STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wayland Nursing and Rehabilitation Center	730 Lunenburg Highw Keysville, VA 23947

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to notify the physician of a change in condition in a timely manner for 1 of 19 residents, Resident #197. The findings include: For Resident #197 (R197), the facility staff failed to notify the physician of swelling and redness to the residents left knee observed on 3/6/24 in a timely manner. R197 no longer resided at the facility and could not be observed or interviewed. The record was reviewed as a closed record. A facility synopsis of events for R197 dated 3/8/24 documented in part, .Swelling & redness noted to LT (left) knee. MD in to see. X-ray of knee ordered- found acute appearing distal femur fx (fracture) proximal to LT knee replacement. Resident sent to ER. See attached summary . The attached summary documented in part, Resident was noted with redness and swelling to LT knee on 3/6/24. Primary nurse was made aware. Primary nurse assessed resident and found redness and swelling to LT knee and decision was made to notify MD. Resident had no complaints of pain when asked. MD saw resident on 3/7/24 and order given for x-ray. [Name of x-ray service] in on 3/8/25 and performed x-ray. Radiology reading of x-ray states resident had an acute-appearing fracture of the distal femur proximal to her knee replacement. Resident sent to the ER for evaluation. The hospital attributed the fracture to her fall on 2/25/24. Orthopedic surgeon felt that surgical intervention could cause more harm to resident than nonsurgical intervention. States knee was already starting to heal. Knee immobilizer placed in hospital to help with keeping fracture in alignment during healing. Resident has a diagnosis of osteopenia, osteoarthritis, Vitamin B and D deficiencies. The progress notes for R197 documented in part, - 02/25/2024 09:15 (9:15 a.m.) Incident Note. Note Text: CNA (certified nursing assistant) had resident turned on her side to change her sheets and she was scooting to the edge of the bed and was going to fall. CNA stated she was able to catch her but had to ease her to the floor. No injury noted. VS (vital signs) 122/74 (blood pressure)-70 (pulse)-18 (respirations)-98.4 (temperature)-97% (oxygen saturation). - 02/27/2024 13:30 (1:30 p.m.) Note Text: No injury noted from fall on 2/25/24. Voices no complaints of pain or discomfort. (continued on next page)

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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 03/07/2024 13:38 (1:38 p.m.) Note Text: Order for x-ray of residents left knee ordered by [Name of physician]. Call placed to [Name of x-ray service] to alert them of the order. Copy of x-ray order and residents face sheet placed in the front nurses station. - 03/08/2024 11:36 (11:36 a.m.) Note Text: X-ray tech in facility at this time to obtain X-ray. - 03/08/2024 13:45 (1:45 p.m.) Note Text: Received results of Xray. MD notified and gave order to send resident to ER. The physician progress note for R197 dated 3/7/24 documented in part, .Chief complaint/reason for this visit: Left knee pain. HPI (history of present illness) relating to this visit: [age and sex of R197] with history of CAD (coronary artery disease), Dementia, Chronic A. (atrial) fibrillation, CVA (cerebrovascular accident) and OA (osteoarthritis) is seen today for evaluation of pain in her left knee with swelling that she complained about this morning. This knee has had joint replacement in 2011. There were no reports of any trauma. She does complain of pain with moving the knee .Musculoskeletal: Joint Swelling/Inflammation, Mobility, Painful Movement, Left knee tender . Assessment and Plan: 1. left knee pain has had surgery 2021. 1: Obtain x-ray. Tylenol prn (as needed) pain. 2. Dementia: Continue safety precautions. Reorient as necessary . The clinical record failed to evidence documentation regarding the swelling and redness of the left knee first observed on 3/6/24 or notification of the physician. On 4/15/25 at 10:27 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing who stated that R197 had been assisted to the floor during care by a former CNA on 2/25/24 and had only complained of some back pain the day after the fall which was addressed by the physician. She stated that the physician assessed R197 on 2/26/24 and started Tylenol for back pain. She stated that when she had investigated the incident, she had found that R197 had only complained of generalized pain when turning and had not knee pain or swelling until 3/6/24 when the CNA observed it and reported it to the LPN (licensed practical nurse). ASM #2 stated that the LPN had assessed R197's knee and notified the physician by placing it in the physician communication book. She stated that the physician saw R197 on 3/7/24 and ordered the x-ray which was obtained on 3/8/24 and the resident was sent out when the results came in. She stated that in hindsight the nurse should have called the physician and documented the assessment and findings in the medical record. On 4/15/25 at 12:42 p.m., an interview was conducted with LPN #1 who stated that the former CNA had called her on 2/25/24 when R197 was on the floor. She stated that the CNA told her that she was changing the resident and R197 had grabbed the rail and rolled over too far, and the CNA was not able to catch her in time to keep her in the bed and had lowered her to the floor. She stated that R197 was a one person assist at that time and would use the rail to hold herself over when they were providing care but had a habit of going over too far. She stated that she had assessed R197 who had no complaints of pain or injuries observed. She stated that she had notified the physician and resident representative at that time. LPN #1 stated that the physician book was used to communicate anything non-urgent that they needed to address when they came in the next day. She stated that the physician came in twice a week and the nurse practitioner came in three days a week and someone was on call on the weekends. LPN #1 stated that observed swelling and redness in the knee should have been documented in the medical record to cover them and show what was going on and should have been called to the physician rather than placed in the book. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/25 at 1:01 p.m., ASM #3, the facility nurse consultant provided a binder which documented a five-point performance improvement plan for regarding pain management. Review of the plan with an initiation date of 3/9/24, documented the following actions taken: Like Patient or System: - On 3/9/24, the DON initiated a Pain Assessment of all residents not able to report for signs and symptoms of pain. The purpose of the assessments is to identify any resident with new onset of pain or pain not relieved with current interventions and to ensure all residents with s/s pain have been assessed with interventions initiated, MD/RR notified with documentation in the clinical record, and the resident is care planned for pain/pain interventions. All areas of concern will be immediately addressed during the audit. The audit will be completed by 3-10-24. - On 3/15/24 the social worker initiated resident questionnaires with all alert and oriented residents regarding pain. The purpose of the questionnaires is to identify any resident with new onset of pain, worsening pain or pain not relieved with current interventions and to ensure all residents with s/s of pain have been assessed with interventions initiated, MD/RR notified with documentation in the clinical record, and the resident is care planned for pain/pain interventions. All areas of concern will be immediately addressed during the audit. The questionnaires will be completed by 3-15-24. - On 3/9/24, the facility nurse consultant will review the MAR (medication administration record) for all residents receiving pain medication for the past 30 days. The audit ensures the resident's pain medication regimen is effective, including PRN pain medications. The physician will be contacted for any identified areas of concern during the audit. The audit will be completed by 3/10/24. - On 3/21/24 the DON initiated staff questionnaires to ensure there were no residents with unrelieved pain. This was to ensure staff had reported any changes in pain to a nurse and follow-up had occurred. Plan: - On 3/9/24, the DON initiated and in-service with all nursing assistants regarding reporting changes in resident condition including but not limited to pain. - On 3/9/24 the DON initiated an in-service with all nurses regarding assessment of acute changes in condition to include but not limited to pain, notification to the physician and resident representative, initiation of an intervention to address the pain, updates to the resident care plan, and documentation in the clinical record. - The inservices will be completed on 3/15/24. After 3/15/24 all nurses that have not worked and received the inservice will complete upon their next scheduled shift. Monitoring: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The DON/SDC will review residents' progress notes 5x per week x 4 weeks, then monthly x 1 month to identify residents with pain. The purpose of the audit is ensuring the pain was assessed by nursing staff with documentation in the electronic record, new onset of pain, worsening pain, or pain not relieved by current interventions are referred immediately to the physician for further interventions, the RR (Resident Representative) is notified of the pain, and the plan of care reflects pain. The resident will be assessed and/or notification to the provider with documentation in the clinical records, and the nurse will be retrained for all identified areas of concern. - The audit will be discussed during the cardinal IDT (interdisciplinary team) meeting 5x per week x 4 weeks then monthly x 1 month and documented on the pain audit tool. - The administrator or DON will present the findings of the Audit Tools to the QAA committee monthly for 2 months. The QAA committee will meet monthly for 2 months and review the Audit Tools to determine trends and/or issues that may need further interventions and the need for additional monitoring. The performance improvement plan documented a compliance date of 3/21/24. Review of the evidence binder documented completed resident pain assessments, resident and staff questionnaires, pain medication audits, progress note audits and education sign-in sheets documenting training on assessing for change in condition, pain, notification of the physician and resident representative, updating the care plan, pain interventions and documentation in the clinical record. The staff sign-in sheets for the inservice training were reviewed and verified by multiple staff interviews. The other points of the plan of correction as described in this writing were verified with resident interviews and observations. No current concerns were identified. On 4/16/25 at 3:38 p.m., ASM #1, (administrator), ASM #2, (director of nursing), ASM #3, (facility nurse consultant) and ASM #4, (administrator colleague from another facility) were made aware of the concern at past non-compliance. No further information was provided prior to exit. PAST NONCOMPLIANCE