PRINTED: 11/17/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		495255	B. WING		11	1/02/2023	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
SKYVIEV	V SPRINGS REHAB AND N	JURSING CENTER		30 MONTVUE DRIVE			
OKTVILV	OI KINGO KENADANDI	TORSING CENTER		LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
E 000	Initial Comments		E	000			
F 000	survey was conducted The facility was in sub CFR Part 483.73, Req Care Facilities. No en complaints were inves INITIAL COMMENTS	ergency Preparedness 1 10/31/23 through 11/2/23. stantial compliance with 42 juirement for Long-Term nergency preparedness tigated during the survey.	F(	000			
	survey was conducted Corrections are require CFR Part 483 Federal Requirements. The Lift survey/report will follow One complaint was inv survey (VA00059056, s deficient practice.)	10/31/23 through 11/2/23. ed for compliance with 42 Long Term Care e Safety Code v. restigated during this substantiated with no					
F 550 SS=D	107. The survey samp residents and five closs Resident Rights/Exerci CFR(s): 483.10(a)(1)(2 §483.10(a) Resident R The resident has a righ self-determination, and access to persons and outside the facility, inclution in the section.  §483.10(a)(1) A facility with respect and dignity resident in a manner ar	se of Rights )(b)(1)(2)  ights. It to a dignified existence, communication with and services inside and uding those specified in  must treat each resident of and care for each and in an environment that or enhancement of his or	F 5	<ol> <li>The alleged deficient prahas already occurred and near the retroactively corrected for resident #65.</li> <li>All residents of the facility the potential to be affected alleged deficient practice. A of the dining rooms was conducted during lunch ser ensure there were no other residents provided eating assistance by a staff memb standing.</li> </ol>	have by the n audit		
DODATORY	DEGTODIO OD DOG #DET	PPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

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

A95255   B. WING		TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) PLAN OF CORRECTION (X4) PLAN OF CORRECTION (X5) PLAN OF CORRECTION (X6) PLAN OF CORRECTION (X6) PLAN OF CORRECTION (X7) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X7) PLAN OF CORRECTION (X7) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) PLAN OF CORRECTION (X7) PROVIDER/SUPPLIER/CLIA (X7) PLAN OF CORRECTION (X7) PLAN OF			(X3) DATE SURVEY COMPLETED			
NAME OF PROVIDER OR SUPPLIER  SKYVIEW SPRINGS REHAB AND NURSING CENTER    SUMMARY STATEMENT OF DEFICIENCYS   10   10   10   10   10   10   10   1				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				С
SKYVIEW SPRINGS REHAB AND NURSING CENTER    30 MONTYUE DRIVE LURAY, VA 22835   ID   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY OF DATE OF TAG    F 550   Continued From page 1 individuality. The facility must protect and promote the rights of the resident.  § 483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.  § 483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the United States.  § 483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this			495255	B. WING	_		11	/02/2023
SKYPIEW SPRINGS REHAB AND NURSING CENTER   LURAY, VA 22835	NAME OF P	ROVIDER OR SUPPLIER			ı			
(X4) ID PREFIX TAG    CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG	SKYVIEW	SPRINGS REHAB AND I	NURSING CENTER		1			
F550 Continued From page 1 individuality. The facility must protect and promote the rights of the resident.  §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regardless of payment source.  §483.10(b) Exercise of Rights. The resident tas the right to exercise his or her rights as a resident of the facility must ensure that the resident can exercise his or her rights and reprisal from the facility.  §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this	(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		The state of the s		(Y5)
individuality. The facility must protect and promote the rights of the resident.  §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.  §483.10(b) Exercise of Rights.  The resident has the right to exercise his or her rights as a resident of the United States.  §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.  §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to protect the dignity of 1 of 34 residents in the survey sample; Resident #65.  The findings include:  For Resident #65, the facility staff failed to provide eating assistance in a dignified manner.		individuality. The facility promote the rights of the \$483.10(a)(2) The fact access to quality care severity of condition, or must establish and mapractices regarding traprovision of services or residents regardless of \$483.10(b) Exercise of the resident has the rights as a resident of or resident of the Uniter \$483.10(b)(1) The facing resident can exercise interference, coercion, from the facility.  \$483.10(b)(2) The resident end from the facility rights and to be support exercise of his or her risubpart.  This REQUIREMENT by:  Based on observation, record review and facility determined that the fact the dignity of 1 of 34 resample; Resident #65.  The findings include:	ity must protect and the resident.  illity must provide equal regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.  If Rights. ight to exercise his or her the facility and as a citizen ed States.  Ility must ensure that the his or her rights without discrimination, or reprisal  dent has the right to be ercion, discrimination, and y in exercising his or her rted by the facility in the ights as required under this is not met as evidenced  It staff interview, clinical ity document review, it was cility staff failed to protect sidents in the survey	F	550	education to nursing staff regar providing staff assistance durin meals in a dignified manner.  4. DON/Designee will perform audits of the dining room during randomly selected meal service times to ensure staff are provid staff assistance in a dignified manner twice a week for four weeks. Identified variances will corrected and results will be reviewed through QAPI.  5. Date of Compliance: 12/15/26	g e e ing be	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	6 S		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495255	B. WING	_		11.	/02/2023
	ROVIDER OR SUPPLIER SPRINGS REHAB AND N	NURSING CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		
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F 550	Continued From page	2	F :	550			
	Set) Resident #65 was cognitively impaired in decisions. The reside extensive assistance was consisted as a sistance was consisted as a consistency consisted as a consistency consisted as a consistency consiste	M an observation was . She was up in her e dining room area, being ed Nursing Assistant). CNA the resident to feed her. irs nearby where CNA #1 Resident #65 to feed her.  an interview was 1. When asked how one when feeding a resident, them." When asked if she nothing, she stated, "Sitting." a sitting when she was she stated, "No, I was not." was standing over the don't know. I guess I in her geri-chair she was the but I know I should have sked if standing over a them is a dignity concern ated that it was.  Inity," was reviewed. This ach resident shall be cared omotes and enhances his ing, level of satisfaction if self-worth and					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495255	B. WING		11/02/2023	
	PROVIDER OR SUPPLIER  SPRINGS REHAB AND N	IURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	<sup>18 T</sup> ::	0.77	
F 578	Staff Member) the Adr Director of Nursing, As Consultant, ASM #4 th of Operations, and LP Nurse) the Assistant D made aware of the find information was provide survey.	I, ASM #1 (Administrative ministrator, ASM #2 the SM #3 the Regional Nurse he Regional Vice President N #1 (Licensed Practical birector of Nursing, were dings. No further	F 5	578 1. Advanced Directives were		
SS=D	CFR(s): 483.10(c)(6)(8) §483.10(c)(6) The righ discontinue treatment, to participate in experii formulate an advance §483.10(c)(8) Nothing construed as the right the provision of medica services deemed medi inappropriate.  §483.10(g)(12) The fact requirements specified subpart I (Advance Diru (i) These requirements inform and provide writt residents concerning the medical or surgical treatments option, formu (ii) This includes a writt facility's policies to impland applicable State land	t to request, refuse, and/or to participate in or refuse mental research, and to directive.  in this paragraph should be of the resident to receive al treatment or medical cally unnecessary or  cility must comply with the in 42 CFR part 489, ectives).  include provisions to ten information to all adult the right to accept or refuse attment and, at the elate an advance directive. The ement advance directives w.  ted to contract with other afformation but are still	F	1. Advanced Directives were reviewed with residents #78, #3 and #41. 2. All residents of the facility har the potential to be affected by the alleged deficient practice. An audictory of current residents was conducted to ensure a review of each resident's advanced directives worded education to the social services department regarding periodic review of advanced directives. 4. Administrator/ Designee will perform an audit of newly admitticurrent residents to ensure a review of advanced directives had occurred weekly for four weeks. Identified variances will be corrected and results will be reviewed through QAPI. 5. Date of compliance: 12/15/20	ve ne udit sted vas	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		495255	B. WING			11	C /02/2023
togernativotrist societation	ROVIDER OR SUPPLIER	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 30 MONTVUE DRIVE LURAY, VA 22835	ODE		102/2023
(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 ( X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ION SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
	time of admission and information or articula has executed an advamay give advance dire individual's resident rewith State law.  (v) The facility is not reprovide this information or she is able to receive Follow-up procedures the information to the appropriate time. This REQUIREMENT by:  Based on staff intervie and facility document in that the facility staff fair review of Advance Direction in the survey #33 and #41.  The findings include:  1. For Resident #78, the evidence that periodic regarding the resident's wishes.	ection are met.  Ital is incapacitated at the lis unable to receive the whether or not he or she ince directive, the facility ective information to the expresentative in accordance elieved of its obligation to in to the individual once he we such information.  In the in	F	578			
	RESUSCITATE - DNR'	ne physician's orders d 4/24/23 for "DO NOT ', and an order dated vices. In addition, review vealed an "Advance d dated 11/16/2020.					

NAME OF PROVIDER OR SUPPLIER   SKYVIEW SPRINGS REHAB AND NURSING CENTER   STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTYUE DRIVE LURAY, VA 22835     OKA   ID   PREPRIX   TAG   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   PROVIDER'S PLAN OF CORRECTION (EACH OF ORRECTIVE ACTIONS HOULD BE (EACH CORRECTIVE ACTIONS HOULD BE CROSS-REPERRICADE) OT HER APPROPRIANCE DEPICIENCY)   F 578   Continued From page 5   reveal any evidence that the resident and/or resident representative was provided opportunity to review and make changes to the Advance Directive document, formulate a Living Will, or formulate / change other decisions such as organ donation, wishes for any life sustaining treatments, or whether or not to hospitalize if the resident experienced an acute medical condition.  On 11/1/23 at 2:01 PM, an interview was conducted with OSM #3 (Other Staff Member) the Director of Social Services, and OSM #4 the Social Services, assistant. They stated that during quarterly care plan meetings they do ask residents or family about the resident's code status, whether or not to hospitalize the resident if needed, and if they have any questions, but they don't ask about formulating or changing Living Will or Power of Attorney documents, and other wishes the resident may have such as organ donation or life sustaining treatments.  The facility policy, "Advance Directives" documented, "18. The Interdisciplinary Team will periodically [missing word] with the resident his or her advance directives to ensure that such directives are still the wishes of the resident."  On 11/1/23 at 4:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #3 the Regional Nurse Consultant, ASM #4 the Regional Nur		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  SKYVIEW SPRINGS REHAB AND NURSING CENTER    CAN   D					-			С
SKYVIEW SPRINGS REHAB AND NURSING CENTER  (P4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY USET BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 578  Continued From page 5 reveal any evidence that the resident and/or resident representative was provided opportunity to review and make changes to the Advance Directive document, formulate a Living Will, or formulate / Change other decisions such as organ donation, wishes for any life sustaining treatments, or whether or not to hospitalize if the resident experienced an acute medical condition.  On 11/1/23 at 2:01 PM, an interview was conducted with OSM #3 (Other Staff Member) the Director of Social Services, and OSM #4 the Social Services Assistant. They stated that during quarterly care plan meetings they do ask residents or family about the resident's code status, whether or not to hospitalize the resident if needed, and if they have any questions, but they don't ask about formulating or changing Living Will or Power of Attorney documents, and other wishes the resident may have such as organ donation or life sustaining treatments.  The facility policy, "Advance Directives" documented, "18. The Interdisciplinary Team will periodically [missing word] with the resident is or her advance directives to ensure that such directives are still the wishes of the resident."  On 11/1/23 at 4:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #3 the Regional Nurse Consultant, ASM #4 the Regional Nurse			495255	B. WING			11	/02/2023
CALL   DEFICIENCY   SALVAN 22835   SUMMARY STATEMENT OF DEFICIENCIES   CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PROPERTY TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PROPERTY TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY ON THE PROPERTY TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY    F 578   F 578   F 578   F 578    F 578   F 578   F 578   F 578   F 578    F 578   F 578   F 578   F 578   F 578   F 578   F 578    F 578   F 5	NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CALID   PRETIX   SUMMARY STATEMENT OF DEFICIENCIES   PROVIDER'S PLAN OF CORRECTION   PRETIX   REGULATORY OR LSC IDENTIFYING INFORMATION    PRETIX   TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMMENTION   DEFICIENCY    TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY    TAG   PRETIX   TAG   PRETI	SKYVIEW	SPRINGS REHAR AND N	NURSING CENTER		3	0 MONTVUE DRIVE		
FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 578  Continued From page 5 reveal any evidence that the resident and/or resident representative was provided opportunity to review and make changes to the Advance Directive document, formulate a Living Will, or formulate / change other decisions such as organ donation, wishes for any life sustaining treatments, or whether or not to hospitalize if the resident experienced an acute medical condition.  On 11/1/23 at 2:01 PM, an interview was conducted with OSM #3 (Other Staff Member) the Director of Social Services, and OSM #4 the Social Services Assistant. They stated that during quarierly care plan meetings they do ask residents or family about the resident's code status, whether or not to hospitalize the resident if needed, and if they have any questions, but they don't ask about formulating or changing Living Will or Power of Attorney documents, and other wishes the resident may have such as organ donation or life sustaining treatments.  The facility policy, "Advance Directives" documented, "18. The Interdisciplinary Team will periodically [missing word] with the resident."  On 11/1/23 at 4:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #3 the Regional Nurse Consultant, ASM #4 the Regional Nurse	OICI VILV	OF KINGO KENAD AND I	TORONTO OENTER		L	URAY, VA 22835		
reveal any evidence that the resident and/or resident representative was provided opportunity to review and make changes to the Advance Directive document, formulate a Living Will, or formulate / change other decisions such as organ donation, wishes for any life sustaining treatments, or whether or not to hospitalize if the resident experienced an acute medical condition.  On 11/1/23 at 2:01 PM, an interview was conducted with OSM #3 (Other Staff Member) the Director of Social Services, and OSM #4 the Social Services Assistant. They stated that during quarterly care plan meetings they do ask residents or family about the resident's code status, whether or not to hospitalize the resident if needed, and if they have any questions, but they don't ask about formulating or changing Living Will or Power of Attorney documents, and other wishes the resident may have such as organ donation or life sustaining treatments.  The facility policy, "Advance Directives" documented, "18. The Interdisciplinary Team will periodically [missing word] with the resident his or her advance directives to ensure that such directives are still the wishes of the resident."  On 11/1/23 at 4:30 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #3 the Regional Nurse Consultant, ASM #4 the Regional Vice President	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
of Operations, and LPN #1 (Licensed Practical Nurse) the Assistant Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey.  2. For Resident #33 (R33), the facility staff failed		reveal any evidence the resident representative to review and make of Directive document, for formulate / change oth donation, wishes for a treatments, or whether resident experienced as On 11/1/23 at 2:01 PM conducted with OSM # Director of Social Services Assisted during quarterly care presidents or family about status, whether or not needed, and if they had don't ask about formula Will or Power of Attorn wishes the resident madonation or life sustain. The facility policy, "Addocumented, "18. The periodically [missing wher advance directives directives are still the word of Nursing, AS Consultant, ASM #4 the of Operations, and LPN Nurse) the Assistant Director days of the find information was provide survey.	that the resident and/or e was provided opportunity hanges to the Advance ormulate a Living Will, or her decisions such as organ hanges to the Advance ormulate a Living Will, or her decisions such as organ hanges to the Advance ormulate a Living Will, or her decisions such as organ hanges the sustaining or or not to hospitalize if the han acute medical condition.  If, an interview was that (Other Staff Member) the hices, and OSM #4 the hant. They stated that holan meetings they do ask hout the resident's code to hospitalize the resident if hive any questions, but they hating or changing Living her documents, and other hay have such as organ hing treatments.  Interdisciplinary Team will have or or order that such his or to ensure that such his of the resident."  ASM #1 (Administrative hinistrator, ASM #2 the hin	F	578			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY IPLETED
		495255	B. WING			11	C /02/2023
	ROVIDER OR SUPPLIER SPRINGS REHAB AND I	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  30 MONTVUE DRIVE  LURAY, VA 22835			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	Allowed August 1997	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
	advance directives.  R33 was admitted to treview of R33's clinical documents for a gene 3/30/12 and an advandated 3/26/14. Further record failed to reveal review of all aspects of conducted with R33 or representative (only the was reviewed).  On 11/1/23 at 2:01 PM conducted with OSM # Director of Social Services Assisted during quarterly care presidents or family about status, whether or not needed, and if they have they don't ask about fool Living Will or Power of other wishes the reside organ donation or life soon 11/1/23 at 4:41 p.m. staff member) #1 (the ask about) and they don't ask about fool to the reside organ donation or life soon 11/1/23 at 4:41 p.m. staff member) #1 (the ask about) #1 (the ask about)	he facility on 7/11/14. A all record revealed ral power of attorney dated ce directive for health care ar review of R33's clinical evidence that a periodic f advance directives was the resident's re resident's code status  I, an interview was d3 (Other Staff Member) the rices, and OSM #4 the rant. They stated that ran meetings they do ask but the resident's code to hospitalize the resident if reve any questions. However, rmulating or changing Attorney documents, and rent may have such as resustaining treatments.  A., ASM (administrative radministrator) and ASM #2 but were made aware of the  resident's advance	F	578			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495255	B. WING			C 11/02/2023	
	PROVIDER OR SUPPLIER	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 30 MONTVUE DRIVE LURAY, VA 22835	DDE	11102/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		ON SHOULD BE E APPROPRIAT		
F 578	assessment reference resident scored a 15 c interview for mental stresident was not cognidally decisions.  The physician order d "DNR (do not resuscit Review of the clinical documents related to documentation of any wishes for an advance On 11/1/2023 at 2:01 conducted with OSM Director of Social Services Assist during quarterly care presidents or family abostatus, whether or not needed, and if they had they don't ask about for Living Will or Power of other wishes the reside organ donation or life stadministrator, ASM #2 ASM #3, the regional regional director of (licensed practical nursidirector of nursing, we above concern on 11/1	al assessment, with an e date of 9/6/2023, the out of 15 on the BIMS (brief tatus) score, indicating the ditively impaired for making ated 6/1/2017 documented, ate)."  record failed to evidence advanced directives and review of the resident's ed directive.  p.m., an interview was #3 (Other Staff Member) the vices, and OSM #4 the ant. They stated that colan meetings they do ask out the resident's code to hospitalize the resident if eve any questions. However, formulating or changing attorney documents, and ent may have such as sustaining treatments.  taff member) #1, the , the director of nursing, nurse consultant, ASM #4, fo perations, and LPN se) #1, the assistant re made aware of the //2023 at 4:32 p.m.		578			
F 580 SS=D	Notify of Changes (Inju	iry/Decline/Room, etc.)	F 58	80			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2.0	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495255	B, WING_		11	C /02/2023	
2-1-1-1-1	ROVIDER OR SUPPLIER	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		102/2020	
(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  CROSS-REFERENCED TO THE APPROFICIENCY)	BE	(X5) COMPLETION DATE	
	consult with the reside consistent with his or representative(s) whe (A) An accident involveresults in injury and haphysician intervention (B) A significant changmental, or psychosocideterioration in health, status in either life-threclinical complications); (C) A need to alter treat a need to discontinue treatment due to advercommence a new form (D) A decision to trans resident from the facility \$483.15(c)(1)(ii). (ii) When making notification of the section, the all pertinent information is available and provide physician. (iii) The facility must all resident and the resident when there is-(A) A change in room cas specified in §483.10 (B) A change in resident	action of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident in there is- ing the resident which as the potential for requiring; ge in the resident's physical, al status (that is, a mental, or psychosocial eatening conditions or eatment significantly (that is, an existing form of rese consequences, or to n of treatment); or fer or discharge the ty as specified in cation under paragraph (g) he facility must ensure that in specified in §483.15(c)(2) ed upon request to the so promptly notify the ent representative, if any, or roommate assignment O(e)(6); or not rights under Federal or is as specified in paragraph cord and periodically ailling and email) and	F5	1. The provider was notified of unavailable medication for res #35.  2. All residents of the facility has the potential to be affected by alleged deficient practice. An a of current residents receiving diabetic related medications we conducted to identify those that were unavailable over the last weeks to ensure the provider wonotified.  3. DON/Designee provided education to licensed nursing a regarding notification of the profor unavailable medication.  4. DON/Designee will perform audit of current residents receit diabetic related medications to identify those that were unavail to ensure the provider was not twice per week for four weeks. Identified variances will be corrand results will be reviewed the QAPI.  5. Date of Compliance: 12/15/2	dent ave the udit as t two vas taff vider an ving able fied ected ough		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  SPRINGS REHAB AND I	NURSING CENTER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		
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	that is a composite dis §483.5) must disclose its physical configurati locations that comprispart, and must specify room changes betwee under §483.15(c)(9). This REQUIREMENT by:  Based on staff interviere review, the facility staff physician of a possible one of 34 residents in Resident #35.  The findings include:  For Resident #35 (R35 notify the physician who medication Jardiance (administration on 10/9/A review of R35's clinic physician's order dated mg (milligrams) by moutwo diabetes mellitus.  2023 MAR (medication revealed the same phy Jardiance. On 10/9/23 documented the code, Notes." Nurses' notes 10/10/23 documented the	esite distinct part. A facility strinct part (as defined in in its admission agreement on, including the various enthe composite distinct the policies that apply to its different locations.  Is not met as evidenced ew and clinical record failed to notify the eneed to alter treatment for the survey sample,  I), the facility staff failed to en the resident's 1) was not available for 123 and 10/10/23.  Ital record revealed a 13/13/23 for Jardiance 25 outh one time a day for type A review of R35's October administration record) sician's order for and 10/10/23, the MAR 19 = Other/ See Progress	F	580			
	review of R35's clinical	record failed to reveal the s notified and made aware					

	OF DEFICIENCIES F CORRECTION	I DENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER	100,000		STREET ADDRESS, CITY, STATE, ZIP CODE	11/02/2023	
SKYVIEW	SPRINGS REHAB AND N	NURSING CENTER		30 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 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)		
F 645 SS=D	the medication was not administration.  On 11/1/23 at 2:19 p.n. conducted with LPN (I LPN #4 stated the phy a medication is not avisee if the physician wasternative medication so the resident can be effects from not received.  On 11/1/23 at 4:41 p.m. staff member) #1 (the (the director of nursing above concern.  Reference: (1) Jardiance is used to for people with diabete information was obtain https://medlineplus.gov.tml  PASARR Screening for CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmissing individuals with a ment with intellectual disability \$483.20(k)(1) A nursing or after January 1, 198 (i) Mental disorder as disorder as disorder in the proposed authority has determine independent physical as	ot available for  n., an interview was icensed practical nurse) #4. resician should be notified if ailable for administration to ants to adjust for an that may be available, and monitored for any adverse ing the medication.  n., ASM (administrative administrator) and ASM #2 g) were made aware of the  o lower blood sugar levels as mellitus. This and from the website: ar/druginfo/meds/a614043.h  or MD & ID 3)  on Screening for all disorder and individuals ity.  g facility must not admit, on 9, any new residents with: lefined in paragraph (k)(3) as the State mental health and mental evaluation	F 58		e dit ed ded	
is .		or entity other than the thority, prior to admission,		,		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER SPRINGS REHAB AND N	NURSING CENTER		30	TREET ADDRESS, CITY, STATE, ZIP CODE 0 MONTVUE DRIVE URAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	condition of the individual red services, whether the specialized services; (ii) Intellectual disability of authority has determine (A) That, because of the condition of the individual red services properties, whether the individual red services, whether the inspecialized services properties, whether the inspecialized services for \$483.20(k)(2) Exceptions section—(i) The preadmission so paragraph(k)(1) of this for determinations in the total authority has determined in the individual red services, whether the inspecialized services for \$483.20(k)(2) Exceptions section—(i) The preadmission screen in the preadmission screen in the preadmission screen in paragraph (k)(1) of this total authority of a (A) Who is admitted to hospital after receiving hospital, (B) Who requires nursing services in the individual red services for the individual after receiving hospital, (B) Who requires nursing services produced in the individual after receiving hospital, (B) Who requires nursing services produced in the individual after receiving hospital, (B) Who requires nursing services produced in the individual after receiving hospital, (B) Who requires nursing services produced in the individual after receiving hospital, (B) Who requires nursing services produced in the individual after receiving hospital, (B) Who requires nursing services produced in the individual red services produced in the individ	the physical and mental dual, the individual requires rovided by a nursing facility; quires such level of individual requires or y, as defined in paragraph of the physical and mental understand the individual requires rovided by a nursing facility; quires such level of individual requires rovided by a nursing facility; quires such level of individual requires or intellectual disability.  The physical and mental understand the individual requires or intellectual disability.  The physical and mental understand the requires or intellectual disability.  The physical and mental understand the requires of the readmission and individual who, after the physical lates are not to apply the grogram under the section to the admission and individual-the facility directly from a acute inpatient care at the individual received care in	F	645	4. Administrator/Designee will perform an audit of current resigneely admitted to ensure each resident has a PASSAR comple weekly for four weeks. Identified variances will be corrected and results will be reviewed through QAPI.  5. Date of compliance: 12/15/20	ted I	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	E SURVEY PLETED
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	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE	 10212023
OKTVIEW	OF KINGO KENABANDI	TORONG CENTER			LURAY, VA 22835	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
*	before admission to the is likely to require less facility services.  §483.20(k)(3) Definition section— (i) An individual is condisorder if the individual disorder defined in 485 (ii) An individual is condisorder defined in 485 (ii) An individual is condition in tellectual disability if intellectual disability at or is a person with a redescribed in 435.1010 This REQUIREMENT by:  Based on staff intervidual facility document in that the facility staff fair (Preadmission Screen was completed for one survey sample; Resident #24 was admitted in the findings include:  For Resident #45, the PASARR.  Resident #24 was admitted in the finding include in the finding i	the facility that the individual of than 30 days of nursing on. For purposes of this sidered to have a mental all has a serious mental 3.102(b)(1). Insidered to have an the individual has an so defined in §483.102(b)(3) collected condition as of this chapter. In its in the interview review, it was determined led to ensure a PASARR ing and Resident Review) are of 34 residents in the cent #24.  In facility failed to complete a sittle to the facility on the clinical record revealed a graph of the facility on the clinical record revealed a graph of the facility on the clinical record revealed a graph of the facility on the clinical record revealed a graph of the facility on the clinical record revealed a graph of the facility on the clinical record revealed a graph of the facility on the clinical record revealed a graph of the facility on the clinical record revealed a graph of the facility on the clinical record revealed and graph of the facility on the clinical record revealed and graph of the facility on the clinical record revealed and graph of the facility on the clinical record revealed and graph of the facility on the clinical record revealed and graph of the facility on the clinical record revealed and graph of the facility on the clinical record revealed and graph of the facility on t	F	645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495255	B. WING			11	C /02/2023
SC WINDOWS CONTROL OF	PROVIDER OR SUPPLIER  / SPRINGS REHAB AND I	NURSING CENTER	•	3	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MONTVUE DRIVE LURAY, VA 22835		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 645	form.  On 11/1/23 at 2:30 PM Member) the Director asked about this docu was all the facility had requirement of a PAS/ The facility policy Long Supports (LTSS) Scre Screening and Reside was reviewed. This policy Long Supports (LTSS) screening and Reside was reviewed. This policy Long Screening and Reside was reviewed. This policy has reviewed prior resident is already Me financially eligible by volume by the ePAS system, the Admissions Coordinate that the referral provid Screening Team comp	M, OSM #3 (Other Staff of Social Services, was ment. She stated that it and that it did not meet the ARR.  g-Term Services and ening, Preadmission nt Review (PASRR) Policy" policy documented, " Level evel 1 Screening has not to admission and the dicaid member OR vay of application as verified the Social Worker, or, or designee will request er and/or Community lete the screen prior to	F	645			
	Medicaid eligible by wanursing facility will be a of the Level 1 screening. On 11/1/23 at 4:30 PM Staff Member) the Administration of Nursing, AS Consultant, ASM #4 the of Operations, and LPI Nurse) the Assistant Dimade aware of the find information was provid survey.	esponsible for completion g"  , ASM #1 (Administrative ninistrator, ASM #2 the SM #3 the Regional Nurse e Regional Vice President N #1 (Licensed Practical frector of Nursing, were lings. No further ed by the end of the	F 6	56			
	CFR(s): 483.21(b)(1)(3 §483.21(b) Compreher	,				9.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	5,000		LE CONSTRUCTION		E SURVEY PLETED
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	200 (1050 00 0) (100) (150	433233	5	_		1 11	/02/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE  30 MONTVUE DRIVE		
SKYVIEW	SPRINGS REHAB AND I	NURSING CENTER			LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	§483.21(b)(1) The fact implement a compreh care plan for each res resident rights set fort §483.10(c)(3), that incobjectives and timefra medical, nursing, and needs that are identific assessment. The comdescribe the following (i) The services that are or maintain the resider physical, mental, and required under §483.2 (ii) Any services that wunder §483.24, §483.2 provided due to the resunder §483.10, includit reatment under §483. (iii) Any specialized sere habilitative services provide as a result of Frecommendations. If a findings of the PASARI rationale in the resident (iv) In consultation with resident's representativ (A) The resident's goal desired outcomes.  (B) The resident's prefetutive discharge. Facility whether the resident's community was assessiocal contact agencies entities, for this purpos	ility must develop and ensive person-centered ident, consistent with the hat §483.10(c)(2) and dudes measurable mes to meet a resident's mental and psychosocial ed in the comprehensive prehensive care plan must - re to be furnished to attain and the sychosocial well-being as 4, §483.25 or §483.40; and rould otherwise be required estor §483.40 but are not esident's exercise of rights and the right to refuse 10(c)(6).  Invices or specialized the nursing facility will each the R, it must indicate its the resident and the resident and the record. The resident and the record and potential for ties must document desire to return to the sed and any referrals to and/or other appropriate e. the comprehensive care accordance with the	F	656	1. A medication error was completed for resident #94. The alleged deficient practice has already occurred and may not be retroactively corrected for reside #11. The alleged deficient practic has already occurred and may not be retroactively corrected for resident #29. The oxygen concentrators for residents #97 at #46 were adjusted and verified at eye level to the prescribed rate. Resident #106 has discharged for the facility. The provider was notified of the unavailable medication for resident #35. A coplan focus related to PTSD was added to the care plan for reside #23. The alleged deficient practic has already occurred and may not be retroactively corrected for resident #46.	e ent ce ot and at rom	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER  SPRINGS REHAB AND I	NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		102/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	section. §483.21(b)(3) The ser by the facility, as outling care plan, must- (iii) Be culturally-comp. This REQUIREMENT by: Based on observation interview, clinical recondocument review, it was facility staff failed to do the comprehensive caresidents in the survey. #11, #29, #97, #106, is The findings include:  1. For Resident #94, the follow the comprehension administration of diabetordered.  A review of the comprehension administration of diabetordered.  A review of the comprehension administration and sordered.  A review of the clinical following orders:  1. An order dated 7/27 units twice daily, before 2. An order dated 7/7/5 sliding scale, before broughers and the service of the clinical following scale, before broughers and the service of the clinical following scale, before broughers.	vices provided or arranged ned by the comprehensive setent and trauma-informed. Is not met as evidenced as, resident interview, staff or review and facility as determined that the evelop and/or implement are plan for eight of 34 as sample; Residents #94, #23, #35, and #46.  The facility staff failed to sive care plan for the effic related medications as set ensive care plan included the 23 for "The resident has is care plan included the 23 for "Diabetes by doctor"  The record revealed the 1/23 for Humalog (1) 10 as breakfast and lunch. 23 for Humalog, dose per eakfast and lunch.	F	656	2. All residents of the facility hav the potential to be affected by the alleged deficient practice. A medication administration competency was completed with LPN #5. An audit of current residents was completed to ensure the base and shower task is available for increasidents with an order for fluid restriction was conducted to ensure the order was entered appropriated to allow for documentation of interestriction was conducted for the pattern of the administration records of current residents recedially is was conducted for the pattern of	dents thing the ure tely ast done tion	

ALTERNATION CONTRACTOR AND ADDRESS OF THE PARTY OF THE PA	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		495255	B. WING	-		11/	/02/2023
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SKAMEN	SPRINGS REHAB AND I	MIDSING CENTED		3	0 MONTVUE DRIVE		
SKIVIEW	SERINGS REHAD AND I	TORSING CENTER		L	URAY, VA 22835		
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	On 11/01/23 at 8:20 A Administration task wa (Licensed Practical Nu following was observe  1. Humalog 10 units, administered after the 2. Humalog 2 units be administered after the On 11/1/23 at 2:49 PN conducted with LPN # #94's insulin was adm the physician's order of stated it was not, becar after breakfast. She se take it before breakfast glucose will drop. Wh aware of this, she state aware but that this was have been given befor if the care plan was fol administer diabetic me stated that it was not. purpose of the care plan make sure all the goals the resident's needs an The facility policy "Car Comprehensive Perso This policy documente develop and implement person-centered care plan includes measurable of to meet a resident's me	and, the Medication as conducted with LPN #5 arse) for Resident #94. The ad:  scheduled, was resident had breakfast. ased on sliding scale, was resident had breakfast.  If an interview was 5. When asked if Resident inistered in accordance with of before breakfast, she ause it was administered tated that the resident won't at because he is afraid his en asked if the doctor was ed that the doctor was s still the order, so it should be breakfast. When asked flowed if it documented to edication as ordered, she when asked what was the an, she stated it was to s are being followed and re being met.  e Planning - n-Centered" was reviewed. d, "2. The facility will at a comprehensive plan for each resident, that bjectives and timeframes edical, nursing, and mental dis as identified throughout sident Assessment	F	656	An audit of current residents with weight orders was performed to ensure weights were completed porder; the provider was notified or identified variances. An audit of current residents receiving diabet related medications was conducted identify those that were unavailable over the last two weeks to ensure provider was notified. An audit of current residents with a diagnosis PTSD was performed to ensure the care plan appropriately addressed diagnosis. An audit of residents we splinting devices was conducted the ensure each was in place per ord 3. DON/Designee provided educated to licensed nursing staff regarding development and implementation the care plan.  4. DON/Designee will perform a medication administration audit we randomly selected nurse twice a week for four weeks. DON/Design will perform an audit of 10% of curresidents to ensure bathing/showering was document as provided in the electronic mediate record. DON/Designee will perform an audit of current residents with a corder for fluid restriction to ensure documentation reflects monitoring intake weekly for four weeks. DON/Designee will perform an audit the administration record of curresidents receiving dialysis to ensure the bruit and thrill were monitored each shift weekly for four weeks. DON/Designee will perform	per f iic ed to ole et the sof he s the vith to er. ation g of iith a nee rrent ed ical m an e g of idit rrent ure	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SKYVIEV	SPRINGS REHAB AND I	NURSING CENTER		3	30 MONTVUE DRIVE		
OK! VIEV	OI KINGO KENADANDI	TORONO CENTER		L	LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	On 11/1/23 at 4:30 PM Staff Member) the Adr Director of Nursing, At Consultant, ASM #4 th of Operations, and LP of Nursing, were made further information was survey.  References:  1. Humalog is used to Information obtained finttps://medlineplus.gov tml  2. For Resident #11, th implement the compre ADL's (activities of dail Resident #11 was adm 11/22/21 with diagnose not limited to: peripher right AKA (above the kidiabetes mellitus.  The most recent MDS assessment, a quarterl with an ARD (assessment yes 15 on the BIMS (brief in indicating the resident with an ARD (assessment yes 15 on the BIMS (brief in indicating the resident yes 15 on the BIMS (brief in indic	A, ASM #1 (Administrative ministrator, ASM #2 the SM #3 the Regional Nurse he Regional Vice President N #1 the Assistant Director aware of the findings. No se provided by the end of the otreat diabetes. From V/druginfo/meds/a697021.h where facility staff failed to hensive care plan for Ny living).  Initted to the facility on the est that included but were all vascular disease (PVD), nee amputation) and (minimum data set) Ny Medicare assessment, ent reference date) of ident as scoring a 15 out of interview for mental status), was not cognitively the MDS Section realed the resident was ensive assistance for bed sing and hygiene; total	F	656	an audit of current resident receit dialysis to ensure communication with the dialysis centered occurred each scheduled dialysis day wee for four weeks. DON/Designee were conduct an audit of current reside ordered supplemental oxygen to ensure the tank/concentrator is statistic per week for four weeks. DON/Designee will conduct an a of current residents with newly implemented side rails to ensure review of risk and benefits, as we consent was obtained. DON/Designee will perform an air of 10 % of current residents with weight orders was performed to ensure weights were completed porder weekly for four weeks. DON/Designee will perform an air of current residents receiving dia related medications to identify the that were unavailable and ensure provider was notified twice a weef for four weeks. DON/Designee will perform and audit of newly admit residents with a diagnosis of PTS to ensure the care plan appropriate addresses the diagnosis weekly four weeks. DON/Designee will perform and audit of 10% of current residents ordered a splinting devito ensure placement per order two a week for four weeks. Identified variances will be corrected and results will be reviewed through QAPI.  5. Date of compliance: 12/15/202	ed ekly vill ents et to rate udit ell as udit betic ose the k ill ted ED tely for ent ce ice	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495255	B. WING			11	/02/2023
4.	ROVIDER OR SUPPLIER  SPRINGS REHAB AND N	JUDGING CENTED			STREET ADDRESS, CITY, STATE, ZIP CODE 80 MONTVUE DRIVE		
SKIVIEW	SPRINGS REHAB AND I	NURSING CENTER		L	URAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	self-care performance and right leg amputati Provide supervision at ADLs. Physical assist A review of the ADL domedical record reveals for Wednesday and Sa August 2023 record redocumentation on 8/23 of the September 2023 documentation on 9/6/ the October 2023 record documentation on 10/4 10/18/23, 10/21/2	deficit related to weakness on. INTERVENTIONS: nd cuing as needed with as needed with the as needed with ADLs."  Document in Resident #11's ed showers were scheduled aturday. Review of the evealed missing 3/23 and 8/26/23. Review 3 record revealed missing 4/23, and 9/30/23. Review of ord revealed missing 4/23, 10/7/23, 10/11/23, 10/25/23 and 10/28/23.  Sucted on 11/1/23 at M with LPN (licensed PN #4 stated the purpose of out the care that each if the care plan was being was no evidence of #4 stated, "No, it is not."  ASM (administrative staff inistrator, ASM #2, the M #3, the regional nurse regional director of the findings.  Was provided prior to exit.  The staff failed to implement replan for dialysis care and sitted to the facility on	F	656			
	10/4/23 with diagnoses	that included but were not					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
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		495255	B, WING			11/	/02/2023
	ROVIDER OR SUPPLIER  SPRINGS REHAB AND I	NURSING CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE  MONTVUE DRIVE  URAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	diabetes.  The most recent MDS assessment, a Medica an ARD (assessment coded the resident as the BIMS (brief intervi indicating the resident impaired. A review of functional status, reve coded as being independent of the compression of the c	(minimum data set) are 5-day assessment, with reference date) of 10/10/23, scoring a 15 out of 15 on ew for mental status) score, was not cognitively the MDS Section G, aled the resident was endent for eating, bed	F	356			
	(medication administration (treatment administration of asset	on record) revealed no	ş				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495255	B. WING				С
		493233	D. WING			11.	/02/2023
	PROVIDER OR SUPPLIER  SPRINGS REHAB AND N	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE		(X5) COMPLETION DATE
	A review of Resident # communication book r communication forms provider for six of twel 10/11/23, 10/13/23, 10/13/23, 10/13/23.  An interview was cond AM with RN (registere the purpose is to defininterventions for each documentation of fluid dialysis site are missin implemented.  On 11/1/23 at 4:32 PM member) #1, the admindirector of nursing, AS consultant, ASM # 4, the operations and LPN #1 nursing were made aw  No further information were made aw  No further information were resident #97 was adminuted 10/2/23 with a diagnosion obstructive pulmonary were resident #97 was adminuted 10/2/23 with a diagnosion obstructive pulmonary were resident #97 was adminuted 10/2/23 revealed, "FOO	de to the facility on the regional director of the findings.  Was provided prior to exit.  Was provided prior to exit.  Was provided prior to exit.  Was provided to implement e plan for oxygen therapy.  Was predicted to implement e plan for oxygen therapy.  Was predicted to implement e plan for oxygen therapy.  Was provided prior to exit.  Was provided to implement e plan for oxygen therapy.  Was provided prior to exit.  Was provided prior to exit.  Was provided to implement e plan for oxygen therapy.  Was provided to the facility on the facilit	F	656			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

그는 가는 경험하다면서 하는 사람들이 있는 사람들이 그리지 않는데 그렇게 하는데 이번 이번에 보는데 하는데 그리고 있다면서 그렇게 하는데 되었다.		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495255	B. WING			11	1/02/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CICAD/IETA	CODINGO DELLAD AND A	ILIDOING OFNITED			30 MONTVUE DRIVE		
SKTVIEW	SPRINGS REHAB AND N	NURSING CENTER			LURAY, VA 22835		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 656	Continued From page	21	F	656	3		
	A review of the physic	ian orders dated 10/22/23					
		: "O2 at 2LPM (liters per					
		nula to maintain oxygen at					
	90% or above. Every						
	,						
	An interview was cond	lucted on 10/31/23 at 1:53					
	PM with LPN (licensed						
		kygen setting for Resident					
		t is on 2.5 liters. I checked					
	it this morning and it is						
	1.2	eing implemented if the per minute, and the care					
	plan documents oxyge						
		not being implemented.					
	otated the dare plants	not boing implemented.					
	On 11/1/23 at 4:32 PM	, ASM (administrative staff					
	member) #1, the admir						
	director of nursing, AS	M #3, the regional nurse					
	consultant, ASM # 4, tl						
		, the assistant director of					
	nursing were made aw	are of the findings.			8		
	No further information	was provided prior to exit.					
	5. For Resident #106,	the staff failed to develop					
	the comprehensive car bedrails.						
	Resident #106 was obs	served in hed with one					
1	quarter bed rails on both						
		11/1/23 at 9:00 AM, and					
	11/1/23 at 10:45 AM.						
	A review of the compre	hensive care plan dated					
		CUS: Resident is at risk for				),	
1	alteration in nutritional :				· ·		
		tment, CKD, diuretic use					
	for edema. INTERVEN	ITIONS: Weights per					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION			SURVEY PLETED
			A. BOILD				С
		495255	B. WING		=	11.	/02/2023
	ROVIDER OR SUPPLIER  SPRINGS REHAB AND I	NURSING CENTER		STREET ADDRESS, CITY, ST. 30 MONTVUE DRIVE LURAY, VA 22835	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	( (EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	revealed the following three days) days, West monthly."  A review of the weight evidence of a weight of 10/23/23 and 10/30/23. An interview was concapproximately 11:00 A practical nurse) #4. Lt a care plan is to lay our resident needs. When bedrails should be on stated they usually are plan is completely devinformation regarding with the weight of th	ian orders dated 10/6/23 : "Daily Weight x3 (times ekly Weight x4 weeks, then documentation revealed no documentation on 10/16/23, 3.  Bucted on 11/1/23 at M with LPN (licensed PN #4 stated the purpose of at the care that each asked if weights and the care plan, LPN #4 When asked if the care eloped if it does not include weights and bedrails, LPN  ASM (administrative staff nistrator, ASM #2, the M #3, the regional nurse he regional director of are of the findings.  was provided prior to exit.  35), the facility staff failed ent's comprehensive care ation.  care plan dated 7/22/21 as diabetes mellitus.	F	556			
	Interventions: Diabetes doctor" A review of F	medication as ordered by R35's clinical record					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL <sup>-1</sup> A. BUILDI		(X3) DATE SURVEY COMPLETED		
		405055	D. WING				С
		495255	B, WING_	_		11	/02/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SKYVIEW	SPRINGS REHAB AND	NURSING CENTER			0 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		E ATE	(X5) COMPLETION DATE	
9	Jardiance (1) 25 mg (I time a day for type two review of R35's Octobe administration record) physician's order for J 10/10/23, the MAR do Other/ See Progress N 10/9/23 and 10/10/23 Jardiance was not admorder.  On 11/1/23 at 2:19 p.m. conducted with LPN (ILPN #4 stated the purallow for the most persindividual resident, and available for nurses' reimplemented. LPN #4 be re-ordered from the five-day supply of the stated that if a medical administration, then the medication from the fa supply, and if the medisupply, then nurses shand resident's family.  On 11/1/23 at 4:41 p.m staff member) #1 (the action from the five-day supply of the supply, then nurses shand resident's family.  Reference: (1) Jardiance is used to for people with diabete information was obtain	s order dated 3/13/23 for milligrams) by mouth one of diabetes mellitus. A ser 2023 MAR (medication revealed the same ardiance. On 10/9/23 and cumented the code, "9= Notes." Nurses' notes dated documented the medication ministered and was on the care plan is to sonalized care of each diall care plans are exiew to ensure they are stated medications should a pharmacy when there is a medication left. LPN #4 tion is not available for the enurses should pull the cility backup medication cation is not in the backup ould update the physician the care made aware of the collower blood sugar levels is mellitus. This	F	656			
1	tml	, a. agimo/modo/do 14040.11					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL <sup>*</sup> A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				242000			С
		495255	B. WING			11.	/02/2023
	ROVIDER OR SUPPLIER  SPRINGS REHAB AND N	NURSING CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 0 MONTVUE DRIVE .URAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	24	F	656			
		R23), the facility staff failed ensive care plan regarding post-traumatic stress					
	diagnosis of PTSD. R plan dated 11/7/21 doc psychotropic medication failed to document any as goals and intervent PTSD. A psychiatry re documented, "Addition psychotherapy interve Psychotherapy, 1:1 Su	ote dated 10/16/23 nal supportive ntions: Insight-oriented upportive therapy, s, Active Problem Solving,					
	social services assista purpose of the care pla about the resident and on. OSM #4 stated R2 and symptoms of PTSI plan should explain mo PTSD, such as the cau potential signs and synnightmares and flashbar R23's care plan should interventions for the reshould be based on ear	other staff member) #4 (the nt). OSM #4 stated the an is so that staff knows everything that is going 23 does not display signs D, but she felt the care per regarding the resident's use of the PTSD and inptoms such as acks. OSM #4 stated I include goals and sident's PTSD, and this ich specific individual.					
8		., ASM (administrative administrator) and ASM #2 ) were made aware of the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL <sup>*</sup> A. BUILDI		(X3) DATE SURVEY COMPLETED			
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		495255	B. WING			11	/02/2023
NAME OF P	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE		
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200,000	at the control of the			L	URAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	25	F	656			
	implement the compre administering oxygen	per the physician orders.					
	assessment, a quarter assessment reference resident scored a 15 o interview for mental st	DS (minimum data set) rly assessment, with an date of 8/2/2023, the rut of 15 on the BIMS (brief atus) score, indicating the rely impaired for making					
	documented in part, "F altered respiratory stat	OB when lying					
		ated 2/15/2022 therapy at 1 L/min (liters annula every shift for SOB					
	approximately 1:30 p.n with a nasal cannula in delivered. The oxyger was numbered two to t number on the bottom number on the flowmet below the number two oxygen below two. The	place with oxygen being in concentrator flowmeter en, with two being the first and ten being the top er. There were no lines to indicate any level of ball was set at the bottom op of the ball was touching					
	A second observation v	vas made of the R46 on					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495255	B. WING			11	/02/2023
	SOVIDER OR SUPPLIER SPRINGS REHAB AND N	IURSING CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 10 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
the second of th	was set with the top of for two liters per minut nasal cannula in her n A third observation wa 11/1/2023 at 12:00 p.n practical nurse) #5. Wi was set at, LPN #5 sta When asked the locatione liter per minute, Li screwed up. I thought I could feel oxygen corone." LPN #5 was asked the oxygen. She sta prescribed rate should the ball. When asked it according to the physical was not. LPN #5 stated blan is to make sure the short and long term, are to get the best care. Wolan was being followe administration, she stated administrator, ASM #2, ASM #3, the regional ne regional director of licensed practical nurse above concern on 11/12. We further information was found that it is to further information was found to the regional director of nursing, were above concern on 11/12.	The oxygen concentrator if the ball touching the line ie. The resident had the ose.  Is made of R46 on in. with LPN (licensed then asked what the oxygen ated that it was on one. Only the line indicating in the line indicating in the line indicating in the line indicating in the line in the line in the line of line line line line line line line line	F	656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 8		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	9	495255	B. WING			C 11/02/2023	
	ROVIDER OR SUPPLIER  SPRINGS REHAB AND I	NURSING CENTER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	documented in part, "I ADL (activities of daily deficit r/t (related to) F (stroke) with left hemip contracture." The "Interpart, "CONTRACTUR contractures of the left care to keep clean and The care plan further or resident has potential dermatitis, incontinent hemiparesis and decre "Interventions" documented treatments as ordered effectiveness."  The physician order dadocumented, "Ensure inside of left grip at all daily or as needed if so contracture, skin prote.  Observation was made 8:27 a.m. There was nhand. The resident staremembers to put it in the don't.  A second observation of 11/1/2023 at 11:54 a.m. in the resident's left has was warm and moist.	are plan dated, 5/16/2023, Focus: The resident has an viving) self-performance ibromyalgia, prior CVA paresis and left hand/wrist erventions" documented in ES: The resident has thand/wrist. Provide skind prevent skin breakdown." documented, "Focus: The for skin impairment r/t pe, candidiasis (1). Left pease in mobility." The pented in part, "Administer and monitor for ated 5/22/2023 rolled up washcloth to times, change washcloth poiled, every shift for cition."  The of R46 on 11/1/2023 at the owashcloth in her left ted sometimes the staff there and sometimes they was made of R46 on . No washcloth was noted and. The resident's hand sucted with LPN (licensed)	F	656			
	asked if R46 is to have	nother nurse is doing the					7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		The state of the s	(X2) MULT A. BUILDIN		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDI	ING			С	
		495255	B. WING				/02/2023	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
SKYVIEW	SPRINGS REHAB AND I	JURSING CENTER			30 MONTVUE DRIVE			
OKT VILVE	OF KINGO KENADARD I	TORONG CENTER			LURAY, VA 22835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 658 SS=D	LPN #5 stated most of LPN #5 was asked who washcloth in her hand because she has a coinfections in that hand purpose of the care placesident's goal, both side being followed for the washcloth in the left hashe stated it was not.  ASM (administrative standinistrator, ASM #2 ASM #3, the regional regional director of (licensed practical nursulative of the regional director of nursing, we above concern on 11/10.	out what is needed for R46, if the aides know about it. by the resident had the and the stated, "It's intracture and gets yeast." LPN #5 stated the an is to make sure the hort and long term, are in to get the best care. Ident's care plan for the and was being followed, aff member) #1, the and the director of nursing, nurse consultant, ASM #4, if operations, and LPN is se) #1, the assistant in the made aware of the 1/2023 at 4:32 p.m. was provided prior to exit.	F6	656 658				
	as outlined by the commust- (i) Meet professional st This REQUIREMENT by: Based on observation, record review and facilidetermined that the face	or arranged by the facility, prehensive care plan, andards of quality. is not met as evidenced staff interview, clinical ty document review, it was illity staff failed to follow of practice for one of 34			potential to be affected by the alle deficient practice. A medication administration competency was completed with LPN #5.  3. DON/Designee provided educa to licensed nursing staff regarding rights of medication.  4. DON/Designee will perform a medication administration audit wir randomly selected nurse twice a v for four weeks. Identified variance be corrected and results will be reviewed through QAPI.  5. Date of Compliance: 12/15/202:	eged tion the 5 th a veek s will		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495255	B. WING				С	
NAME OF B	ROVIDER OR SUPPLIER	433233			CTREET ADDRESS OFF, CTATE 712 CORE	1	1/02/2023	
NAIVIL OF F	NOVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
SKYVIEW	SPRINGS REHAB AND	NURSING CENTER			30 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	( (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFI TAG			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
					DEFICIENCY)			
F 658	Continued From page	29	F	658	В			
	The findings include:							
	For Resident #94, the administer Humalog a	facility staff failed to s ordered by the physician.						
	A review of the clinical following orders:	record revealed the						
	units twice daily, befor 2. An order dated 7/7/ sliding scale, before by (Resident #94's glucos	23 for Humalog, dose per reakfast and lunch.						
	On 11/01/23 at 8:20 Al Administration task wa	s conducted with LPN #5 rse) for Resident #94. The						
	Humalog 10 units, s administered after the s     Humalog 2 units ba administered after the s	resident had breakfast. sed on sliding scale, was						
	order of before breakfa because it was adminis stated that the resident breakfast because he is drop. When asked if th	ance with the physician's st, she stated it was not, stered after breakfast. She won't take it before s afraid his glucose will be doctor was aware of a doctor was aware but that so it should have been		П		,		
	A review of the compre 9/2/23 revealed: "The re	hensive care plan dated esident has Diabetes						

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		495255	B. WING		C 11/02/2023	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	11/02/2023	
SKYVIEW	/ SPRINGS REHAB AND I	NURSING CENTER		30 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 658	Mellitus." This care pleated 9/2/23 for "Diable by doctor"  The facility policy, "Geometric Medication Administrate policy documented, "Nadministered as presegood nursing principle persons legally author On 11/1/23 at 4:30 PM Staff Member) the Administered of Nursing, AS Consultant, ASM #4 the of Operations, and LPI of Nursing, were made further information was survey.	an included the intervention etes medication as ordered neral Guidelines for tion," was reviewed. This fedications are ribed in accordance with s and practices and only by	F6	558		
SS=D	tml Increase/Prevent Decre CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facil resident who enters the range of motion does in range of motion unless	ease in ROM/Mobility Bity must ensure that a efacility without limited ot experience reduction in the resident's clinical that a reduction in range e; and	F 68	1. The alleged deficient practice already occurred and may not be retroactively corrected for reside #46.  2. All residents of the facility have the potential to be affected by the alleged deficient practice. An aud of residents with splinting device was conducted to ensure each win place per order.	e nt e e dit s	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
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		495255	B, WING_			11	/02/2023	
7 200 3000	ROVIDER OR SUPPLIER SPRINGS REHAB AND I	NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  30 MONTVUE DRIVE  LURAY, VA 22835			2		
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
	§483.25(c)(3) A reside receives appropriate sassistance to maintain the maximum practica reduction in mobility is This REQUIREMENT by:  Based on observation interview, facility docurecord review, it was dailed to implement intervention of a decrea one of 34 residents in Resident #46.  The findings include:  For Resident #46 (R46 place a washcloth in the physician orders.  On the most recent ME assessment, a quarter ARD (assessment refethe resident scored a 1 (brief interview for men resident is not cognitive daily decisions. In Section 1 (brief interview for men resident was coded limitations in range of rone side of upper and ladocumented, "Ensure residented."	ange of motion and/or to ase in range of motion.  ent with limited mobility services, equipment, and or improve mobility with able independence unless a demonstrably unavoidable. It is not met as evidenced on, resident interview, staff ment review and clinical determined the facility staff erventions for the ase in range of motion for the survey sample,  3), the facility staff failed to be resident's left hand per a sessessment, with an arence date) of 8/2/2023, and status), indicating the ely impaired for making tion G, Functional Status, as having functional motion with impairment on lower extremities.	F6	688	3. DON/Designee provided education to licensed nursing stregarding implementation of intervention to prevent a decrearange of motion per provider's of 4. DON/Designee will perform a audit of 10% of current resident ordered a splinting device to enplacement per order twice a wefor four weeks. Identified variant will be corrected and results will reviewed through QAPI.  5. Date of Compliance: 12/15/20	se in order. nd s sure ek ces be		
		times, change washcloth						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILD	ING.		С	
		495255	B. WING	_		1	/02/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SKYVIEW	SPRINGS REHAB AND N	NURSING CENTER			30 MONTVUE DRIVE		
				'	LURAY, VA 22835		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 688	Continued From page	32	F	688			
	contracture, skin prote	ection."					
	8:27 a.m. There was r hand. The resident sta	e of R46 on 11/1/2023 at no washcloth in her left ated sometimes the staff there and sometimes they					
		was made of R46 on n., no washcloth was noted ind. The resident's hand					
-	nursing assistant) #4 of When asked if there we needed to be done for positioning, CNA #4 stapillow under her left and the resident required a hand. CNA #4 stated serident had a brace at had a washcloth in that asked how she finds of which was the control of th	ated the resident likes a m. CNA #4 was asked if nything special for her left he remembered the t one time, and that she t hand the other day. When ut what a resident may sident, CNA #4 stated: I			,		
	practical nurse) #5 on a asked if R46 is to have hand, LPN #5 stated ar treatments for the day a off. When asked how th about what is needed for most of the aides know the purpose of the wasl	nother nurse was doing the and had already signed it he aides are informed or R46, LPN #5 stated about it. LPN #5 stated holoth in the left hand is ntracture, and the resident			-		

AND PLAN OF CORRECTION INDENTIFICATION NUMBER:		(X2) MUL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		405255	B WING			1	С
		495255	B. WING	_		11	/02/2023
NAME OF P	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
SKYVIEW	SPRINGS REHAB AND N	JURSING CENTER			30 MONTVUE DRIVE		
OICI VILVI	or minos nervisorino i	toronto oznizio			LURAY, VA 22835		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	ATE.	DATE
			-				
F 600							
F 688	Continued From page	33	F	688	3		
	The comprehensive ca	are plan dated, 5/16/2023,					
		Focus: The resident has an					
		living) self-performance					
		ibromyalgia, prior CVA					
		paresis and left hand/wrist					
		ACTURES: The resident					
		e left hand/wrist. Provide					
	skin care to keep clear						
		e resident has potential for					
	skin impairment r/t der				1		
		emiparesis and decrease in eatments as ordered and					
	monitor for effectivene						
	monitor for electivene	33.					
	The facility policy, "Re-	sident Mobility and Range					
	of Motion," documente						
	Residents will not expe						
		notion (ROM), 2. Residents					
		otion will receive treatment					
		se and/or prevent a further					
	decrease in ROM. 3. R	Residents with limited					
	mobility will receive ap	propriate services,					
	equipment, and assista	ance to maintain or					
		s reduction in mobility is					1
	unavoidable6. Interve						1
		of necessary equipment,					1
1	and/or exercises and w						
	professional standards	2			,		1
		ws and practice acts. 7.					- 1
	The care plan will inclu						
	and duration of interver						1
		objectives. The resident					l
1		be included in determining					l
	these goals and objecti	ves.					
	ASM (administrative sta	aff member) #1 the			6		
	administrator, ASM #2,				*		
		urse consultant, ASM #4,					
	the regional director of						
	-3 6 00.01 01	- p					

STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDII		С	
		495255	B. WING_		11/02/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SKYVIEW	SPRINGS REHAB AND I	NURSING CENTER		30 MONTVUE DRIVE		
OKT VIZIT				LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 688	Continued From page	34	F6	88		
	(licensed practical nur director of nursing, we above concern on 11/	ere made aware of the				
	No further information	was provided prior to exit.				
SS=D	yeast (a type of fungual information was obtain website: https://www.cdc.gov/fu Respiratory/Tracheost CFR(s): 483.25(i)  § 483.25(i) Respiratory tracheostomy care and The facility must ensure needs respiratory care care and tracheal suct care, consistent with p practice, the comprehe care plan, the resident and 483.65 of this sub This REQUIREMENT by: Based on observation document review and of was determined the far respiratory services petwo of 34 residents in t Residents #46 and #97 The findings include:  1. For Resident #46 (R	angal/diseases/candidiasis/. comy Care and Suctioning  y care, including d tracheal suctioning. The that a resident who expected in the control of the control control of the control	F 6	residents #46 and #97 were adjust and verified at eye level to the prescribed rate.  2. All residents of the facility have potential be affected by the allege deficient practice. An audit of curresidents ordered supplemental oxygen was performed to ensure tank/concentrator was set to delive the prescribed rate.  3. DON/Designee provided educate licensed nursing staff regarding providing oxygen at the prescriber rate.  4. DON/Designee will conduct an audit of current residents ordered supplemental oxygen to ensure the tank/concentrator is set to deliver oxygen at the prescribed rate twice per week for four weeks. Identified variances will be corrected and rewill be reviewed through QAPI.	the ed ent the er tion d	
9	to have the correct oxy			5. Date of compliance: 12/15/2023	5.	

	ID DI AN OF CODDECTION			FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495255	B. WING_			C 11/02/2023	
	ROVIDER OR SUPPLIER  SPRINGS REHAB AND N	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZI 30 MONTVUE DRIVE LURAY, VA 22835	P CODE		702/2020
(X4) ID PREFIX TAG			ID PREFI) TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	assessment, a quarter assessment reference resident scored a 15 c interview for mental st resident is not cognitive daily decisions.  Observation was made approximately 1:30 p.r with a nasal cannula in delivered. The oxygen was numbered two to number on the bottom number on the flowment below the number two oxygen below two. The of the flowmeter. The the line for two liters per the line for two liters per minute) via nasal of (shortness of breath)."  A second observation was set with the top of	DS (minimum data set) rly assessment with an e date of 8/2/2023, the out of 15 on the BIMS (brief ratus), indicating the rely impaired for making  e of R46 on 10/31/2023 at m. R46 was lying in bed in place with oxygen being concentrator flowmeter ten, with two being the first and ten being the top iter. There were no lines to indicate any level of the ball was set at the bottom top of the ball was touching ter minute.  ated 2/15/2022 therapy at 1 L/min (liters tannula every shift for SOB  was made of the R46 on The oxygen concentrator the ball touching the line the the touching the line	F6		INCY)		
	was set at, LPN #5 sta When asked the location one liter per minute, LF	n. with LPN (licensed nen asked what the oxygen	4			У	

EMENT OF DEFICIENCIES ( PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
				С	
	495255	B. WING		11/	02/2023
NAME OF PROVIDER OR SUPPLIER  SKYVIEW SPRINGS REHAB AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		
REFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG			(X5) COMPLETION DATE
of the oxygen. She stat prescribed rate should the ball. When asked if according to the physic was not.  The comprehensive cal documented in part, "For altered respiratory statu (related to) hx (history) lung, hx of smoking. Related by the facility policy, "Oxydocumented in part, "Porticiant of the physician's order for this physician's order for this physician's orders or far administration5. Turn on umber of liters / minute physician/practitioner."  The manufacturer's bood Platinum 10 L (liter) Oxydocumented in part, "1. the setting prescribed by therapist. To properly rethe prescribed flowrate Next, turn the flow knob line. Now, center the bas prescribed."  ASM (administrative stat administrator, ASM #2, 1	ning out, then it was at ed how to set the flow rate ted the line of the go through the center of it the oxygen was set the cian order, LPN #5 stated it the plan dated 9/29/2022 ocus: The resident has us/difficulty breathing r/t of malignant neoplasm of equires HOB (head of OB when lying d."  Tour of the purpose of vide guidelines for safe to the cility protocol for oxygen on the oxygen at the es as ordered by the oxygen Concentrator Turn the flowrate knob to y your physician or ead the flowmeter, locate line on the L/min line of member) #1, the	F	595		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495255	B. WING			C	
NAME 05.0	DOLUMES OF STREET	493233	B. WING _			1 11	1/02/2023
	ROVIDER OR SUPPLIER SPRINGS REHAB AND I	NURSING CENTER		30	REET ADDRESS, CITY, STATE, ZIP CODE  MONTVUE DRIVE  IRAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695			F	895			
	the regional director o (licensed practical nur director of nursing, we above concern on 11/	se) #1, the assistant are made aware of the					
	No further information	was provided prior to ext.					
	provide respiratory the #97 was observed with	the facility staff failed to erapy as ordered. Resident on oxygen setting at 2.5 Inc on 10/31/23 at 12:00 PM PM.					
	Resident #97 was adm 10/2/23 with diagnosis fibrillation, multiple frac obstructive pulmonary	that included atrial ctures and COPD (chronic					
	date) of 10/25/23, code 15 out of 15 on the BIM mental status), indicati cognitively impaired. S	re 5-day admission RD (assessment reference ed the resident as scoring a MS (brief interview for ng the resident was not ection G, functional, status being dependent for bed sing and hygiene; total					
	10/4/23, revealed, "FO						
	revealed, "O2 at 2LPM	an orders dated 10/22/23 via nasal cannula to 6 or above. every shift for				. ,	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		405055	D WING			C	
	200//250 05 0//250 155	495255	B. WING_	_		11/02/2023	
NAME OF P	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SKYVIEW	SPRINGS REHAB AND N	NURSING CENTER			30 MONTVUE DRIVE		
					LURAY, VA 22835		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
IAG	THE SECTION OF E	SO IDENTIFY THE INTO CHARACTERY	IAG		DEFICIENCY)		5: 4:5
F 695	Continued From page	38	F6	605			
1 000	Continued From page	30	_ F	090			
	An intension was cond	ducted on 10/31/23 at 1:53					
	THE RESIDENCE OF THE PROPERTY	d practical nurse) #3. When					
		kygen setting for Resident					
		was on 2 liters. She stated:					
	2.1	ing and it is at the same					
	setting." LPN #3 state	ed the middle of the					
	flowmeter ball should I	be on the line for the					
	correct number of liter	s.					
		I, ASM (administrative staff				-	
	member) #1, the admi	The state of the s					
	consultant, ASM # 4, ti	M #3, the regional nurse					
	The second of th	1, the assistant director of					
	nursing were made aw						
	narang ware made aw	are of the infamgs.					
	A review of the facility's	s "Oxygen Administration"					
		ourpose of this procedure is					
	to provide guidelines for						
ĺ		that there is a physician's					
	1,21	e. Review the physician's					1
	orders or facility protoc	col for oxygen					1
	administration."						
	No further information	was provided prior to exit.			1. The alleged deficient practice h	as	1
F 698	Dialysis	was provided prior to exit.	F 69	QΩ	already occurred and may not be	-	
	CFR(s): 483.25(I)		F 0:	90	retroactively corrected for residen	t #29.	ŀ
00 2	0111(0). 100.20(1)				The fluid restriction is not longer		
	§483.25(I) Dialysis.				appropriate for resident #29 and h	ias	İ
	The facility must ensure	e that residents who			been discontinued.		
		such services, consistent			<ol><li>All residents of the facility have</li></ol>		
	with professional stand				potential to be affected by the alle		
		-centered care plan, and			deficient practice. An audit of curre	ent	
	the residents' goals and				residents with an order for fluid		
1		is not met as evidenced			restriction was conducted to ensur		
	by:				order was entered appropriately to		
	Based on resident inte	rview, staff interview,			allow for documentation of intake.		1

A. BUILDING	C 11/02/2023
ADESE D WING	11/02/2023
495255 B. WING	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
SKYVIEW SPRINGS REHAB AND NURSING CENTER  30 MONTVUE DRIVE	
LURAY, VA 22835	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Continued From page 39 clinical record review and facility document review, it was determined the facility staff failed to provide dialysis care and services for one of 34 residents in the survey sample, Resident #29.  The findings include:  The findings include:  For Resident #29, the facility failed to monitor for fluid restriction and intake, failed to assess for bruit and thrill at the dialysis access site, and failed to maintain a complete communication system with the dialysis center.  Resident #29 was admitted to the facility on 10/4/23 with diagnosis that included but were not limited to: ESRD (end stage renal disease) and diabetes.  The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 10/10/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as being independent for eating, bed mobility, transfer, walking and locomotion.  A review of the comprehensive care plan dated 10/4/23, which revealed, "FoCUS: Resident has ESRD and receives Hemodialysis at dialysis center on Monday-Wednesday-Friday. INTERVENTIONS: Auscultation/palpation of the AV fistula (pulse, bruit and thrill) to assure adequate blood flow per protocols."  A review of the physician's orders dated 10/4/23, revealed. "Dialvsis at (specify place) on Monday.	s ks as der y; I dit

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495255	B. WING			C 11/02/2023	
	PROVIDER OR SUPPLIER	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZII 30 MONTVUE DRIVE LURAY, VA 22835	P CODE		102/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ( X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA		(X5) COMPLETION DATE
	Wednesday, Friday. In Daily every shift Reconder in the Pristula/Graft to Right of Daily and signs and syshift. Check dialysis publift. Check dialysis	Fluid Restriction 1500 ml rd shift Intake and every or Intake. Assess Dialysis forearm for Thrill and Bruit ymptoms of infection every out to Right forearm each ry on bath days. Do not will be done at dialysis.  #29's October 2023 MAR ation record) and TAR fon record) revealed no ressment of the dialysis dibruit, and for signs of fon 10/5/23, 10/6/23 and  #29's dialysis revealed missing from the facility to the redialysis treatments: //16/23, 10/18/23, 10/27/23  29's October 2023 MAR tion record) and TAR fon record) and TAR fon record) and TAR fon record) and TAR fon record) revealed no record in the saked in the saked in the saked in the saked where the sakes are documented, she timented on the TAR. She cumentation, then the	F	598			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495255		B, WING		C 11/02/2023	
	ROVIDER OR SUPPLIER	NURSING CENTER		STREET ADDRESS, CITY, STATE, 3 30 MONTVUE DRIVE LURAY, VA 22835	ZIP CODE	1110212020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE EIENCY)	(X5) COMPLETION DATE	
	(licensed practical nurestriction on Residenthe dietician, She statwith the NP (nurse prasked to provide evidewas discontinued, LPI for it."  On 11/1/23 at approximate approx	mately 11:00 AM, LPN rse) #4 stated the fluid at #29 was discontinued by ed she was going to talk actitioner) about this. When ence that the fluid restriction N #4 stated, "Let me search mately 1:30 PM, Resident istula was checked. Yes, they check the bruit ed if he takes a with him to dialysis, Yes, they put papers in it s center." When asked if he on, he stated he was not ided: "I watch what I drink, I, ASM (administrative staff nistrator, ASM #2, the M #3, the regional nurse he regional director of in the assistant director of vare of the findings.  In the individual state I watch what I drink I watch what I drink I he regional nurse he regional director of I he assistant director of vare of the findings. I team there is no policy for is policy for item the polic	F	698			

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.11.01 0.111 0.1		DEITH IO HIGH HOMBER	A, BUILD	ING_		C	
		495255	B. WING				/02/2023
Tourist Control of the Control of th	ROVIDER OR SUPPLIER SPRINGS REHAB AND I	NURSING CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	physician/practitioner dietitian will be kept in interdisciplinary team and document resider until the team agrees factors are stabilized of A review of the facility Resident #29's provide send to provider docupatient's care is mana necessary to provide sond to provider sond to provide sond to provider sond to provide sond to provider sond to provide sond to	or per facility protocol. The  Informed of status. The will update the care plan Int response to interventions that fluid intake and relating or resolved."  's dialysis contract with er revealed, "Facility will mentation as to how the ged and all medical records services."  was provided prior to exit.  (4)  Inpt to use appropriate stalling a side or bed rail. If ed, the facility must ensure e, and maintenance of bed limited to the following  the resident for risk of rails prior to installation.  Ithe risks and benefits of ent or resident ain informed consent prior  that the bed's dimensions resident's size and weight.  The manufacturers'		700	1. Resident #106 has discharged from the facility. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audicurrent residents with side rails viconducted to ensure review of the risks and benefits occurred, as we as informed consent was obtained. DON/Designee provided education to licensed nursing staregarding review of risks and benefits of side rails and obtaining informed consent for side rails. 4. DON/Designee will conduct an audit of current residents with ne implemented side rails to ensure review of risk and benefits, as we as consent was obtained. Identifity variances will be corrected and results will be reviewed through QAPI. 5. Date of compliance: 12/15/202	e e e dit of vas e e vell ed.  aff n wly ell ed	
		specifications for installing			5. Date of compliance. 12/19/202		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		,				С	
		495255	B. WING	-		11	/02/2023
	ROVIDER OR SUPPLIER  SPRINGS REHAB AND I	NURSING CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	by: Based on staff interviand facility document the facility staff failed to requirements for one of survey sample, Reside. The findings include: For Resident #106, the evidence a review of the bedrails, and failed to the use of the rails.  Resident #106 was obquarter bed rail bilaters PM, 11/1/23 at 9:00 AN AM.  The most recent MDS assessment, a Medica assessment, with an Adate) of 10/11/23, code 15 out of 15 on the BIN mental status) score, in not cognitively impaired status, the resident was independent for bed m  A review of the clinical evidence of a bed rail econsent for Resident #106 PM with Resident #106 PM with Resident #106	ails.  is not met as evidenced  ew, clinical record review review, it was determined to implement bed rail out of 34 residents in the ent # 106.  e facility staff failed to he risks and benefits of obtain informed consent for  served in bed with one ally on 10/31/23 at 12:00 M, and 11/1/23 at 10:45  (minimum data set) re 5-day admission RD (assessment reference ed the resident as scoring a MS (brief interview for ndicating the resident was d. In Section G, functional s coded as being obility and transfers.  record revealed no evaluation or informed 106.  ucted on 10/31/23 at 12:00 6. When asked if she used	F	700			
		#106 stated, "Yes, I use					

percentage and property and a	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1000		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						1	С
		495255	B. WING			11	/02/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		70-1-10-10
					30 MONTVUE DRIVE		
SKYVIEW	SPRINGS REHAB AND I	NURSING CENTER			LURAY, VA 22835		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 700	Continued From page	44	F	700			
	An interview was cond	ducted on 10/31/23 at 1:00					
		d practical nurse) #3. When					
		be followed for a resident's					
		ed, "We do an assessment					
		of the bed rails, obtain a					
	consent and put it on t	the care plan."					
		1, ASM (administrative staff					
	member) #1, the admi						
		M #3, the regional nurse					
	consultant, ASM # 4, t	ne regional director of 1, the assistant director of					
	nursing were made aw	*					
	naising were made aw	vare or the infulfigs.					
	A review of the facility'	s "Bed Rail Risk and					
		d, "This organization will					
	take measures to deve						
	strategy to minimize th	e possibility of resident					
	entrapment and or inju	ry while using bed rails.					
	This will include an eva	aluation of residents who					
I		ire to use bed rails and that					
	may have characteristi						
	special risk for entrapn						
		m or her as appropriate for					
		he following procedures					
1		te the resident/resident					
	use. The resident and	isks and obtain consent for					
1		nt for use of the bed rails					
1		the medical record. The					
1	resident's representativ						1
		ician/practitioner will be					1
		order for the use of bed					
		y / type of rails, which side					
		d when they are to be in					- 1
		The reason for the bed					
1	rails and their proper us	se will be integrated into					
	the comprehensive car						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495255	B. WING			C	
	PROVIDER OR SUPPLIER	NURSING CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MONTVUE DRIVE LURAY, VA 22835		//02/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Pharmacy Srvcs/Proci CFR(s): 483.45(a)(b)( §483.45 Pharmacy Se The facility must providuring and biologicals of them under an agreent §483.70(g). The facility personnel to administed permits, but only under a licensed nurse. §483.45(a) Procedures pharmaceutical services that assure the accuration dispensing, and administration biologicals) to meet the §483.45(b) Service Comust employ or obtain pharmacist who- §483.45(b)(1) Provides aspects of the provision the facility. §483.45(b)(2) Establish receipt and disposition sufficient detail to enabreconciliation; and	was provided prior to exit. edures/Pharmacist/Records 1)-(3)  ervices de routine and emergency to its residents, or obtain ment described in ty may permit unlicensed er drugs if State law or the general supervision of  s. A facility must provide es (including procedures te acquiring, receiving, istering of all drugs and e needs of each resident.  Insultation. The facility the services of a licensed  se consultation on all of pharmacy services in  these a system of records of of all controlled drugs in le an accurate		700	1. The provider was notified of the unavailable medication for reside 35. 2. All residents of the facility have potential to be affected by the alled deficient practice. An audit of curresidents receiving diabetic relater medications was conducted to identify those that were unavailable over the last two weeks to ensure provider was notified. 3. DON/Designee provided educated licensed nursing staff regarding notification of the provider for unavailable medication. 4. DON/Designee will perform an audit of current residents receiving diabetic related medications to identify those that were unavailable and ensure the provider was notifitwice a week for four weeks. Identified variances will be correct and results will be reviewed throug QAPI. 5. Date of Compliance: 12/15/202.	the eged rent d le the tion le ed ed ed	
	order and that an accou is maintained and perio	les that drug records are in unt of all controlled drugs dically reconciled.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	405055	D WING		С	
	495255	B. WING		11/02/2023	
NAME OF PROVIDER OR SUPPLIER  SKYVIEW SPRINGS REHAB AND	NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835		
PREFIX (EACH DEFICIENCE	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
and clinical record re to provide pharmacy residents in the surver The findings include:  For Resident #35 (R3 ensure the medication available for administ 10/10/23.  A review of R35's climphysician's order dateing (milligrams) by metwo diabetes mellitus. 2023 MAR (medication revealed the same phylardiance. On 10/9/2 documented the code Notes." Nurses' notein 10/10/23 documented was not administered  On 11/1/23 at 2:19 put conducted with LPN (LPN #4 stated medication from the pharmacy which supply of the medication is not at then the nurses should the facility backup memedication is not in the nurses should update resident's family.  A review of the facility	view, facility document review view, the facility staff failed services for one of 34 ey sample, Resident #35.  35), the facility staff failed to n Jardiance (1) was tration on 10/9/23 and  sical record revealed a ed 3/13/23 for Jardiance 25 outh one time a day for type and Areview of R35's October on administration record) hysician's order for 13 and 10/10/23, the MAR et and 10/10/23 and the medication Jardiance and was on order.  The many staff failed to not not not many staff failed to not not many staff failed to not not not not not not not not not	F 755			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495255	B, WING			C 11/02/2023	
desidente total - evanuation desidente	PROVIDER OR SUPPLIER		3 3 3 3	3	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MONTVUE DRIVE LURAY, VA 22835	111	02/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
SS=D	staff member) #1 (the (the director of nursing above concern.  The facility pharmacy Guidelines for Medicat documented, "Medicat prescribed"  Reference: (1) Jardiance is used to for people with diabete information was obtain https://medlineplus.gov.tml  Free of Medication ErrocFR(s): 483.45(f)(1)  §483.45(f) Medication The facility must ensure \$483.45(f)(1) Medication percent or greater; This REQUIREMENT by: Based on observation, record review and facility determined that the facility medication error rate of 34 residents in the survey.	n., ASM (administrative administrator) and ASM #2 g) were made aware of the policy titled, "General tion Administration" tions are administered as o lower blood sugar levels as mellitus. This led from the website: w/druginfo/meds/a614043.h or Rts 5 Pront or More  Errors. e that its-	F7	755	1. A medication error was complifor resident #94. 2. All residents of the facility have potential to be affected by the all deficient practice. A medication administration competency was completed with LPN #5. 3. DON/Designee will perform a medication administration competency with licensed nursing staff. 4. DON/Designee will perform a medication administration competency with a randomly selenurse twice a week for four week.	e the eged g	
	opportunities, resulting of 5.71%.  The findings include:	in a medication error rate			Identified variances will be correct and results will be reviewed throug API.  5. Date of Compliance: 12/15/202	ıgh	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495255	B. WING				C
NAME OF PROVIDER OR SUPPLIER  SKYVIEW SPRINGS REHAB AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP C 30 MONTVUE DRIVE LURAY, VA 22835	CODE	11/	02/2023
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
administering the medic ordered by the physicial On 11/01/23 at 8:20 AM Administration task was (Licensed Practical Nurfollowing was observed 1. Humalog (1) 10 units administered after the readministered in accordance of before breakfast because it was administered that the resident was breakfast because he is drop. When asked if the	alog insulin was alkfast instead of before a medication error of not cation at the right time as an.  If, the Medication a conducted with LPN #5 se) for Resident #94. The : s, scheduled, was esident had breakfast. sed on sliding scale, was esident had breakfast. secord revealed the  23 for Humalog 10 units afast and lunch. 3 for Humalog, dose per akfast and lunch. e level was 217. The included, 200 - 249 = 2  #94's insulin was nce with the physician's t, she stated it was not, ered after breakfast. She won't take it before afraid his glucose will e doctor was aware but that to it should have been When asked about the	F	759			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495255	B. WING			C 11/02/2023	
NAME OF PROVIDER OR SUPPLIER  SKYVIEW SPRINGS REHAB AND NURSING CENTER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 759	right route, right time.' #94's insulin was adm those rights she state breakfast was not the  A review of the compr 9/2/23 revealed, in pa Diabetes MellitusDia ordered by doctor"  The facility policy, "Ge Medication Administra policy documented, " Rights - right resident, route, and right time - medication administrat steps in the process of medication is selected removed from the cont dose is prepared and to away"  On 11/1/23 at 4:30 PM Staff Member) the Adn Director of Nursing, AS Consultant, ASM #4 th of Operations, and LPI of Nursing, were made further information was survey.  References:  1. Humalog is used to Information obtained from	right medication, right dose, " When asked if Resident inistered in accordance with d it was not, because after right time.  ehensive care plan dated rt: "The resident has abetes medication as abetes medication as abetes medication as an eneral Guidelines for tion" was reviewed. This abetes medication as a reviewed. This abetes medication as a reviewed at three for the should be applied to all tion and reviewed at three for preparation: (1) when and (2) when the dose is tainer, and (3) after the she medication is put the she medication is put the she Regional Nurse are Regional Vice President and the Regional Vice President and the she reviewed by the end of the treat diabetes.	F	759			
F 842 SS=D	tml Resident Records - Ide	entifiable Information	F 8	42			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 180	E) MULTIPLE CONSTRUCTION (X3			(X3) DATE SURVEY COMPLETED	
		405255		-			С	
		495255	B. WING			11	/02/2023	
NAME OF PROVIDER OR SUPPLIER  SKYVIEW SPRINGS REHAB AND NURSING CENTER				3	STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	CFR(s): 483.20(f)(5), 4 §483.20(f)(5) Residen (i) A facility may not re- resident-identifiable to (ii) The facility may rel- resident-identifiable to accordance with a con- agrees not to use or di- except to the extent th- to do so.  §483.70(i) Medical rec- §483.70(i) Medical rec- §483.70(i)(1) In accord- professional standards must maintain medical that are- (i) Complete; (ii) Accurately documen- (iii) Readily accessible; (iv) Systematically orga- §483.70(i)(2) The facili- all information container regardless of the form records, except when r- (i) To the individual, or representative where p- (ii) Required by Law; (iii) For treatment, payno operations, as permitte with 45 CFR 164.506; (iv) For public health ac neglect, or domestic vicactivities, judicial and a law enforcement purpos- purposes, research pur-	t-identifiable information. elease information that is the public. ease information that is an agent only in elease information that is an agent only in elease information the agent isclose the information e facility itself is permitted  ords. dance with accepted and practices, the facility records on each resident  ented; and anized  ty must keep confidential ed in the resident's records, or storage method of the elease is- their resident ermitted by applicable law; ment, or health care d by and in compliance  ctivities, reporting of abuse, plence, health oversight dministrative proceedings, ses, organ donation	F	842	1. The alleged deficient practice already occurred and may not be retroactively corrected for resider #11 and #106.  2. All residents of the facility have potential to be affected by the alledeficient practice. An audit of cur residents was completed to ensure the bathing and shower task is available for the nursing staff to complete documentation.  3. DON/Designee will education nursing staff regarding document of bathing/showers in the electron medical record.  4. DON/Designee will perform an audit of 10% of current residents ensure bathing/showering was documented as provided in the electronic medical record twice poweek for four weeks. Identified variances will be corrected and results will be reviewed through 05. Date of compliance: 12/15/202	e the eged rent re cation nic		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495255	B. WING	NG		44	C	
NAME OF B	ROVIDER OR SUPPLIER	100200		ет	REET ADDRESS, CITY, STATE, ZIP CODE	1 11	/02/2023	
SKYVIEW SPRINGS REHAB AND NURSING CENTER			30	MONTVUE DRIVE JRAY, VA 22835				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	0.500	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
	by and in compliance §483.70(i)(3) The faci record information aga unauthorized use. §483.70(i)(4) Medical for- (i) The period of time in (ii) Five years from the there is no requiremer (iii) For a minor, 3 yeal legal age under State §483.70(i)(5) The med (i) Sufficient information (ii) A record of the resi (iii) The comprehensive provided; (iv) The results of any and resident review evel determinations conduct (v) Physician's, nurse's professional's progress (vi) Laboratory, radiolo services reports as record This REQUIREMENT by: Based on staff interview and facility document in the facility staff failed to	alth or safety as permitted with 45 CFR 164.512.  lity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or a date of discharge when at in State law; or resafter a resident reaches law.  lical record must containant to identify the resident; dent's assessments; e plan of care and services preadmission screening reluations and sted by the State; and other licensed is notes; and gy and other diagnostic quired under §483.50. is not met as evidenced rew, clinical record review eview, it was determined to provide complete and in for two of 34 residents in	F	842				
	1. For Resident #11, th evidence complete and	e facility staff failed to I accurate documentation						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495255	B. WING	B. WING			C /02/2023
NAME OF PROVIDER OR SUPPLIER SKYVIEW SPRINGS REHAB AND NURSING CENTER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 10 MONTVUE DRIVE LURAY, VA 22835		702/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	2/3/23, which revealed an ADL (activities of diperformance deficit releg amputation. INTE supervision and cuing Physical assist as need.  A review of the ADL domedical record, reveal showers was missing Shower documentation 9/6/23, 9/30/23, 0/4/23 10/18/23, 10/21/23	ehensive care plan dated d., "FOCUS: Resident has aily living) self-care lated to weakness and right RVENTIONS: Provide as needed with ADLs. ded with ADLs."  Document in Resident #11's ed documentation for for 8/23/23 and 8/26/23. In was also missing for 8, 10/7/23, 10/11/23, 10/25/23 and 10/28/23.  Lucted on 10/31/23 at 3:00 Resident #11 stated, showers consistently. I do mately 11:00 AM, LPN se) #4 stated, "This is the e on Resident #11's dindivdual shower sheet When asked if this included in the electronic 4 stated, "Yes, it is to be the stated if the included in the electronic dical record is not sucted on 11/1/23 at 2:00 nursing assistant) #2.	F	342			

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
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		495255	B. WING			11	/02/2023
NAME OF PROVIDER OR SUPPLIER  SKYVIEW SPRINGS REHAB AND NURSING CENTER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	An interview was conda AM with CNA #3. Who and bathing are docur is to be documented in record. Sometimes we sheets." She stated if included in the electro medical record is not of the condition of the condition of the consultant, ASM #4, the consultant, ASM #4, the consultant, ASM #4, the consultant was and LPN #7 nursing were made aw A review of the facility. Documentation policy provided to the resider plan goals, or any charmedical, physical, function condition, will be documedical record. The macommunication between team regarding the response to care."	ducted on 11/2/23 at 8:00 en asked where showers nented, CNA #3 stated, "It in [the electronic medical document it on the shower the documentation is not nic medical record, the complete or accurate.  I, ASM (administrative staff nistrator, ASM #2, the M #3, the regional nurse the regional director of in the assistant director of in the assistant director of in the resident's interest of the findings.  Is "Charting and In revealed, "All services int, progress toward the care inges in the resident's tional, or psychosocial mented in the resident's edical record will facilitate in the interdisciplinary ident's condition and  was provided prior to exit.  The facility staff failed to		842	Company of Control of the Control of	TE	DATE
	10/6/23 revealed, "FOC alteration in nutritional s	hensive care plan dated CUS: Resident is at risk for status related to new tment, CKD, diuretic use					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		000		_		С	
		495255	B. WING			11	/02/2023
NAME OF PROVIDER OR SUPPLIER  SKYVIEW SPRINGS REHAB AND NURSING CENTER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 10 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	revealed, "Daily Weight x4 weeks, then month A review of the weight medical record and the administration record) weight documentation 10/30/23.  On 11/1/23 at approximate (licensed practical number of the provided for Resident #106. A resident #106. A resident #106 has done. When asked if the tincluded in the electror stated, "Yes, it is to be stated if the documentation was conditional record, the record accurate.  An interview was conditional record with CNA (certified When asked where we CNA #3 stated, "It is to electronic medical record sometimes the staff do sheets. She stated if the documented in the electronic is not accurate of the conditional record is not accurate of the conditional	ian orders dated 10/6/23 ht x3 days, Weekly Weight ly."  sheet in the electronic e October TAR (treatment revealed no evidence of on 10/16/23, 10/23/23 and  mately 11:00 AM, LPN se) #4 stated, "This is the re on Resident #106's d individual weight sheets eview of the sheets for revealed documentation d refused to have weights this documentation is to be nic medical record, LPN #4 documented there." She ation is not in the electronic cord is not complete or  ucted on 11/2/23 at 8:00 nursing assistant) #3. ights are documented, be documented in [the ord." She stated cument it on the weight e weights are not ctronic medical record, the or complete.	F	342	DEFICIENCY		
1	member) #1, the admin	ASM (administrative staff histrator, ASM #2, the M #3, the regional nurse		0			я

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  IDENTIFICATION NUMBER: A, BUILDING		(X3) DATE SURVEY COMPLETED			
		495255	B. WING		1	C <b>(02/2023</b>
NAME OF PROVIDER OR SUPPLIER  SKYVIEW SPRINGS REHAB AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 30 MONTVUE DRIVE LURAY, VA 22835			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD I  CROSS-REFERENCED TO THE APPROPR  DEFICIENCY)		(X5) COMPLETION DATE
F 842	operations and LPN # nursing were made av	the regional director of 1, the assistant director of	F	342		