating. Section O-special ts coded the resident as					

Facility ID: VA0050

		ND HUMAN SERVICES				FOF	ED: 08/03/202 RM APPROVE IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		DNSTRUCTION		TE SURVEY MPLETED
		495226	B. WING			0	7/28/2022
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
WAYLANI	NURSING AND REHAB	ILITATION CENTER			LUNENBURG HIGHW 'SVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 657	Restriction." A review of the physic revealed, "Fluid restri On 7/27/22 at 12:00 I evidence of 1200 mill monitoring for July 20 A review of the nursir 7/27/22 at 7:00 PM, r clarify fluid restriction On 7/28/22 at 9:00 A member) #2 stated, " evidence of monitorir milliliters. Normally th with dietary and nursi amounts." When ask have been revised to	rdered; 1000ml daily Fluid cian's order dated 7/15/22, iction 1200 milliliters daily." PM, a request was made for liliters daily fluid restriction 022. og progress note dated evealed, "Physician called to order for the resident." M, ASM (administrative staff We do not have any og the fluid restriction at 1200 he order is more specific ing having specific set ed if the care plan should reflect the new order, ASM have been revised. The care	F	557			
	When asked the purp #1 stated the care pla for that resident. Whe should be on the care should. When asked revised if the fluid res LPN #1 stated, if ther plan, it should be revi On 7/27/22 at approx (administrative staff n	(licensed practical nurse) #1. pose of the care plan, LPN an is the plan of care specific en asked if fluid restrictions e plan, LPN stated yes, it if the care plan should be striction amount is changed, e is an amount on the care ised. imately 4:30 PM, ASM					

Facility ID: VA0050

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	
		495226	B. WING		07/	28/2022
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COL		
			7	30 LUNENBURG HIGHW		
WATLANL	NURSING AND REHA		H	EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIC DATE
				Denciencity		
F 657	Continued From pag	e 14	F 657			
	aware of the findings	s.				
	A review of the facilit	y's "Resident Care Plan"				
		reveals, "Review and/or				
		an will occur after each				
		ig the comprehensive and				
		essments. Any new problem				
		nt, which is identified				
		eduled care plan review, will				
		care plan by the appropriate				
		pht to the next scheduled				
	care plan meeting to		F 689	On 7-28-22, the ADON(Assist	ant Director of	9/01/20
	(interdisciplinary care	e plan) team of its addition."		Nursing) re-assessed resident		
	No further informatio	n was provided prior to exit		wandering risk. Resident was		
F 689		n was provided prior to exit. ards/Supervision/Devices		wandering based off assessm		
SS=E				was removed, and care plan u On 7-27-22 the DON (Director	of	
	S492 25(d) Appidant			Nursing)assessed resident #3 any signs of injuries related to		
	§483.25(d) Accidents The facility must ens			without a fire extinguisher. The		
		sident environment remains		concerns identified.		
		azards as is possible; and		On 8-1-22 the DON assessed		
				smoking areas to include the f smoking area to ensure that a		
		esident receives adequate		allowed smoking in designated		
		stance devices to prevent		that included ashtrays of non-		
	accidents.	T is not mat as suidanced		material and safe design, smo		
		T is not met as evidenced		smoking blanket and fire extin		
	by: Based on staff inten	view, resident interview,		provided as safety measures.		
		iew and clinical record		Nursing addressed all conce during the audit to include pro-		
		nined the facility staff failed to		safety devices. Audit will be co		
		inderguard monitoring for		9-1-22		
	one of 29 residents,	Residents #22; and failed to		On 7-29-22, the ADON initiate		
		ols were in place per facility		residents who are at risk for w		
		ents smoking, Residents		audit is to ensure all residents		
	#36, #38, and #5.			were care planned for at risk f wandering interventions were		
	The findings include:			wander guards were monitore	d per facility	
	Ũ			protocol with documentation o	f monitoring.	

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

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		CONSTRUCTION	(X3) DATE	0938-03
	CORRECTION	IDENTIFICATION NUMBER:					LETED
		495226	B. WING			07/	28/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WAYLANI	NURSING AND REHA	BILITATION CENTER			0 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 689	 The facility staff f of (R22's) wandergu physician's orders (R22) was admitted that included but we (1). (R22's) most recent quarterly assessmer reference date) of 00 scoring a 13 on the I status (BIMS) of a se cognitively intact for Section P "Restraint for a wander guard " The physician's orde part, "WANDERGUA expiration every shift The comprehensive 12/04/2019 docume CARE GUIDE Date "Interventions" it doo - wander guard in pla 02/10/2022." The facility's "Wande 05/10/2022 for (R22 5.0. I. NOTE: A resis 5 (five) is at risk for w The facility's "Transr "June 22 (2022) doc Oct (October) 23(20) documented, "Day or 	ailed to check the placement ard according to the to the facility with diagnoses re not limited to: dementia MDS (minimum data set), a nt with an ARD (assessment 5/2/2022, coded (R22) as brief interview for mental core of 0 - 15, 13 - being making daily decisions. s and Alarms" coded (R22) "Used daily." er for (R22) documented in ARD- Check Location and t. Date Order: 07/11/2022." care plan for (R22) dated nted. "FOCUS: RESIDENT Initiated: 12/04/2019." Under cumented in part, "WANDERS ace Date Initiated: ering Risk Assessment" dated) documented in part, "Score: dent who scores greater than	F	589	On 7-29-22 the Facility Consultate the Transmitter log book for all re- risk for wandering. On 7-29-22 the DON developed transmitter tracking log. On 8-11-22the ADON initiated and with all staff regarding Safe Smo- emphasis on ensuring residents allowed to smoke in designated areas that included but not limited ashtrays of non-combustible mais safe design, smoke aprons, smo- and fire extinguishers. This in-sec completed by 9-1-22. After 9-1-2 who has not worked or received service will complete in-service of scheduled work shift. All newly he will be in-serviced during orientar regarding Safe Smoking. On 8-11-22, the ADON initiated with all nurses , the scheduler, the maintenance dept and manager the Residents at Risk for Wande emphasis on accurate completion wandering assessments, initiating interventions for residents at risk wandering to include wander gu facility protocol with documentat updating care plan for residents wandering or with changes in was status/interventions. This in-service completed by 9-1-22. After 9-1-2 nurses, schedulers, maintenance managers on duty that have not received the in-service will receiv prior to next schedulers, maintenance managers on duty will be in-service orientation regarding Residents in Wandering.	esidents at an updated in in-service king with are only smoke d to terial and king blanket rvice will be 2 any staff the in- upon next ired staff tion an in-service ne on duty on ring with n of g for ards, uard per ion and at risk for andering ice will be 2 any e and worked or ve in-service t. All newly enance or iced during	

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

Facility ID: VA0050

If continuation sheet Page 16 of 60

	ERS FOR MEDICARE & MEDICAID SERVICES NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA I OF CORRECTION IDENTIFICATION NUMBER:	T	(Y2) MERT		CONSTRUCTION	1). 0938-03
						(X3) DATE COMP	LETED
		495226	B. WING			07/	28/2022
NAME OF P	ROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
1878371 A MI				73	0 LUNENBURG HIGHW		
WATLAN	D NURSING AND REHAI	BILITATION CENTER		KE	EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 689	Review of the "Trans document the facility review revealed miss transmitter tests on (06/12/2022, 06/18/21 and on 06/26/2022. The facility's "Transr 22 (2022) document (October) 23(2023).' documented, "Day o OK; Transmitter Test Review of the "Trans document the facility review revealed miss transmitter tests on (07/10/2022, 06/18/21 07/17/202, 07/23/20) On 07/28/22 at appr interview was condu staff member) # 2, d asked to explain "Ex shift" written on the p wander guard as stat that expiration referr wander guard, locati wearing the wander to all three nursing s 3:00 p.m 11:00 p.r a.m. When asked to testing log as stated they indicated it was facility's "Transmitter stated that the locati was being checked a shift. They further st would need to be refer	ge 16 smitter Testing Log" failed to t's nursing shifts. Further sing check marks for D6/04/2022, 06/11/2022, 022, 06/19/2022, 06/25/2022 mitter Testing Log" dated "July ed, "Expiration Date: Oct " Under the heading it of Month; Transmitter Test ted By" and "Comments." smitter Testing Log" failed to t's nursing shifts. Further sing check marks for D7/02/2022, 07/03/2022, 022, 07/15/2022, 07/16/2022, 22 and on 07/24/2022. oximately 8:04 a.m., an toted with ASM (administrative irector of nursing. When the above ASM # 2 stated red to the expiration date of ion referred to the resident guard and every shift referred thifts, 7:00 a.m 3:00 p.m., m. and 11:00 p.m. to 7:00 to interpret the blanks on the above ASM # 2 stated that in't done. After reviewing the r Testing Logs" ASM # 2 on of (R22's) wander guard and not being done every tated that the facility's form vised to reflect the physician's ing the comprehensive car	F	589	The Director of Nursing (DON), As Director of Nursing (ADON) and Q Assurance Nurse (QA) will monitor smoking areas weekly for 4 weeks monthly x 1 month using Smoking Audit Tool. This audit is to ensure are only allowed to smoke in desig smoking areas with appropriate sa measure in place to include but no ashtrays of non-combustible mater safe design, smoke aprons, smoki and fire extinguishers. The Director (ADON) and Quality Assurance Nu will address all concerns identified audit to include providing appropri- measures and re-training of the sta Administrator will review the Smok Audit Tool weekly x 4 weeks then 1 month to ensure all concerns we addressed. The Director of Nursing (DON), As Director of Nursing (ADON) and Q Assurance Nurse (QA) will monitor notes for signs of wandering behar changes in wandering status 5 tim x 4 weeks then monthly x 1 month the Wandering Audit Tool. This au ensure residents at risk for wande who have changes in wandering s assessed, interventions initiated w indicated with monitoring of interve with documentation of monitoring a plan updated for appropriate wand status. The Director of Nursing or will address all concerns were initiating interventions when indicated audit to include assessment of the initiating interventions when indicated audit to include assessment of the initiating interventions when indicated audit to include assessment of the initiating of staff. The DON will review Wandering Audit Tool weekly x 4 weekly x 4 weekly x 4 weekly a tool weekly x 4 weekly	uality the the Area residents nated fety t limited to ial and ng blanket r of of Nursing urse (QA) during the ate safety off. The ing Area monthly x re sistant uality progress <i>viors</i> or es a week utilizing dit is to ing or atus are hen ontions and care ering designee during the resident, ted with	

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

Facility ID: VA0050

TATEMENT (OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE). 0938-039 SURVEY LETED	
		495226	B. WING		07/28/2022		
	ROVIDER OR SUPPLIER	BILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 689	 plan for (R22's) wand ASM # 2 stated that the physician order for On 07/28/2022 at ap # 1, administrator an aware of the findings No further information 2. The facility staff fa equipment specifical designated smoking A list of smoking time 10:30 AM, 1:30 PM as smoking area front p of C Hall Dining room Resident #36 was ob at 1:30 PM in the from provided cigarettes at the bag they brought present with resident #36 did not exhibit an Resident #36 wore a cigarette butt disposa There was no fire ext area. Resident #36 was ac 6/27/19 with diagnos 	der guard as stated above the care plan should match or the wander guard. proximately 11:00 a.m., ASM d ASM # 2, were made a. n was provided prior to exit. iled to provide safety ly a fire extinguisher in the area for Resident #36. es revealed smoking times of and 3:30 PM. Designated atio/carport and gazebo off	F 689	then monthly x 1 month to ensure concerns were addressed. The Director of Nursing will forwar results of the Smoking Area Audi the Wandering Audit Tool to the I Quality Assurance Performance Improvement (QAPI) Committee months. The Executive QA Commission meet monthly x 2 months and rev Smoking Area Audit Tool and the Audit Tool to determine trends ar issues that may need further inte put into place and to determine th further and / or frequency of mon	and the t Tool and Executive monthly x 2 nittee will view the Wandering ad / or rventions he need for		
	chronic kidney diseas The most recent MD	se.					

		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 08/0 FORM APPI OMB NO: 093	ROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	1	(X3) DATE SURVE COMPLETED	
		495226	B. WING		_	07/28/20	22
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
WAYLAND	NURSING AND REHAB	ILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)	COMP	(X5) PLETION PATE
F 689	ARD (assessment ref coded the resident as the BIMS (brief interv indicating the residen impaired. A review of G-functional status co independent for bed, dressing, eating, hygi annual assessment w J: coded current toba A review of the compr 8/23/20, revealed, "Fe or user of tobacco pro continue to smoke sa next review. INTERV resident's continued a consistent and regula obtaining smoking ma storage area upon ref A review of the smoking at 11:24 AM, revealed an unsafe smoker an while smoking." An interview was con PM with Resident #36 has smoked, while he Resident #36 stated, On 7/26/22 at 1:45 PI conducted with OSM activities aide. When were in place for resid stated, they have to w cigarettes and lights.	Arry assessment, with an ference date) of 6/20/22, a scoring a 15 out of 15 on iew for mental status) score, t was not cognitively the MDS Section boded the resident as being transfer, locomotion, ene and bathing. The MDS vith ARD of 1/13/22, Section cco use "yes". The measure plan dated OCUS: Resident is a smoker bolucts. Resident will fely in designated areas thru YENTIONS: Evaluate ability to smoke safely on a ir basis. Assist resident in aterials from secured quest." Ing evaluation dated 4/25/22 at the following, "Resident is d requires direct supervision ducted on 7/26/22 at 12:00 b. When asked how long he a has been a resident, since I came here.	F 6				
FORM CMS-256	in the gazebo location 7(02-99) Previous Versions Obs		411	Facility ID: VA0050	If continue	ation sheet Page	10 01 00

Facility ID: VA0050

If continuation sheet Page 19 of 60

ENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING			E SURVEY PLETED
		495226	B. WING		07	//28/2022
AME OF PI	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CO		
	NURSING AND REHAE	BILITATION CENTER		LUNENBURG HIGHW YSVILLE, VA 23947		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 689	Continued From page	e 19	F 689			
		to use that location. This	1 000			
		ed and the residents have				
		kimately 4:30 PM, ASM				
	(administrative staff r					
		2, the director of nursing and rector of nursing, were made				
	aware of the findings					
		ity's policy "Smoking Policy" veals, "This facility allows				
		gnated outdoor areas.				
		Smoking Areas: This facility				
		designated outside smoking				
		als who desire to smoke. All g is permitted have ashtrays				
		naterial and safe design.				
		self-closing cover devices				
		an be emptied are readily				
		where smoking is permitted.				
		aprons, smoking blankets, s are provided as safety				
	measures."					
	No further information	n was provided prior to exit.				
	3. The facility staff fa	ailed to provide safety				
		lly a fire extinguisher, in the				
	designated smoking	area for Resident #38.				
		es revealed smoking times of and 3:30 PM. Designated				
		atio/carport and gazebo off				
	of C Hall Dining room	۱.				
		served smoking on 7/26/22				
	at 1:30 PM in the from	nt patio/carport area. Staff				

						FOR	D: 08/03/2022 M APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	O. 0938-0391 E SURVEY PLETED
		495226	B. WING			07	/28/2022
	ROVIDER OR SUPPLIER	ILITATION CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 689	the bag they brought present with residents #38 did not exhibit an Resident #38 wore a cigarette butt disposa There was no fire exti area. Resident #38 was add 3/31/20 with diagnosi limited to: congestive obstructive disease, a cardiovascular disease The most recent MDS assessment, a quarte ARD (assessment ref coded the resident as the BIMS (brief interv indicating the residen impaired. A review of G-functional status co independent for bed, walking, dressing, eat The MDS annual asse 12/15/21, Section J: co "yes". A review of the compu- 11/19/21, revealed, "F smoker or user of tob will continue to smoke thru next review. INT resident's continued a consistent and regula Smoker-unsafe. Assi	with them. Three staff were a as they smoked. Resident y unsafe smoking behavior. smoking apron. There was I containers available. inguisher available in the mitted to the facility on s that included but were not heart failure, chronic atherosclerotic atherosclerotic and tobacco use. 6 (minimum data set) orly assessment, with an ference date) of 6/24/22, s scoring a 15 out of 15 on iew for mental status) score, t was not cognitively the MDS Section oded the resident as being transfer, locomotion, ting, hygiene and bathing. essment with ARD of coded current tobacco use rehensive care plan dated FOCUS: Resident is a acco products. Resident a safely in designated areas ERVENTIONS: Evaluate ability to smoke safely on a	F	689			

Facility ID: VA0050

If continuation sheet Page 21 of 60

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495226	B. WING			07/	28/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND	NURSING AND REHAB				730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 689	A review of the smoki at 11:36 AM, revealed an unsafe smoker and while smoking." An interview was com- PM with Resident #38 has smoked, while he Resident #38 stated, where he smokes, Re- smoke out under the building. On 7/26/22 at 1:45 Pf conducted with OSM activities aide. When were in place for reside stated, they have to w cigarettes and lights. in the gazebo location residents that smoke location is also cover space between them. On 7/27/22 at approx (administrative staff m administrator, ASM #2 ASM #3, assistant dir aware of the findings. According to the facili revision date 3/19, re- smoking only in desig Designated Outside S provides appropriate of areas for all individua areas where smoking of non-combustible m	ng evaluation dated 5/15/22 d the following, "Resident is d requires direct supervision ducted on 7/26/22 at 12:15 3. When asked how long he has been a resident, for a while. When asked esident #38 stated, we carport at the front of the M, an interview was (other staff member) #3, the asked what safe guards dents to smoke, OSM #3 vear aprons, we keep their We have a fire extinguisher h, but there are too many to use that location. This ed and the residents have imately 4:30 PM, ASM hember) #1, the 2, the director of nursing and ector of nursing, were made ty's policy "Smoking Policy" veals, "This facility allows	F	689			

Facility ID. VA0050

If continuation sheet Page 22 of 60

	MENT OF HEALTH AN S FOR MEDICARE &						PRINTED: 0 FORM AF OMB NO. 09	PROVED
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM	R/CLIA	• •	LE CONSTRUCTION	-	(X3) DATE SUR COMPLETI	VEY
		495226		B. WING			07/28/:	2022
NAME OF PI	ROVIDER OR SUPPLIER			L	STREET ADDRESS, CITY, S	TATE, ZIP CODE	011201	
	NURSING AND REHAB				730 LUNENBURG HIGHW	1		
MAILANG		ICHANON CENTER			KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)	- 1	(X5) OMPLETION DATE
F 689	Continued From page into which ashtrays ca available in all areas Additionally, smoking and fire extinguishers measures." No further information 4. The facility staff fa equipment specifically designated smoking a A list of smoking time 10:30 AM, 1:30 PM a smoking area front pa of C Hall Dining room Resident #5 was obs 1:30 PM in the front p provided cigarettes a the bag they brought present with residents #5 did not exhibit any Resident #5 wore a s cigarette butt disposa There was no fire ext area. Resident #5 was adm 7/22/19 with diagnosi limited to: hemiplegia and hypertension. The most recent MDS assessment, a quarte ARD (assessment ref coded the resident as the BIMS (brief interv	an be emptied are real where smoking is per aprons, smoking bla s are provided as safe in was provided prior t hiled to provide safety y a fire extinguisher in area for Resident #5. Is revealed smoking t atio/carport and gaze atio/carport and gaze n. erved smoking on 7/2 batio/carport area. St nd lighter to residents with them. Three sta s as they smoked. Re unsafe smoking beh moking apron. There al containers available in hitted to the facility on is that included but we here a sessment, with ference date) of 7/7/2 s scoring a 14 out of 1 iew for mental status	mitted. nkets, ety o exit. n the imes of ated bo off 26/22 at caff s from aff were esident avior. e was e. the ere not pathy an 2, 15 on	F 68	19			
EODA CHO STO	indicating the residen	t was not cognitively				· · · · · · · · · · · · · · · · · · ·		
FURM UMS-256	7(02-99) Previous Versions Obs	sure(e	Event ID: XEE411		Facility ID: VA0050	If continu	ation sheet Pa	ge 23 of 60

	MENT OF HEALTH AN						FORM	08/03/2022 APPROVED 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′				X3) DATE	
-		495226	B. WING				07/:	28/2022
NAME OF P	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CO	DE		
WAYLAND	NURSING AND REHAB	ILITATION CENTER		1	730 LUNENBURG HIGHW			
04 A 15		ATEMENT OF DEFICIENCIES		L	KEYSVILLE, VA 23947	ODDECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	E	(X5) COMPLETION DATE
F 689	locomotion, walking, o bathing; supervision f assessment with ARE coded current tobacco A review of the compo- 7/1/20, revealed, "FO at the facility and requisafely. INTERVENTI- continued ability to sm and regular basis. As smoking materials fro- upon request." A review of the smoki at 11:33 AM, revealed an unsafe smoker and while smoking." An interview was com- PM with Resident #5. has smoked, while sh Resident #5 stated, si When asked how fred #5 stated, two or three On 7/26/22 at 1:45 Pf conducted with OSM activities aide. When were in place for reside	the MDS Section ded the resident as ssistance for bed, transfer, dressing, hygiene and or eating. The MDS annual 0 of 12/13/21, Section J: b use "yes". rehensive care plan dated CUS: Resident is a smoker uires assistance to smoke ONS: Evaluate resident's noke safely on a consistent ssist resident in obtaining m secured storage area Ing evaluation dated 5/15/22 d the following, "Resident is d requires direct supervision ducted on 7/26/22 at 2:15 When asked how long she e has been a resident, ince I have been here. guent she smokes, Resident e times a day. M, an interview was (other staff member) #3, the asked what safe guards dents to smoke, OSM #3	F	68				
	cigarettes and lights. in the gazebo locatior residents that smoke	vear aprons, we keep their We have a fire extinguisher h, but there are too many to use that location. This ed and the residents have						

Facility ID: VA0050

If continuation sheet Page 24 of 60

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

		MEDICAID SERVICES					. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING			07/2	28/2022
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
AAAVI ANT		U ITATION OFNITED		7	30 LUNENBURG HIGHW		
WATLANL	NURSING AND REHAB			ĸ	EYSVILLE, VA 23947		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETIO
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	DATE
F 689	Continued From page	e 24	F	689			
	On 7/27/22 at approx	imately 4:30 PM, ASM					
	(administrative staff r						
		2, the director of nursing and					
	ASM #3, assistant dia aware of the findings	rector of nursing, were made					
		ity's policy "Smoking Policy"					
	-	veals, "This facility allows					
	smoking only in desig						
		Smoking Areas: This facility					
		designated outside smoking Is who desire to smoke. All					
		is permitted have ashtrays					
		naterial and safe design.					
		self-closing cover devices					
		an be emptied are readily					
	available in all areas	where smoking is permitted.					
		aprons, smoking blankets,					
		s are provided as safety					
	measures."						
	No further information	n was provided prior to exit.			On 7 27 and 7 28 the Equility Consultant		0/04/20/
F 690 SS=D		tinence, Catheter, UTI -(3)	F	690	assessed the position of the catheter ba	ig of	9/01/202
00 0		(0)			resident #11 and corrected the positioning the bag	ng of	
	§483.25(e) Incontine	nce.			On 7-29-22 the ADON (Assistant Directo	orof	
		cility must ensure that			Nursing)completed a 100% audit of all		
		nent of bladder and bowel on			residents with indwelling catheters to en	sure	
		ervices and assistance to			that all catheters bags were positioned		
		unless his or her clinical les such that continence is			properly and off the floor. The ADON	46-0	
	not possible to mainta				addressed all concerns identified during audit.	me	
	her possible to maint				On 8-11-22 the ADON initiated an in-sei	rvice	
	§483.25(e)(2)For a re	esident with urinary			with all nurses and nursing assistants		
	incontinence, based	on the resident's			regarding Foley Catheters with emphasi		
:		ssment, the facility must			positioning of foley bags for safety and t	1	
	ensure that-				prevention of infection. This in-service we be completed by 9-1-22. After 9-1-22 and		
					be completed by 5-1-22. Alter 9-1-22 an	ıy.	

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495226 B. WING 07/28/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER **KEYSVILLE, VA 23947** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 690 Continued From page 25 nurse or nursing assistant who has not F 690 worked or received the in-service will (i) A resident who enters the facility without an complete upon next scheduled shift. All indwelling catheter is not catheterized unless the newly hired nurses and nursing assistants resident's clinical condition demonstrates that will be in-serviced during orientation catheterization was necessary; regarding Foley CathetersThe DON(Director (ii) A resident who enters the facility with an of Nursing), ADON, QA (Quality indwelling catheter or subsequently receives one Assurance)nurse and designees will audit is assessed for removal of the catheter as soon all residents with Foley catheters 3 times a as possible unless the resident's clinical condition week x 4 weeks then monthly x 1 month demonstrates that catheterization is necessary; utilizing the Foley Catheter Audit Tool. This and audit is to ensure Foley bags are positioned (iii) A resident who is incontinent of bladder off the floor for safety and prevention of receives appropriate treatment and services to infection. The DON or designee will address prevent urinary tract infections and to restore all concerns identified during the audit to include re-positioning Foley bag when continence to the extent possible. indicated and/or re-training of staff. The DON will review the Foley Catheter Audit §483.25(e)(3) For a resident with fecal Tool 3 times weekly x 4 weeks then monthly incontinence, based on the resident's x 1 month to ensure all concerns were comprehensive assessment, the facility must addressed. ensure that a resident who is incontinent of bowel The Director of Nursing will forward the receives appropriate treatment and services to results of the Foley Catheter Audit Tool to restore as much normal bowel function as the Executive Quality Assurance possible. Performance Improvement (QAPI) This REQUIREMENT is not met as evidenced Committee monthly x 2 months. The by: Executive QA Committee will meet monthly Based on observation, staff interview, clinical x 2 months and review the Foley Catheter record review, and facility document review, it Audit Tool to determine trends and / or was determined that facility staff failed to provide issues that may need further interventions care and services for an indwelling catheter for put into place and to determine the need for one of 29 residents in the survey sample, further and / or frequency of monitoring. Residents #11 (R11). The facility staff failed to keep (R11's) catheter collection bag off the floor. The findings include: (R11) was admitted to the facility with diagnoses that included but were not limited to: neuromuscular dysfunction of the bladder (1).

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

Facility ID: VA0050

	MENT OF HEALTH A							FORM): 08/03/2022 APPROVED
STATEMENT	S FOR MEDICARE 8 OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SL IDENTIFICATIO	IPPLIER/CLIA			CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		49	95226	B. WING				07/	28/2022
NAME OF P	ROVIDER OR SUPPLIER		******			TREET ADDRESS, CITY, STATE, ZIP COL	DE		
WAYLAN	NURSING AND REHA	BILITATION CENT	ER			30 LUNENBURG HIGHW EYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFIC CY MUST BE PRECED LSC IDENTIFYING IN	ED BY FULL	ID PREFI TAG	×	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B E APPROPRI/		(X5) COMPLETION DATE
F 690	Continued From pag	je 26		F	690				
	(R11's) most recent quarterly assessmen reference date) of 0 scoring a 3 (three) of mental status (BIMS impaired cognition for Section H "Bladder a having an indwelling On 07/26/22 at appr observation of (R11) their wheelchair with attached to the unde Observation of the of revealed that it was the wheelchair. On 07/26/22 at appr observation of (R11) their wheelchair with attached to the unde Observation of the of revealed that it was the wheelchair. On 07/26/22 at appr observation of the of revealed that it was the wheelchair. On 07/26/22 at appr observation of the of revealed that it was the wheelchair.	nt with an ARD (a 7/18/2022, coded on the brief intervi b) which indicated or making daily d and Bowel" coded or and Bowel" coded or analy 12:32 () revealed they w of the catheter collection dragging on the f roximately 1:58 p) revealed they w of the catheter collection dragging on the f roximately 3:50 p.) revealed they w of the catheter collection dragging on the f	Assessment (R11) as ew for I severely ecisions. d (R11) as o.m., an ere sitting in ection bag elchair. a bag floor under m., an ere sitting in ection bag elchair. a bag floor under m., an ere sitting in ection bag elchair. a bag floor under m., an ere sitting in ection bag elchair. a bag floor under						
	The physician's orde documented in part, catheter to gravity d	" indwelling uri							
	The comprehensive								
FORM CMS-256	67(02-99) Previous Versions Of	osolete	Event ID: XEE411		Fa	cility ID: VA0050	If continu	uation sheel	t Page 27 of 60

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 08/03/2022 1 APPROVED): 0938-0391
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBED		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		495226	B. WING			07/	28/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 017	
WAYLAND	NURSING AND REHAB	ILITATION CENTER			0 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	;	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 690	Pattern of Urinary Elin Catheter At Risk retention Date Initiate On 07/27/2022 at app interview was conduc nurse) #1. When ask collection bag should resident is in a wheel collection bag is hook wheelchair and off the was important to keep floor RN #1 stated that spread of infection an resident. On 07/27/2022 at app #1, administrator and of the findings.	ted in part, "Focus: Altered mination with Indwelling for Infection due to urinary ed: 03/22/2022." proximately 12:53 p.m. an eted with RN (registered ted how the catheter be positioned when a chair RN #1 stated that the ted up underneath e floor. When asked why it p the collection bag off the at is was to prevent the	F 6	90			
F 692 SS=D	References: (1) A problem in whic control due to a brain condition. This inform the website: https://medlineplus.go Nutrition/Hydration St CFR(s): 483.25(g)(1) §483.25(g) Assisted r (Includes naso-gastric both percutaneous er percutaneous endosc enteral fluids). Based	ch a person lacks bladder , spinal cord, or nerve nation was obtained from ov/ency/article/000754.htm. tatus Maintenance -(3) nutrition and hydration. c and gastrostomy tubes, ndoscopic gastrostomy and copic jejunostomy, and	F 6	92	On 7-29-22, the DON(Director of Nur clarified the fluid restriction order for #29 and updated the care plan and medication administration record to re order for fluid restriction. Resident #2 assessed by the DON and the physic notified of assessment with no new ordersOn 8-3-22, the DON initiated a of all residents with orders for fluid re to include resident #29. This audit is f	esident eflect 9 was ian n audit striction	9/01/2022

Facility ID: VA0050

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 495226 B. WING 07/28/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER **KEYSVILLE, VA 23947** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID iD (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) ensure residents are being monitored for F 692 | Continued From page 28 F 692 fluid restriction per physician's order with ensure that a residentdocumentation in the electronic record fluid intakeassessment of resident and §483.25(g)(1) Maintains acceptable parameters notification of the physician if fluid intake of nutritional status, such as usual body weight or exceeded for further recommendations. The desirable body weight range and electrolyte Director of nursing or designee will address balance, unless the resident's clinical condition all concerns identified during the audit to demonstrates that this is not possible or resident include updating MAR and care plan for fluid preferences indicate otherwise; restriction orders, assessment of the resident and notification of the physician for any resident who exceeds fluid restriction §483.25(g)(2) Is offered sufficient fluid intake to for further recommendation. Audit will be maintain proper hydration and health; completed by 9-1-22 On 8-11-22, the ADON(Assistant Director of §483.25(g)(3) Is offered a therapeutic diet when Nursing) initiated an in-service with all there is a nutritional problem and the health care nurses and nursing assistants in regards to provider orders a therapeutic diet. Fluid Restrictions with emphasis on This REQUIREMENT is not met as evidenced monitoring fluid intake each shift with hv. documentation in the electronic record and Based on staff interview, resident interview, notification of the physician for further facility document review and clinical record recommendations when resident exceeds review, it was determined the facility staff failed to fluid restriction parameters. In-service will provide monitoring for fluid restriction for one of becompleted by 9-1-22 After 9-1-22 any 29 residents, Resident #29. nurse or nursing assistant who has not worked or received the in-service will complete upon next scheduled shift. All The findings include: newly hired nurses and nursing assistants will be in-serviced during orientation The facility failed to provide monitoring for fluid regarding Fluid Restriction. restriction for Resident #29. The DON, ADON, QA (Quality Assurance)nurse or designee will audit all Resident #29 was admitted to the facility on residents with orders for fluid restriction to 3/19/20 with diagnosis that included but were not include resident #29 3 times a week x 4 limited to: end stage renal disease and heart weeks then monthly x 1 month utilizing the failure. Fluid Restriction Audit Tool. This audit is to ensure residents are being monitored for The most recent MDS (minimum data set) fluid restriction per physician's order with assessment, a quarterly assessment, with an documentation in the electronic record fluid ARD (assessment reference date) of 6/8/22, intake, assessment of resident and coded the resident as scoring a 07 out of 15 on notification of the physician if fluid intake the BIMS (brief interview for mental status) score, exceeded for further recommendations. indicating the resident was severely cognitively

Facility ID: VA0050

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 495226 B. WING 07/28/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER **KEYSVILLE, VA 23947** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) The DON or designee will address all F 692 Continued From page 29 F 692 concerns identified during the audit to impaired. A review of the Section G-functional include updating MAR and care plan for status coded the resident as requiring extensive fluid restriction orders, assessment of the assistance for transfer, dressing and hygiene; resident and notification of the physician for totally dependent for bed mobility, locomotion and any resident who exceeds fluid restriction bathing; supervision for eating. Section O-special for further recommendation. The DON will procedures/treatments coded the resident as review the Fluid Restriction Audit Tool.3 dialysis "yes". times weekly x 4 weeks then monthly x 1 month to ensure all concerns were A review of the comprehensive care plan dated addressed. 2/26/22, which revealed, "FOCUS: End Stage The Director of Nursing will forward the results of the Fluid Restriction Audit Tool to Renal Disease: The resident is at risk for the Executive Quality Assurance complications due to hemodialysis. Performance Improvement (QAPI) INTERVENTIONS: Dialysis (Tuesday, Thursday, Committee monthly x 2 months. The Saturday). Diet as ordered; 1000ml daily Fluid Executive QA Committee will meet monthly Restriction." x 2 months and review the Foley Catheter Audit Tool to determine trends and / or A review of the physician's order dated 7/15/22, issues that may need further interventions revealed, "Fluid restriction 1200 milliliters daily." put into place and to determine the need for further and / or frequency of monitoring On 7/27/22 at 12:00 PM, a request was made for evidence of 1200 milliliters daily fluid restriction monitoring for July 2022. A review of the nursing progress note dated 7/27/22 at 7:00 PM, revealed, "Physician called to clarify fluid restriction order for the resident." On 7/28/22 at 9:00 AM, ASM (administrative staff member) #2 stated, we do not have any evidence of monitoring the fluid restriction at 1200 milliliters. Normally the order is more specific with dietary and nursing having specific set amounts. On 7/28/22 at 9:30 AM, an interview was conducted with LPN (licensed practical nurse) #1. When asked the purpose of fluid restriction, LPN #1 stated, the fluid restriction is for residents who are at risk for fluid overload such as those with FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: XEE411 Facility ID: VA0050 If continuation sheet Page 30 of 60

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
		495226	B. WING		07/28/2022		
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
WAYLAND	NURSING AND REHAB	ILITATION CENTER) LUNENBURG HIGHW EYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
	fluid restriction is more restriction is split betwist the order usually speed on 7/28/22 at approx (administrative staff readministrator, ASM # ASM #3, assistant dia aware of the findings A review of the facility Monitoring" revised 1 may be placed on intresident's condition withe licensed nurse or Consideration for more output may include b restrictions. Restriction administration record allowed with medicate Care Guides may consideration formation Bedrails CFR(s): 483.25(n) Bed Rails The facility must atteratives prior to in a bed or side rail is uteration of the facility must atteration of the facility must atteration of the facility must atteration of the facility must atteratives prior to in a bed or side rail is uteratives prior to intro the facility must atteratives prior to intro the facility must atteration of the facility must atteratives prior to intro the facility must atteratives prior to into the prior to the facility must atteratives prior to into the prior to the pri	failure. When asked how hitored, LPN #1 stated, the ween dietary and nursing, cifies that division. timately 4:30 PM, ASM nember) #1, the i2, the director of nursing and rector of nursing, were made y's "Intake and/or Output 1/12, reveals, "Residents ake and/or output as the varrants, at the discretion of r as ordered by the physician. nitoring the intake and/or ut is not limited to: fluid ed Fluids: tray cards may ons. MARs (medication I) may contain the fluid ion administration. Resident ntain fluid restrictions." In was provided prior to exit. I-(4) S. mpt to use appropriate nstalling a side or bed rail. If sed, the facility must ensure	F 692 F 700	On 7-27-22, the DON(Director of N completed an assessment of reside for use of bed rails to include documentation of risk for entrapmer resident was offered appropriate alternatives prior to use of bed rails resident and/or resident represents was educated on risk and benefits	ent #21 ent, that s, itive		
	rails, including but no elements. §483.25(n)(1) Asses	se, and maintenance of bed of limited to the following s the resident for risk of I rails prior to installation.		of bed rails, informed consent was obtained and that the facility ensur correct installation, use and mainte of bed rails to include ensuring the dimensions are appropriate for the residents size and weight.	ed mance		

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	OMB NO	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:				COMPI	LETED
		495226	B. WING			07/2	28/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND	NURSING AND REHAB	BILITATION CENTER			30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETIO
F 700	Continued From page	e 31	F	700	On 7-27-22, the DON completed an		
					assessment of resident #149 for use rails to include documentation of risk		
		v the risks and benefits of			entrapment, that resident was offered		
	bed rails with the res	btain informed consent prior			appropriate alternatives prior to use o		
	to installation.			rails, resident and/or resident represe was educated on risk and benefits for			
				bed rails, informed consent was obtain			
	§483.25(n)(3) Ensure			and that the facility ensured correct			
	are appropriate for th	ne resident's size and weight.			installation, use and maintenance of to include ensuring the bed dimension		
	§483.25(n)(4) Follow			appropriate for the residents size and			
	recommendations an			On 7-27-22, the DON completed an	_		
	and maintaining bed			assessment of resident #13 for use o rails to include documentation of risk			
	by:	T is not met as evidenced			entrapment, that resident was offered		
		on, resident interview, staff			appropriate alternatives prior to use of	of bed	
	•	record review, the facility			rails, resident and/or resident represe was educated on risk and benefits for		
		ent bed rail requirements for			bed rails, informed consent was obtain		
		he survey sample, Residents			and that the facility ensured correct		
	#21, #149, #13 and #	+22.			installation, use and maintenance of I		
	The findings include:				to include ensuring the bed dimension appropriate for the residents size and On 7-27-22, the DON completed an		
		iled to attempt alternatives			assessment of resident #22 for use o	fbed	
	1.	esident #21's (R21) bed rails,			rails to include documentation of risk		
	1	for the risk of entrapment to educate R21 or the			entrapment, that resident was offered appropriate alternatives prior to use of		
		ative (RR) on the risks and			rails, resident and/or resident represe	entative	
	benefits of bed rails	and failed to obtain informed			was educated on risk and benefits for		
	consent for the use of	of bed rails.			bed rails, informed consent was obta and that the facility ensured correct	inea	
	On the most recent M	MDS (minimum data set), an			installation, use and maintenance of	bed rails	
		ent with an ARD (assessment			to include ensuring the bed dimensio	ns are	
	1 '	24/22, the resident scored 5			appropriate for the residents size and On 8-11-22, the DON and designee i		
	1	S (brief interview for mental			an audit of all residents utilizing bed		
		e resident was severely for making daily decisions.			ensure resident was assessed with		
		tor making dany decisions.			documentation in the electronic recorrisk of entrapment, that resident was		
		.m., R21 was observed lying			appropriate alternatives prior to use of		
	in bed with bilateral of	quarter bed rails in the upright			rails, resident and/or resident represe		

Facility ID: VA0050

OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 495226 07/28/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER **KEYSVILLE, VA 23947** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) was educated on risk and benefits for use F 700 Continued From page 32 F 700 of bed rails, informed consent was obtained position. and that the facility ensured correct installation, use and maintenance of bed A review of R21's clinical record revealed a rails to include ensuring the bed dimensions physical device evaluation dated 5/17/22 that are appropriate for the residents size and failed to document the resident was offered weight. The DON or designee will address appropriate alternatives prior to the use of bed all concerns identified during the audit to rails, failed to document the resident was include assessment of resident with assessed for the risk of entrapment from bed documentation in the electronic record of rails, failed to document the risks and benefits of risk for entrapment, that resident was bed rails were reviewed with R21 or the RR, and offered appropriate alternatives prior to use of bed rails, resident and/or resident failed to document informed consent was representative was educated on risk and obtained. The evaluation documented n/a (not benefits for use of bed rails, informed applicable) for all areas. consent was obtained and that the facility ensured correct installation, use and R21's comprehensive care plan dated 5/18/22 maintenance of bed rails to include documented, "Use of bed rails for increasing or ensuring the bed dimensions are maintaining current bed mobility or transfer ability. appropriate for the residents size and Muscle weakness, Paralysis." weight. Audit will be completed by 9-1-22 On 8-11-22, the ADON(Assistant Director of On 7/27/22 at 12:45 p.m., an interview was Nursing) initiated an in-service with all conducted with RN (registered nurse) #1. RN #1 nurses and maintenance staff in regards to stated a physical device evaluation should be Bed Rails with emphasis on assessment of completed for all residents who use quarter bed resident with documentation in the rails. RN #1 stated she did not know the purpose electronic record for risk of entrapment, that of the evaluation but she completed the resident was offered appropriate alternatives prior to use of bed rails, evaluation for all residents upon admission and she wasn't sure but thought someone completes resident and/or resident representative was educated on risk and benefits for use of bed the evaluation for all residents each quarter. RN rails, informed consent was obtained and #1 stated she does educate residents or RPs on that the facility ensured correct installation. the risks and benefits of bed rails and documents use and maintenance of bed rails to include this on the evaluation. ensuring the bed dimensions are appropriate for the residents size and On 7/27/22 at 4:35 p.m., ASM (administrative weight. In-service will be completed staff member) #1 (the administrator) and ASM #2 by9-1-22. After 9-1-22, any nurse or (the director of nursing) were made aware of the maintenance staff who have not worked or above concern. received the in-service will receive upon next scheduled work shift. All newly hired On 7/28/22 at 7:44 a.m., an interview was nurses and maintenance staff will be inconducted with ASM #2. ASM #2 stated a serviced by the Staff Facilitator during

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: VA0050

PRINTED: 08/03/2022

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 495226 07/28/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 730 LUNENBURG HIGHW WAYLAND NURSING AND REHABILITATION CENTER **KEYSVILLE, VA 23947** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 700 orientation regarding Bed Rails. Continued From page 33 F 700 10% audit of resident utilizing bed rails will be physical device evaluation should be done on completed by the DON, ADON, QA(Quality admission and quarterly, and if criteria for use is Assurance) nurse and designees utilizing the met then quarter bed rails can be used. ASM Bed Rail Audit Tool weekly x 4 weeks then stated some of the nurses may not realize quarter monthly x 1 month. This audit is to ensure bed rails are classified as a physical device. ASM any resident utilizing bed rails has been #2 stated residents should be assessed for other assessed with documentation in the alternatives and this is sometimes done by the electronic record for risk of entrapment, that rehab staff (note- a review of R21's rehab resident was offered appropriate alternatives documentation failed to reveal the rehab staff had prior to use of bed rails, resident and/or assessed other alternatives). ASM #2 further resident representative was educated on risk stated residents should be assessed for the risk and benefits for use of bed rails, informed consent was obtained and that the facility of entrapment, residents or their RPs should be ensured correct installation, use and provided education and informed consent should maintenance of bed rails to include ensuring be obtained. ASM #2 stated this should be the bed dimensions are appropriate for the documented on the physical device evaluation. residents size and weight. The DON or designee will address all concerns identified The facility policy titled, "SIDE RAIL during the audit. The DON will review the GUIDELINES" documented, "Side rails may be Bed Rail Audit Tool weekly x 4 weeks then used to enhance resident mobility and transfer to monthly x 1 month to ensure all areas of and from the bed ... Resident injury or death is concern were addressed. more likely to occur when attempts are made to The DON will present the findings of the Bed get out of bed with the side rails raised. Injury Rail Audit Tool to the Executive Quality may occur when a resident attempts to move Assurance Performance Improvement (QAPI) through, between, or over side rails ... " committee monthly for 2 months. The Executive QAPI Committee will meet monthly No further information was presented prior to exit. for 2 months and review the Bed Rail Audit Tool to determine trends and/or issues that may need further interventions put into place 2. The facility staff failed to attempt alternatives and to determine the need for further prior to the use of Resident #149's (R149) bed frequency of monitoring rails, failed to assess R149 for the risk of entrapment from bed rails, failed to educate R149 or the resident's representative (RR) on the risks and benefits of bed rails and failed to obtain informed consent for the use of bed rails. R149's admission minimum data set assessment was not complete. A nursing admission evaluation documented R149 communicates needs and can be understood. Facility ID: VA0050 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: XEE411 If continuation sheet Page 34 of 60

		D HUMAN SERVICES MEDICAID SERVICES				FORM	: 08/03/2022 APPROVED . 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE S COMPL	SURVEY
		495226	B. WING		_	07/2	28/2022
NAME OF PI	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
WAYLAND	NURSING AND REHAB	ILITATION CENTER		730 LUNENBURG HIGHW			
				KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 700	Continued From page	34	F 70	o			
		o.m., R149 was observed in rter bed rails in the upright					
	conducted with R149 talked to the resident	a.m., an interview was . R149 stated no staff had regarding bed rails or nd benefits of bed rails.					
	physical device evalu- failed to document the appropriate alternativ- rails, failed to docume assessed for the risk rails, failed to docume	of entrapment from bed ent the risks and benefits of ed with R21 or the RR, and formed consent was					
	1	plan dated 7/26/22 bed rails for increasing or ed mobility or transfer ability.					
	conducted with RN (r stated a physical dev completed for all resi rails. RN #1 stated st of the evaluation but evaluation for all resi she wasn't sure but th the evaluation for all #1 stated she does e	dents upon admission and nought someone completes residents each quarter. RN ducate residents or RPs on of bed rails and documents					

Facility ID: VA0050

If continuation sheet Page 35 of 60

CENTER		ND HUMAN SERVICES MEDICAID SERVICES				M APPROVE 0. 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVI COMPLETED		
		495226	B. WING _		0	7/28/2022	
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
WAYLAN	NURSING AND REHAE	BILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIJ TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE JENCY)	(X5) COMPLETION DATE	
F 700	staff member) #1 (the (the director of nursin above concern. On 7/28/22 at 7:44 a conducted with ASM physical device evalu admission and quarter met then quarter bed stated some of the n bed rails are classifie #2 stated residents sa alternatives and this rehab staff (note- a r documentation failed assessed other altern stated residents sho of entrapment, reside provided education a be obtained. ASM # documented on the p No further informatio 3. The facility staff fa prior to the use of Re failed to assess R13 from bed rails, failed resident's representa	.m., ASM (administrative e administrator) and ASM #2 ng) were made aware of the .m., an interview was #2. ASM #2 stated a uation should be done on erly, and if criteria for use is d rails can be used. ASM urses may not realize quarter ed as a physical device. ASM should be assessed for other is sometimes done by the review of R149's rehab d to reveal the rehab staff had natives). ASM #2 further uld be assessed for the risk ents or their RPs should be and informed consent should to aster this should be obysical device evaluation. In was presented prior to exit.	F7	700			

	S FOR MEDICARE 8				OMB NO. 0938	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495226	B. WING		07/28/2022	
NAME OF P	ROVIDER OR SUPPLIER		STRI			
WAYLAND	NURSING AND REHA	BILITATION CENTER		LUNENBURG HIGHW (SVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPL	
F 700	Continued From page	ge 36	F 700			
	making daily decisio	ons.				
	On 7/26/22 at 12:31 p.m., R13 was observed in bed with bilateral quarter bed rails in the upright position.					
	physical device eval to document the res alternatives prior to document the reside of entrapment from I the risks and benefit with R13 or the RR failed to document in	inical record revealed a luation dated 5/2/22 that failed ident was offered appropriate the use of bed rails, failed to ent was assessed for the risk bed rails, failed to document ts of bed rails were reviewed (resident representative), and nformed consent was uation documented none and for these areas.				
	documented, "Use c	ve care plan dated 5/3/22 of bed rails for increasing or bed mobility or transfer ability. Safety in transfers."				
	conducted with RN (stated a physical de completed for all res rails. RN #1 stated s of the evaluation but	-				
	she wasn't sure but the evaluation for all #1 stated she does	idents upon admission and thought someone completes l residents each quarter. RN educate residents or RPs on ts of bed rails and documents n.				
		o.m., ASM (administrative administrator) and ASM #2				

		ID HUMAN SERVICES					D: 08/03/2022 M APPROVED
		MEDICAID SERVICES				1	<u>). 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		495226	B. WING			07	/28/2022
NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND	NURSING AND REHAB	ILITATION CENTER					
(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
F 700	admission and quarter met then quarter bed stated some of the nu- bed rails are classifier #2 stated residents sh alternatives and this i rehab staff (note- a re- documentation failed assessed other altern stated residents shou of entrapment, reside provided education and be obtained. ASM #2 documented on the p No further information 4. The facility staff fail prior to the use of Re- and failed to assess F entrapment from bed On the most recent M quarterly assessment reference date) of 6/2 out of 15 on the BIMS status), indicating the impaired for making of On 7/26/22 at 2:02 p.	m., an interview was #2. ASM #2 stated a ation should be done on erly, and if criteria for use is rails can be used. ASM urses may not realize quarter d as a physical device. ASM hould be assessed for other s sometimes done by the eview of R13's rehab to reveal the rehab staff had hatives). ASM #2 further ld be assessed for the risk ints or their RPs should be hysical device evaluation. In was presented prior to exit. led to attempt alternatives sident #22's (R22) bed rails R22 for the risk of rails. IDS (minimum data set), a with an ARD (assessment /22, the resident scored 14 5 (brief interview for mental resident was not cognitively	F	700			
	On 7/27/22 at 8:00 a.	m., an interview was					

If continuation sheet Page 38 of 60

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

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA N OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495226	B. WING		07/28/2022	
	ROVIDER OR SUPPLIER	ILITATION CENTER	730	REET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO	
F 700	doesn't use the bed r about to fall. R22 sta the risks and benefits A review of R22's clir physical device evalu to document the resider of entrapment from b the risks and benefits with R13 or the RR (r failed to document in obtained. The evalua n/a (not applicable) for R22's comprehensive documented, "Use of maintaining current b Muscle weakness, Sa On 7/27/22 at 12:45 r conducted with RN (r stated a physical dev completed for all resi rails. RN #1 stated sh of the evaluation for all evaluation for all resi she wasn't sure but to the evaluation for all #1 stated she does e	R22 stated the resident ails unless the resident is ated the staff had explained a of bed rails to the resident. mical record revealed a lation dated 5/2/22 that failed dent was offered appropriate he use of bed rails, failed to nt was assessed for the risk ed rails, failed to document a of bed rails were reviewed resident representative), and formed consent was ation documented none and for these areas. a care plan dated 12/4/19 bed rails for increasing or led mobility or transfer ability. afety in transfers." o.m., an interview was registered nurse) #1. RN #1 ice evaluation should be dents who use quarter bed he did not know the purpose she completed the dents upon admission and hought someone completes residents each quarter. RN ducate residents or RPs on a of bed rails and documents	F 700			
	staff member) #1 (the	m., ASM (administrative e administrator) and ASM #2 g) were made aware of the solete Event ID:XEE		ty ID: VA0050 f (continuation sheet Page 39 of	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

			(20) 10 11		(X3) DATE	0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		LETED	
		495226	B. WING			07/00/0000	
		433220		STREET ADDRESS, CITY, STATE, 2		28/2022	
				730 LUNENBURG HIGHW			
WAYLAND	NURSING AND REHAE	BILITATION CENTER		KEYSVILLE, VA 23947			
(X 4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE JIENCY)	(X5) COMPLETIO DATE	
F 700	Continued From page 39		F	700			
	physical device evaluation admission and quarter met then quarter bed stated some of the nubed rails are classifie #2 stated residents a alternatives and this rehab staff (note- a redocumentation failed assessed other alternatives)	 #2. ASM #2 stated a Jation should be done on erly, and if criteria for use is rails can be used. ASM urses may not realize quarter ed as a physical device. ASM hould be assessed for other is sometimes done by the 					
F 756 SS=D			F	audit is to ensure the (DON) provided the pl recommendations to t and a written respons electronic record follor ADON or designee wi identified during the a limited to assessment indicated, providing pl recommendations to t and initiating new ord physician with docum electronic record. Auc 9-1-22	acy review and he Hospice Physician to change in order On ssistant Director of udit of all pharmacy the past 60 days. This Director of Nursing harmacy he physician for review e documented in the wing review. The II address all concerns udit to include but not to fresident when harmacy the provider for review ers as directed by the	9/01/202	

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

CENTERS		MEDICAID SERVICES			OMB NO	APPROVE 0. 0938-039 SURVEY
ND PLAN OF CO		IDENTIFICATION NUMBER:				PLETED
		495226	B. WING		07/	28/2022
NAME OF PRO	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND N	URSING AND REHAB	ILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
	CI BRADY CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COR	PECTION	~
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION 6 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
addin a (() rii add ptt - Sin dii tt vin Tibliattoo# - Tin tta - Tioco	irector and director of inimum, the resider ind the irregularity th ii) The attending phy esident's medical red regularity has been ction has been taken e no change in the r hysician should doc he resident's medical 483.45(c)(5) The factor haintain policies and rug regimen review mited to, time frame the process and step when he or she ident equires urgent action this REQUIREMENT y: Based on staff interview and clinical record re- to act upon pharmacy if 29 residents in the i25. The facility staff failed intipsychotic medical the findings include: On the most recent M parterly assessment	nd the facility's medical of nursing and lists, at a it's name, the relevant drug, e pharmacist identified. visician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in I record. cility must develop and procedures for the monthly that include, but are not is for the different steps in is the pharmacist must take ifies an irregularity that in to protect the resident. is not met as evidenced iew, facility document review view, the facility staff failed y recommendations for one survey sample, Resident d to follow up on pharmacy ted 3/30/22 and 4/29/22 for dent #25's (R25)	F 75	6 This audit is to ensure there is clinical indication for use of pre- medications, the facility attem gradual dose reduction per pl- orders/pharmacy recommend documentation of a clinical ra- physician that GDR is contrait On 8-11-22 the ADON initiates service with the Director of Ni- regarding Pharmacy Recomm- with emphasis on ensuring the provided a copy of the pharma- recommendations monthly for written response is received to orders are initiated when indi- documentation in the electror service will be completed by newly hired DON will be in-se- orientation regarding Pharma- Recommendations. The Facility Consultant will re- pharmacy recommendations months utilizing the Pharmac- Recommendations/Psychotro- Audit Tool. This audit is to em- physician is provided a copy pharmacy recommendations review, that a written respons- timely, and orders are initiate indicated with documentation electronic record. The Facility will address all concerns ider the audit to include re-training Administrator will review the Recommendations/Psychotro- Audit Tool monthly x 2 month concerns were addressed. The Administrator will presen- of the Pharmacy Recommen- Psychotropic Medication Aud- Executive Quality Assurance	sychotropic pted a hysician lations and/or tional by the ndicated. ad an in- ursing and nendations the physician is lacy r review, that a timely, and cated with hic record. In- 9-1-22AII erviced during try poic Medication usure the of the monthly for se is received d when h in the y Consultant htified during g of staff. The Pharmacy poic Medication is to ensure all ht the findings dations/ lit Tool to the	

If continuation sheet Page 41 of 60

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MU		CONSTRUCTION		D. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				• •	PLETED
		495226	B. WING			07/28/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND	NURSING AND REHAE	BILITATION CENTER			30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 756	A review of R25's clir physician's order dat (milligrams) twice a c clinical record reveal progress notes dated documented, "Medic completed. Recomm care physician)." A p progress note dated (Medical Doctor) revi recommendation. Re Hospice, PCP will re Hospice MD to evalu faxed to (name) Hos A pharmacy recomm regimen review date "Please add the indic directions for Seroqu off. Change to Seroqu off. Change to Seroqu ofher care. A pharmacy recomm regimen review date "Please add the indic director's no her care. A pharmacy recomm regimen review date "Please add the indic directions for Seroqu off. Change to Seroqu	nical record revealed a red 3/3/22 for Seroquel 25 mg day. Further review of R25's red pharmacist consultant d 3/30/22 and 4/29/22 that ation regimen review rendation to PCP (primary oharmacist consultant 5/9/22 documented, "MD iewed Pharmacy esident is being cared for by fer recommendations to uate. Recommendations pice. " rendation with a medication of 3/30/22 documented, cation for use to the uel. Please consider tapering quel 25 mg (milligrams) qhs o) x 14 days, then d/c e was no response except for the set that R25 was not under hendation with a medication of 4/29/22 documented, cation for use to the uel. Please consider tapering quel 25 mg (milligrams) qhs that R25 mg (milligrams) qhs	F	756	committee monthly for 2 months Executive QAPI Committee will for 2 months and review the Pha Recommendations/Psychotropid Audit Tool to determine trends a that may need further interventid place and to determine the need frequency of monitoring	meet monthly armacy c Medication and/or issues ons put into	
	(every hour of sleep) (discontinue)." There physician/prescriber was on hospice.) x 14 days, then d/c e was no response except that R25 a.m., an interview was					

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

		AND HUMAN SERVICES				P	RINTED: 08/ FORM APP	
		& MEDICAID SERVICES				<u>0</u>	MB NO. 093	8-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	¢	(X3) DATE SURVEY COMPLETED	
		495226	B. WING _				07/28/20	22
NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP	CODE		
		ADII ITATION CENTED		730 L	UNENBURG HIGHW			
WATLANL	NORSING AND KEN	ABILITATION CENTER		KEY	SVILLE, VA 23947			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	1	PROVIDER'S PLAN OF	CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	COM	PLETION
F 756	Continued From pa	age 42	F 7	56		88899 3444 ANY 444 44		
		rector of nursing). ASM #2						
		sist completes monthly reviews						
		nendations to her. ASM #2						
	stated she gives th	e recommendations to the						
	physician who eval	uates what she is going to do.						
:	ASM #2 stated the physician writes her orders							
	-	mmendations with a follow up						
	response back to A							
	-	ndations with response to the ployee who scans the						
		nto the computer. ASM #2						
		mendations were provided to						
:		r but R25 is not under her care						
	so the recommend	ations were faxed to hospice.						
	ASM #2 stated she	could not provide evidence						
	that the hospice ph recommendations.	ysician responded to the						
	On 7/28/22 at 12.0	4 p.m., ASM #1 (the						
		ASM #2 were made aware of						
	the above concern.							
		tled "CONSULTANT ESPONSIBILITIES"						
		port shall be prepared monthly						
		ninistrator reporting the						
		en Review and any significant						
	irregularities. The	Director of Nursing will review						
		and document action taken on						
		ons of the Consultant						
	Pharmacist."							
	No further informat	ion was presented prior to exit.						
	Reference:							
	(1) "Quetiapine (Se	roquel) tablets and						
		long-acting) tablets are used to						
		of schizophrenia (a mental						
ORM CMS-256	7(02-99) Previous Versions (<u>l</u>	Facility	ID: VA0050	If continue	tion sheet Page	

****	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	OMB NO. 09 (X3) DATE SUR	VEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETE	Đ
		495226	B. WING		07/28/2	2022
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND	NURSING AND REHA	BILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE CC	(X5) DMPLETION DATE
F 756	Continued From pa	ge 43	F 75	6		
		disturbed or unusual thinking,				
		e, and strong or inappropriate				
	emotions). Quetiap	ine tablets and				
		ablets are also used alone or				
	with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or					
	•	nts with bipolar disorder				
	, ,	disorder; a disease that				
	· ·	depression, episodes of				
	•	onormal moods). In addition,				
		and extended-release tablets				
		medications to prevent				
		or depression in patients with				
	,	nportant warning for older ia: Studies have shown that				
		mentia (a brain disorder that				
		remember, think clearly,				
	communicate, and	perform daily activities and				
		anges in mood and personality)				
		otics (medications for mental				
	, , ,	etiapine have an increased risk atment. Quetiapine is not				
	-	ood and Drug Administration				
		nent of behavioral problems in				
		ementia." This information was				
	obtained from the v					
	https://medlineplus tml	.gov/druginfo/meds/a698019.h				
F 758	Free from Unnec P	sychotropic Meds/PRN Use	F 75	0n 7-29, the DON(Director of	Nursing) 9/	01/202
SS=D	CFR(s): 483.45(c)(3)(e)(1)-(5)		clarified with Hospice agency		
				use of psychotropic medicatio	on for resident	
	§483.45(e) Psycho			#25. On 7-29-22, the DON initiated	an audit of all	
		ychotropic drug is any drug that		residents receiving psychotro		
	affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to drugs in the following		10.00	This audit is to ensure there i	s adequate	
		avior. These drugs include, to, drugs in the following		clinical indication for use of p		
				clinical indication for use of p medications, the facility attem dose reduction per physician	pted a gradual	

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/03/20 FORM APPROV OMB NO: 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495226	B. WING	9999	07/28/2022
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
WAYLANI	NURSING AND REHAE	BILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 758	resident, the facility n §483.45(e)(1) Reside psychotropic drugs a unless the medication specific condition as in the clinical record; §483.45(e)(2) Reside drugs receive gradua behavioral interventic contraindicated, in ar drugs; §483.45(e)(3) Reside psychotropic drugs p unless that medication diagnosed specific co in the clinical record; §483.45(e)(4) PRN o are limited to 14 days §483.45(e)(5), if the a prescribing practition appropriate for the PI beyond 14 days, he o rationale in the reside indicate the duration §483.45(e)(5) PRN o drugs are limited to 1 renewed unless the a	ensive assessment of a nust ensure that ents who have not used re not given these drugs n is necessary to treat a diagnosed and documented ents who use psychotropic al dose reductions, and ons, unless clinically n effort to discontinue these ents do not receive ursuant to a PRN order on is necessary to treat a ondition that is documented and orders for psychotropic drugs s. Except as provided in attending physician or er believes that it is RN order to be extended or she should document their ent's medical record and	F 758	 documentation of a clinical rational by physician that GDR is contraindicated Director of Nursing or designee will ac all concerns identified during the audit include clarification with physician on indication for use, obtaining order for 0 when indicated and/or documentation clinical rational by the physician that 0 contraindicated. Audit will be complete 9-1-22 On 8-11-22, the ADON(Assistant Dire Nursing) initiated an in-service with the nurses and physician regarding Psych Medications with emphasis on ensurir orders for psychotropic medications in adequate clinical indication for use, a attempted per physician order/pharma recommendation and/or documentatic clinical rational by the physician that 0 contraindicated. In-service will be complex 9.1-22. All newly hired DON or nur be in-serviced during orientation regar Psychotropic Medications. The DON, ADON, QA(Quality Assura nurse or designees will review 10% of residents receiving psychotropic medication and/or documentatic psychotropic Medication Audit Tool. T audit is to ensure all orders for psychotropic medication for use, a GDR is attempted physician that GDR is contraindication for use, a GDR is attempted psychotropic Medication Audit Tool. T audit is to ensure all orders for psychot physician that GDR is contraindication for use, a GDR is attempted psychotropic Medication Audit Tool. T audit is to ensure all orders for psychot physician that GDR is contraindication for use, a GDR is attempted physician that GDR is contraindication for use, a GDR is attempted physician that GDR is contraindication for use, a GDR is attempted physician that GDR is contraindication for use, a GDR is attempted physician that GDR is contraindication for use, a GDR is attempted physician that GDR is contraindication for use, a GDR is attempted physician that GDR is contraindication for use, a GDR is attempted physician that GDR is contraindication for use, a GDR is attempted physician that GDR is contraindication for use and/or document	. The ddress ito GDR of a GDR is ad by ctor of e all notropic ng all ave an GDR is acy on of a GDR is on on a on of a GDR is on on a on on a on al by ated. I include will on s/ on thly x

Facility ID: VA0050

If continuation sheet Page 45 of 60

		ND HUMAN SERVICES				FORM	D: 08/03/2022 MAPPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		495226	B. WING			07/28/2022	
	ROVIDER OR SUPPLIER	BILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 0 LUNENBURG HIGHW EYSVILLE, VA 23947	0772672022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 758	by: Based on observation document review and facility staff failed to en- unnecessary medicate the survey sample, R The facility staff failed adequate clinical indii (R25) continued use (1) and failed to atten or document a clinical contraindication of a en- The findings include: On the most recent M quarterly assessment reference date) of 6/1 skills for daily decision severely impaired. A hospital discharges documented, "While and Scopolamine (2), and see how she doe hospice and facility p helped with patient ha Seroquel was utilized possibly paranoia." A review of R25's clini physician's order date (milligrams) twice a d medication was docu R25's clinical record of	of that medication. F is not met as evidenced an, staff interview, facility d clinical record review, the ensure a resident was free of tion for one of 29 residents in tesident #25. d to ensure there was an cation for Resident #25's of the medication Seroquel npt a gradual dose reduction al rational for the gradual dose reduction. MDS (minimum data set), a t with an ARD (assessment 1/22, the resident's cognitive in making was coded as summary dated 3/2/22 Seroquel was started for her , these could be weaned off as apart from these. Defer to roviders. Scopolamine andling her secretions and I because of anxiety and hical record revealed a ed 3/3/22 for Seroquel 25 mg ay (no diagnosis for the mented). Further review of	F7	58	The Administrator will present the fi of the Pharmacy Recommendations Psychotropic Medication Audit Tool Executive Quality Assurance Perfor Improvement (QAPI) committee mo 2 months. The Executive QAPI Cor- will meet monthly for 2 months and the Pharmacy Recommendations/ Psychotropic Medication Audit Tool determine trends and/or issues that need further interventions put into p to determine the need for further free of monitoring	to the mance nthly for nmittee review to may lace and	

	S FUR MEDIUARE &	MEDICAID SERVICES			OMBI	IO. 0938-03
ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DA	TE SURVEY MPLETED
		495226	B. WING		07/28/2022	
AME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP COE		
AYLAN	NURSING AND REHAD	BILITATION CENTER	1	LUNENBURG HIGHW SVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
F 758	 4/29/22 that docume review completed. R (primary care physici consultant progress i documented, "MD (M Pharmacy recommendations to Recommendations to Recommendations fat A pharmacy recommendations fat A pharmacy recommendations fat directions for Seroqui off. Change to Seroci (every hour of sleep) (discontinue)." There physician/prescriber medical director's no her care. A pharmacy recommendations for Seroqui off. Change to Seroci (every hour of sleep) (discontinue)." There physician/prescriber medical director's no her care. A pharmacy recommendate "Please add the indice directions for Seroqui off. Change to Seroci (every hour of sleep) (discontinue)." There physician/prescriber was on hospice. Another physician's of documented an orded day for vascular demi disturbance. A review of R25's MA 	nted, "Medication regimen ecommendation to PCP ian)." A pharmacist note dated 5/9/22 Medical Doctor) reviewed indation. Resident is being , PCP will refer Hospice MD to evaluate. axed to (name) Hospice. " endation with a medication of 3/30/22 documented, cation for use to the tel. Please consider tapering quel 25 mg (milligrams) qhs ix 14 days, then d/c e was no response except for the te that R25 was not under endation with a medication of 4/29/22 documented, cation for use to the tel. Please consider tapering quel 25 mg (milligrams) qhs ix 14 days, then d/c e was no response except that R25 prder dated 7/14/22 r for Seroquel 25 mg twice a ientia without behavior	F 758			

		ID HUMAN SERVICES				FOR	D: 08/03/2022 M APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495226	B. WING			07	/28/2022
NAME OF P	ROVIDER OR SUPPLIER		- ·		TREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAN	NURSING AND REHAB	ILITATION CENTER			30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 758	July 2022. On 7/26/22 at 12:41 p and 7/27/22 at 8:11 a quietly lying in bed. R25's hospice physic interview during the s On 7/28/22 at 11:35 a conducted with ASM member) #2. ASM #2 recommendations we #2 stated she could n hospice physician res recommendations. On 7/28/22 at 10:43 a conducted with ASM a conducted with ASM M #6 stated the ind include: hallucinations aggressive behaviors ASM #6 stated paran for use and Seroquel there are medications can be used for the e doesn't typically like to residents are admitted tries to taper off the m recommendations. In use, ASM #6 stated h but she has interacted stated R25 does not p except for calling out	2.m., 7/26/22 at 3:58 p.m. .m., R25 was observed ian was not available for urvey. a.m., an interview was (administrative staff 2 stated R25's pharmacy re provided to the medical at under her care so the re faxed to hospice. ASM not provide evidence that the sponded to the a.m., an interview was #6 (the medical director). dications for Seroquel use s, depression, and with worsening dementia. oia is an adequate indication can be used for anxiety but s with less toxic effects that Iderly. ASM #6 stated she o use Seroquel but a lot of d on the medication so she nedication per the pharmacy n regards to R25's Seroquel iospice manages R25's care d with the resident. ASM #6 present with any behaviors when CNAs (certified ve care. ASM #6 stated	F	758			

Facility ID: VA0050

If continuation sheet Page 48 of 60

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					D: 08/03/2022 MAPPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY
		495226	B. WING		an Malan Malan Balancia Ing ang ang ang ang ang ang ang ang ang a	07/	28/2022
NAME OF P	ROVIDER OR SUPPLIER			57	TREET ADDRESS, CITY, STATE, ZIP CODE		
14/41/1 A 61P		U ITATION OFNITED		73	80 LUNENBURG HIGHW		
WATLANL	NURSING AND REHAB	ILITATION CENTER		ĸ	EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	conducted with ASM is presents with agitatio and moving in bed. A present with hallucina verbal behaviors or pl On 7/28/22 at 12:04 p administrator) and AS the above concern. The facility policy title DRUG MONITORING will be the policy of th use of antipsychotic of such therapy is NOT acceptable clinical dia use." No further information Reference: (1) "Quetiapine (Sero extended-release (lon treat the symptoms of illness that causes dia loss of interest in life, emotions). Quetiapine extended-release tab with other medication (frenzied, abnormally depression in patients (manic depressive dia causes episodes of di- mania, and other abn quetiapine tablets and are used with other medication	a.m., another interview was #2. ASM #2 stated R25 n as evidenced by scooting ASM #2 stated R25 does not ations, delusions, paranoia, hysical behaviors. 0.m., ASM #1 (the SM #2 were made aware of d, "ANTIPSYCHOTIC B POLICY" documented, "It re facility to discourage the drugs in residents for whom supported by: 1. An agnosis or indication for n was presented prior to exit.	F	758			

Facility ID: VA0050

If continuation sheet Page 49 of 60

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/03 FORM APPRO	OVED
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE SURVEY COMPLETED	
		495226	B. WING		07/28/2022	,
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	0.120.2022	
WAYLAND	NURSING AND REHAB			0 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ETION
F 758	adults with dementia: older adults with dem affects the ability to re communicate, and pe that may cause chang who take antipsychot illness) such as queti of death during treatm approved by the Food (FDA) for the treatme older adults with dem obtained from the we https://medlineplus.ge	ortant warning for older Studies have shown that entia (a brain disorder that emember, think clearly, erform daily activities and ges in mood and personality) ics (medications for mental apine have an increased risk nent. Quetiapine is not d and Drug Administration ent of behavioral problems in entia." This information was	F 758			
F 839	vomiting. This inform website:	bation was obtained from the	F 839	On 7-28-22 the DON (Director of	0/04/2	000
SS=D	CFR(s): 483.70(f)(1)(§483.70(f) Staff quali §483.70(f)(1) The fac full-time, part-time or professionals necess provisions of these re §483.70(f)(2) Profess certified, or registered applicable State laws This REQUIREMENT by: Based on staff interv	fications. ility must employ on a consultant basis those ary to carry out the equirements. ional staff must be licensed, d in accordance with is not met as evidenced iew, facility document review review, it was determined	1 009	Nursing)verified certification of NA #1 #1 certification was current until 2/28/2023.On 7-28-22,the AP (Accou Payable) staff initiated an audit of all professional staff licenses, registratio certifications. This audit is to ensure a professional staff have the require lice registration or certification in accordar with applicable state laws and the fac monitoring license/certifications per fa protocol. The DON or Administrator w address all concerns identified during audit to include but not limited to immediately removing staff from the schedule who do not meet qualificatio current. The audit will be completed b 9-1-22	nts n and all ense, nce ility is acility vill the ons on is	JUZZ

If continuation sheet Page 50 of 60

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	SURVEY
		495226	B. WING		07/	28/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
WAYLAND	NURSING AND REHAE	BILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN		0(5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 839	maintenance of requi one CNA (certified nu reviews. The facility staff failed required certification employed for greater The findings include: On 7/27/22 at approx (administrative staff r administrative staff r administrator and OS the personnel/payroll facility has only 1 (or employed greater that A request was made evaluation/annual rev mandatory required e and dementia training On 7/27/22 at approx the director of nursing certification. In a rev CNA #1, there was e from the Virginia Dep Professionals dated certification expiratio was shown that licen 2:15 PM, with the exp provided was an onli for CNA #1 for renew 5/24/22 at 2:34 PM. An interview was cor	ired certification for one of ursing assistant) record d to provide the evidence of for one CNA that was than one year, CNA #1. dimately 12:00 PM, ASM member #1, the SM (other staff member) #4 manager stated that the ne) CNA that has been an one year, CNA #1. for CNA #1's performance view, CNA license and education (abuse, neglect g). dimately 3:00 PM, ASM #2, g provided CNA #1's iew of the certification for vidence of license lookup partment of Health 11/17/21 with the CNA n date as 2/28/22. Evidence se lookup dated 7/27/22 at piration date of 2/28/23. Also ne licensing payment receipt d license process dated	F 83		Assistant Director of service with the of Nursing, Staff pasis on the ity to ensure ensed, certified or with applicable state completed by 9-1-22. rator, Director of and Payroll will be in- on regarding Staff or and Payroll will be in- on regarding Staff ation or to be beeks then monthly x 1 Qualification Audit sure all staff who cation are current in ble state laws and the nse/certifications per N or Administrator will entified during the audit to immediately schedule who do not license, certification or he Administrator will ation Audit Tool nonthly x 1 month. resent the findings of udit Tool to the ance Performance mmittee monthly for 2 QAPI Committee will ths and review the Tool to determine t may need further ace and to determine	
	asked what CNA #1	PM with ASM #2. When had worked between 2/28/22 2 stated, she is as needed				

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/03/2022 M APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		495226	B. WING			07	/28/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND	NURSING AND REHAB	ILITATION CENTER					
	0.000			ĸ	EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 839	Continued From page	e 51	E	339			
	staff, she did not wor						
		M, a request was made to s/payroll for CNA #1 from /22.					
	the administrator and #4, the personnel/pay payroll information fo attached to the sheet	imately 11:00 AM, ASM #1, OSM (other staff member) yroll manager provided the r CNA #1. A sticky note was is revealing 293.75 hours. are the hours worked for					
	ASM #3, the assistar #4, a consultant, ASM	2, the director of nursing, t director of nursing, ASM ᠕ #5, a consultant, and RN , the infection prevention					
	Unlicensed Nursing F Nursing Assistants w specified below for ve	Validation of Nursing revealed, "Validation of Personnel Qualifications: All ill provide the information erification of current listing, at pon renewal, as applicable."					
F 909 SS=E	No further information Resident Bed CFR(s): 483.90(d)(3)	n was provided prior to exit.	F	909	On 7-28-22 the Maintenance Director completed a maintenance inspection resident # 43 bed frames, mattresse bed rails to identify any areas of pos	n of s and	9/01/2022
	bed frames, mattress part of a regular mair areas of possible ent and mattresses are u	ct Regular inspection of all ses, and bed rails, if any, as ntenance program to identify rapment. When bed rails used and purchased red frame, the facility must			entrapment. There were no concerns identified. On 7-28-22, the Maintenance Direct completed a maintenance inspectior resident # 22 bed frames, mattresse bed rails to identify any areas of pos entrapment. There were no concerns identified	s tor s of s and sible	

Facility ID: VA0050

If continuation sheet Page 52 of 60

CENTER		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI				APPROVE . 0938-039
	CORRECTION	IDENTIFICATION NUMBER:				COMPL	
		495226	B. WING			07/2	8/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAN	NURSING AND REHAE	BILITATION CENTER			30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETIOI DATE
F 909	ensure that the bed r frame are compatible This REQUIREMENT by: Based on observation document review, an was determined that evidence documenta inspection for 4 of 29 sample, Residents #4 (R35), and #13 (R13) The findings include: 1. (R43) was observe and left upper bed ra p.m. and on 07/27/22 (R43) was admitted to that included but was falls. (R43's) most recent f admission assessme reference date) of 06 scoring a 14 out of 11 mental status (BIMS) was cognitively intact On 7/27/22 at 12:23 conducted with OSM maintenance director history report that do inspections; the last 7/4/22. OSM #5 stat inspection of all beds the electrical portion checking to see if the	ails, mattress, and bed T is not met as evidenced on, staff interview, facility d clinical record review, it the facility staff failed to tion of current bed/side rail residents in the survey 43 (R43), #22 (R22), #35 ed lying in bed with the right ils raised on 07/26/22 at 2:28	F	909	On 7-28-22, the Maintenance Director completed a maintenance inspection of resident # 35 bed frames, mattresses ar bed rails to identify any areas of possible entrapment. There were no concerns identified. On 7-28-22, the Maintenance Director completed a maintenance inspection of resident # 13 bed frames, mattresses ar bed rails to identify any areas of possible entrapment. There were no concerns identified. On 8-11-22, the Maintenance Director initiated an audit of all resident's bed fra mattresses and bed rails if any to identifi areas of possible entrapment. The Maintenance staff will address all conce identified during the audit. Audit will be completed by 9-1-22 On 8-11-22 the Administrator in-serviced Maintenance staff regarding Routine Inspection of Beds with emphasis on routinely inspecting bed frames, mattres and bed rails if any to identify any areas possible entrapment. The in-serviced will completed by 9-1-22. All newly hired Maintenance staff will be in-serviced du orientation regarding Routine Inspectior Beds. The Administrator will audit Maintenanc records weekly x 4 weeks then monthly month utilizing TELs report to ensure maintenance staff are routinely inspection bed rails if any to identify any areas possible entrapment and corrective measures have been initiated for all con identified. The Administrator will address concerns identified during the Audit. The Administrator will review the TELs repor weekly x 4 weeks then monthly x 1 mon ensure all concerns were addressed.	nd e nd le ames, fy any erns d the sses s of l be ring n of x 1 ng sses s of n of x 2 t	

Facility ID: VA0050

If continuation sheet Page 53 of 60

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TATEMENT OF ND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		495226	B. WING			07/	28/2022	
	OVIDER OR SUPPLIER	ILITATION CENTER	STREETADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
	Inspect the beds for a entrapment. OSM #5 inspects the beds and six months but he did inspects the beds for entrapment. A copy of was requested. On 7/27/22 at 1:20 p. staff member) #2, dire copy of the bed inspector company. The report not contain documen inspected any beds for entrapment. On 07/28/2022 at app # 1, administrator and aware of the findings No further information 2. (R22) was observed and left upper bed rai p.m. and on 07/27/22 (R22) was admitted to that included but was falls. (R22's) most recent M quarterly assessment reference date) of 06 scoring a 13 out of 15	SM #5 stated he does not any possible areas of 5 stated an outside company d completes a report every 1 not know if the company possible areas of of the most recent report m., ASM (administrative ector of nursing, provided a ection report from the outside t was dated 2/26/19 and did tation that the company or possible areas of proximately 11:00 a.m., ASM d ASM # 2, were made n was provided prior to exit. ed lying in bed with the right ils raised on 07/26/22 at 2:02 2 at 8:50 a.m. o the facility with diagnosis a not limited to: a history of MDS (minimum data set), a t with an ARD (assessment /02/2022, coded (R22) as 5 on the brief interview for which indicated the resident	F	909	The Administrator will present the fi the TELs Report to the Executive Q Assurance Performance Improveme (QAPI) committee monthly for 2 mo Executive QAPI Committee will mee for 2 months and review the TELs F determine trends and/or issues that need further interventions put into p to determine the need for further free of monitoring	uality ent nths. The et monthly Report to may lace and		

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

ATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		495226	B. WING		0	7/28/2022
	ROVIDER OR SUPPLIER	BILITATION CENTER	7	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 909	conducted with OSM maintenance director history report that doo inspections; the last i 7/4/22. OSM #5 state inspection of all beds the electrical portion checking to see if the replaced, inspecting of the rails move up. O inspect the beds for a entrapment. OSM #5 inspects the beds and six months but he did inspects the beds and six months but he did inspects the beds for entrapment. A copy was requested. On 7/27/22 at 1:20 p. staff member) #2, dire copy of the bed inspec company. The report not contain documen inspected any beds for entrapment. On 07/28/2022 at app # 1, administrator and aware of the findings. No further information 3. (R35) was observed and left upper bed rai p.m. and at 11:05 a.m (R35) was admitted to	(other staff member) #5, . OSM #5 presented a work cumented monthly bed nspection was done on ed he conducts a monthly that consists of making sure of the head and foot works, a mattress needs to be the frames and making sure SM #5 stated he does not any possible areas of 5 stated an outside company d completes a report every a not know if the company possible areas of of the most recent report , ASM (administrative ector of nursing, provided a ection report from the outside t was dated 2/26/19 and did tation that the company or possible areas of proximately 11:00 a.m., ASM d ASM # 2, were made h was provided prior to exit. ed lying in bed with the right ils raised on 07/27/22 at 8:08	F 909			

If continuation sheet Page 55 of 60

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 08/03/202; RM APPROVEE IO: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		TE SURVEY MPLETED
		495226	B. WING		0'	7/28/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAN	NURSING AND REHAB	ILITATION CENTER		30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 909	admission assessmer reference date) of 06, scoring a 4 out of 15 mental status (BIMS) was severely impaire daily decisions. On 7/27/22 at 12:23 p conducted with OSM maintenance director history report that doo inspections; the last in 7/4/22. OSM #5 state inspection of all beds the electrical portion of checking to see if the replaced, inspecting to the rails move up. OS inspect the beds for a entrapment. OSM #5 inspects the beds for entrapment. A copy of was requested. On 7/27/22 at 1:20 p. staff member) #2, dire copy of the bed inspector not contain document inspected any beds for entrapment.	ADS (minimum data set), an nt with an ARD (assessment /18/2022, coded (R35) as on the brief interview for which indicated the resident d of cognition for making o.m., an interview was (other staff member) #5, . OSM #5 presented a work cumented monthly bed nspection was done on ed he conducts a monthly that consists of making sure of the head and foot works, mattress needs to be the frames and making sure SM #5 stated he does not any possible areas of 5 stated an outside company d completes a report every I not know if the company possible areas of of the most recent report m., ASM (administrative ector of nursing, provided a ection report from the outside t was dated 2/26/19 and did tation that the company or possible areas of	F 909			

Facility ID: VA0050

If continuation sheet Page 56 of 60

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DA	IO. 0938-039 TE SURVEY MPLETED
		495226	B. WING	eremente d'Automate automatica de la construction de la construction de la construction de la construction de l	0	7/28/2022
	ROVIDER OR SUPPLIER	ILITATION CENTER	730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW 'SVILLE, VA 23947		*****
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 909	No further information 4. 3. (R13) was obser- right and left upper be 12:31 p.m. (R13) was admitted to that included but was (upper and middle ba- fracture. (R13's) most recent M- admission assessme- reference date) of 05- scoring a 10 out of 15- mental status (BIMS) was moderately impa- daily decisions. On 7/27/22 at 12:23 p conducted with OSM maintenance director history report that door inspections; the last in 7/4/22. OSM #5-state inspection of all beds the electrical portion of checking to see if the replaced, inspecting to the rails move up. Of inspects the beds for a entrapment. OSM #5- inspects the beds and six months but he did inspects the beds for	n was provided prior to exit. rved lying in bed with the ed rails raised on 07/26/22 at to the facility with diagnosis a not limited to: thoracic lock) vertebrae compression MDS (minimum data set), an nt with an ARD (assessment /09/2022, coded (R13) as 5 on the brief interview for which indicated the resident aired of cognition for making b.m., an interview was (other staff member) #5, . OSM #5 presented a work cumented monthly bed nspection was done on ed he conducts a monthly that consists of making sure of the head and foot works, mattress needs to be the frames and making sure SM #5 stated he does not any possible areas of 5 stated an outside company d completes a report every I not know if the company	F 909			

If continuation sheet Page 57 of 60

STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING		OMB NO ⁻ 0938-039 (X3) DATE SURVEY COMPLETED	
		495226	B. WING		07/	28/2022
	ROVIDER OR SUPPLIER	BILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 230 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X 4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 909	copy of the bed inspec company. The report not contain document inspected any beds freentrapment. On 07/28/2022 at app # 1, administrator and aware of the findings No further information	ector of nursing, provided a ection report from the outside t was dated 2/26/19 and did tation that the company or possible areas of proximately 11:00 a.m., ASM d ASM # 2, were made	F 909		of training	
F 947 SS=D	CFR(s): 483.95(g)(1) §483.95(g) Required aides. In-service training mu §483.95(g)(1) Be suf continuing competen be no less than 12 hd §483.95(g)(2) Include training and resident §483.95(g)(2) Include training and resident §483.95(g)(3) Address determined in nurse and facility assessme address the special r determined by the fac §483.95(g)(4) For nu to individuals with co address the care of t This REQUIREMENT by:	in-service training for nurse ust- ficient to ensure the ce of nurse aides, but must burs per year. e dementia management abuse prevention training. ss areas of weakness as aides' performance reviews ent at § 483.70(e) and may needs of residents as	r 54/	hours for all nursing assistants to incl #1. This audit is to ensure the all nursi assistants completed no less than 12 hours per year to include but not limit abuse, neglect and dementia training will address all concerns identified du audit to include providing required tra- identified staff. Audit will be complete On 8-11-22 the Administrator initiated service with the Director of Nursing, A Director of Nursing and Staff Facilitat regarding Training Hours for Nursing with emphasis on the training of nurs assistants with no less than 12 hours time to include but not limited to abus and dementia. The in-service will be of by 9-1-22. All newly hired Director of N Assistant Director of Nursing and Staff will be in-serviced during orientation r Training Hours for Nursing Assistants he DON,ADON(Assistant Director of N QA(Quality Assurance) nurse or desi review training records for 5 nursing a weekly x 4 weeks then monthly x 1 mu utilizing the Training Hours for Nursing Assistants Audit Tool.	ude NA ing training ed to . The DON ring the ining to d by 9-1-22 I an in- Assistant or Assistants ing of training e, neglect completed Jursing, f Facilitator egarding ursing) gnee will ssistants onth to	9/01/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					<u>). 0938-039</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
		495226	B. WING			07	/28/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
WAYLAN	D NURSING AND REHAD	BILITATION CENTER			NENBURG HIGHW /ILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 947	and employee record that the facility staff f required training for nursing assistants). The facility staff faile- mandatory training for dementia training for The findings include: On 7/27/22 at approx (administrative staff f administrator and OS the personnel/payrol facility has only one greater than one yea A request was made evaluation/annual re- mandatory required a and dementia trainin On 7/27/22 at approx the director of nursin performance review record and CNA cert records for CNA #1, education from 11/22 was no evidence of a training. ASM #2 stated on 7/ PM, she (CNA #1) is She does not have th On 7/28/22 at 11:50 administrator, ASM #2	d review, it was determined ailed to provide annual one of one CNAs (certified d to provide the required or abuse, neglect, and 'CNA #1. kimately 12:00 PM, ASM member #1, the SM (other staff member) #4 I manager stated that the CNA that has been employed ar, CNA #1. for CNA #1's performance view, CNA license and education (abuse, neglect g). kimately 3:00 PM, ASM #2, g provided CNA #1's dated 2/24/22, education ificate. In a review of the there were 1.50 hours of 2/21 through 4/20/22. There abuse, neglect and dementia 27/22 at approximately 3:00 behind on her education. hose courses.	FS	447 as hc ab DC DC DC DC DC DC DC DC DC DC DC DC DC	his audit is to ensure the all n sistants completed no less t burs per year to include but n puse, neglect and dementia t DN or designee will address entified during the audit to in quired training to identified s rector of Nursing will review burs for Nursing Assistants A eekly x 4 weeks then monthly isure all concerns were addr he Director of Nursing will pre- idings of the Training Hours sistants Audit Tool to the Ex- surance Performance Impro- mmittee monthly for 2 month ecutive QAPI Committee wi r 2 months and review the Tur r Nursing Assistants Audit To- ends and/or issues that may reventions put into place and e need for further frequency	han 12 training not limited to raining. The all concerns clude providing taff. The the Training Audit Tool y x 1 month to essed. esent the for Nursing eccutive Quality ovement (QAPI) ns. The II meet monthly raining Hours pol to determine need further d to determine	

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

		ID HUMAN SERVICES					D: 08/03/2022	
		MEDICAID SERVICES). 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
:		495226	B. WING			07/	28/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WAYLAN	NURSING AND REHAB	ILITATION CENTER			30 LUNENBURG HIGHW			
				Гк	(EYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 947	Continued From page	50	-	0.47				
1 047		# #5, a consultant and RN	F	947				
		, the infection prevention						
		ent dated 1/31/22, revealed,						
	staff-required in-servi	ion and competencies: all ce training. Evidence of						
		annual training requirement.						
	Requirements (in par abuse/neglect/resider							
	dementia manageme residents."							
	12 hours minimum, n reveals, "Principle De	e Mandatory Education-CNA ew orientation and annually" ementia, A Day in the Life of Experience and Resident eurses listed.						
	No further information	n was provided prior to exit.						

Facility ID: VA0050

If continuation sheet Page 60 of 60