PRINTED: 07/19/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(3) DATE SURVEY COMPLETED	
		495139	B. WING		07/0	08/2016	
	PROVIDER OR SUPPLIER RE CENTER OF NEW	MARKET		STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844			
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F 000	survey was conducted Corrections are recorded to CFR Part 483 Federequirements. The will follow. The census in this 109 at the time of the consisted of 24 cure (Residents #1 through #23). 483.10(b)(11) NOT (INJURY/DECLINE) A facility must immore consult with the resident involving injury and has the intervention; a significantly (i.e., a existing form of the consequences, or treatment); or a determinant of the resident from the \$483.12(a). The facility must a and, if known, the	Medicare/Medicaid standard sted 7/6/15 through 7/8/16. Quired for compliance with 42 eral Long Term Care Life Safety code survey/report 118 certified bed facility was the survey. The survey sample trent resident reviews ugh #19 and #24 through #28) cord reviews (Residents #20	F 15	Responses to the cited deficient not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the State of Deficiencies. The Plan of Correction is prepared solely a matter of compliance with Feducate Law.	he tement as a eral ified as		
	Water and an	IDEB/CLIDDLIED DEDDESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Facility ID: VA0145

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.

CENTER	S FOR MEDICARE	& WEDICAID SERVICES		- A SALET DI LOTIONI	(X3) DATE SURVEY	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLETED	
		495139	B. WING		07/08/2016	
	PROVIDER OR SUPPLIER		31	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844		
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5	specified in §483. resident rights und regulations as specified in §483.	age 1 roommate assignment as 15(e)(2); or a change in der Federal or State law or ecified in paragraph (b)(1) of	F 157	F 157 Continued from Page 1		
	this section.			1. Resident #3		
	This REQUIREMS by: Based on observ document review was determined to notify the physicial condition for two sample, Resident 1. The facility state a timely manner of bag of Resident of his transfer to the 2. The facility state weight changes p	ecord and periodically update shone number of the resident's we or interested family member. ENT is not met as evidenced ation, staff interview, facility and clinical record review, it hat the facility staff failed to an of a change in resident of 28 residents in the survey as #3 and #9. Iff failed to notify the physician in the facility of the collection are emergency room on 6/30/16. Iff failed to notify the physician of the physician of the physician or orders for		Resident # 3 was identified in this practice. The resident was sent to emergency room via non-emergen transport for super pubic catheter replacement on 06/30/16, per a telephone conversation with the Urologist by facility transportation Based on assessment, LPN charge requested resident # 3 to be evaluate the office but the Urologist was unavailable. The Nurse Practition verified that she was aware reside was being sent to ER for the cather change on 06/30/16. Resident re to facility same day as sent to the hospital.	n aide. e nurse ated at ner ent # 3 eter eturned	
	The findings included in the findings in t		ı	Criterion # 2 - How will the fact identify other residents having potential to be affected by the spractice? Residents that reside in the facilitate potential to be affected by this practice.	the same	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A, BU			E CONSTRUCTION	COMPLETED	
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F 157	Continued From paras being moderated making decisions. Suprapubic cathete. On the following day was observed in his catheter in place drencased in a private and at 3:10 p.m.; 7 p.m. During all obsecollection bag was. A review of the phyrevealed the follow (suprapubic) cath (for BPH (benign prostate) with obsecont the times a day). A review of the nurrevealed, in part, the following with following with following with following with following with following followin	lige 2 ly cognitively impaired for He was coded as having a rr in place. Interest and times, Resident #3 in place, raining into a collection bag, by cover: 7/6/16 at 12:35 p.m. 1/7/16 at 8:10 a.m. and 2:40 in place in the clear yellow. Interest and times, Resident #3 in gorder, written 3/29/16: "SP catheter) to be dide drainage obstatic hyperplasia - enlarged (obstructive) uropathy TID in the following: Interest and times, Resident #3 in gorder, written 3/29/16: "SP catheter) to be side drainage obstatic hyperplasia - enlarged (obstructive) uropathy TID in the following: Interest and times, Resident #3 in gorder, written 3/29/16: "SP catheter) to be side drainage obstatic hyperplasia - enlarged (obstructive) uropathy TID in the following: Interest and times, Resident #3 in gorder with bloody urine in the following: Interest and times, Resident #3 in gorder written in the clear yellow urine." Interest and times, Resident #3 in gorder written in the clear yellow urine." Interest and times, Resident #3 in gorder written in the clear yellow urine." Interest and times, Resident #3 in gorder written in the clear yellow urine." Interest and times, Resident #3 in gorder written in the clear yellow. Interest and times, Resident #3 in gorder written in the clear yellow. Interest and times, Resident #3 in gorder written in the clear yellow. Interest and times, Resident #3 in gorder written in the clear yellow. Interest and times, Resident #3 in gorder written in the clear yellow. Interest and times, Resident #3 in gorder written in the clear yellow. Interest and times, Resident #3 in gorder written in the clear yellow. Interest and times, Resident #3 in gorder written in the clear yellow. Interest and times, Resident #3 in gorder written in the clear yellow. Interest and times, Resident #3 in gorder written in the clear yellow. Interest and times, Resident #3 in gorder written in the clear yellow. Interest and times, Resident #3 in gorder written in the clear yellow. Interest and times, Resident #3 i	F 1	57	Criterion #3 - What measures wiput in place or systematic change made to ensure the practice will reoccur. Beginning on 07/25/16, education be provided by Interim Executive Director (IED), Staff Development Coordinator (SDC) and/or Directo Nursing (DON) to licensed nurses regarding notifying the NP or Atte MD for changes in resident's cond will be completed stating the nurse notify the attending NP or MD whany significant change occurs in a resident's physical, mental or psychological state and this notific must be documented in the medicarecord. This education will be completed by 08/5/16. Same education will be included in orientation for hires. Beginning on 07/25/16, a review of documentation including 24 report orders and nursing/therapy documentation if applicable will be	Il be es not will trof nding ition e must en eation ll cation new	
	catheter bag. Rep - 6/30/16 at 3:26 a (continued) with su continue with blood insertion site"	p.m.: "Resident returned from			completed by the IDT team daily Monday – Friday during the Clini IDT meeting. This review will id residents with a change in condition	cal entify	

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F 157	[name of nurse] that sp cath was placement. Urin Further review of evidence of physical transfer to the end of transfer transfer to the end of transfer tr	page 3 room) at 8:30 p.m. Report from at [name of local hospital] was replaced and x-ray to confirm e is bloody in collection bag" If the nurses notes revealed no sician notification of the blood in ction bag or of Resident #3's mergency room on 6/30/16. Comprehensive care plan for ed 3/29/16 revealed, in part, the ort any changes in bladder status ollow up) with urology as serve for and report any signs and I (urinary tract infection) to O p.m., LPN (licensed practical nterviewed. She regularly cares When asked what should be overs blood in a urinary collection: "If it is a new finding, we would jist." When asked if she had ever a Resident #3's urinary collection: "Most of the time, we will see nmediately after his bag gets ets his catheter changed every actor's office." When asked to of Resident #3's catheter change, she looked in the chart. LPN #4 reveyor a consultant report for ted 6/17/16. The report 20 Fr (French - denotes catheter in pubic) tube changed. F/u (follow for same." When shown the sindicated above and asked about 20/16 describing "clear yellow in 16 describing "bloody urine," LPN in 16 describing "bloody urine," LPN in 16 describing "bloody urine," LPN in 17 mercent in 18 merce	t	areas of follow-up needed. For identified residents, Unit manager (UM) and/or DON will complete change in condition audit form, wincludes physician notification verification. Change of condition will be completed 5 days a week months. Criterion #4 – How will the fact monitor the corrective plan to the deficient practice was corrected and not reoccur? Results of Change in Condition will be reported for review and recommendations to the Quality Assurance/Performance Improve Committee (QA/PI) by the Direct Nursing (DON) or Unit Manage for 3 months or until 100% commits achieved.	a hich audits for 3 cility ensure ected audits	08/05/16

Event ID:8PM911

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F 157	23rd. The nurse urologist should in Resident #3's car insertion site become larger catheter si urologist was awaregularly leaked asked if she could physician had be transfer to the enstated: "I don't k what happened. week. I would has hould have let the urine in the bag. On 7/7/16 at 2:4 was interviewed. referenced nurse physician should urine when it first stated she could assessment/docto the emergence "The doctor should to the emergence "The doctor should that." On 7/7/16 at 5:3 member) #1, the director of nuconcerns. A review of the first largation reveau provide for and drainage and to Observations:	would be a new finding on the practitioner or the doctor or the nave been notified." She stated theter regularly leaked at the ause it was not possible to use a ze for him. She stated the are that the resident's catheter at the insertion site. When d find evidence that the ren notified of Resident #3's mergency room on 6/30/16, she now. There's nothing here to tell That nurse is on vacation this ave written a note. And I know I he doctor know about the bloody	·r	157				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	COMPLETED		
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F 157	output, amount, of A review of the fall Resident's Condithe following: "Not responsible for not physician when: the resident's physician when: the resident's physician when: A decision discharge the resident's physician when: A decision discharge the resident's physician when: A decision discharge in the resident's physician when: A decision discharge in the resident of the properly record in accordance and production and production when we have a small had a catheter because (leakage), urinary or another health taken from the weard taken from the weard taken from the weard taken from the weard to some provider are caused way to avoid beinfollow standards care, and to comproviders. The period of the provider is the provider of the provider of the provider of the providers. The provider are the provider of the provide	color, any sediment" acility policy entitled "Changes in tion or Status" revealed, in part, ursing services will be otifying the resident's attendingThere is significant change in ysical, mental or emotional in has been made to transfer or sident from the facilityAll esident's medical condition must reded in the resident's medical ance with our documentation redures." The catheter (tube) drains urine er. It is inserted into your bladder nole in your belly. You may need use you have urinary incontinence by retention (not being able to that made a catheter necessary, a problem." This information is rebsite in.nih.gov/medlineplus/ency/patient.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		E SURVEY IPLETED
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F 157	weight changes per Resident #9. Resident #9 was a with diagnoses that to: pneumonia, hig pain, dementia, par dysphagia. The most recent Massessment, a quassessment refere resident as being a cognitive decisions requiring extensive staff members for living. Resident #8 limited assistance The physician orde "Daily weight if gain	failed to notify the physician of er the physician orders for admitted to the facility on 3/3/12 at included but were not limited the blood pressure, low back ain, hypothyroid disease, and afterly assessment, with an ence date of 6/14/16, coded the severely impaired to make daily assistance of one or more most of her activities of daily 9 was coded as requiring of one staff member for eating. Lers dated, 5/1/16, documented, ins 2lbs (pounds) or more in a re in a week, notify MD (medical)	F 15	Criterion #1 - How will the caction be accomplished for tresidents found to have been by the deficient practice? Resident # 9 was indicated in practice. On 07/08/16, the ordaily weights for resident # 9 reviewed with the Nurse Prac (NP) and the daily weight ordaiscontinued. A new order was follows: "obtain weekly we Monday and notify MD or NI gain exceeds 4 pounds". Inte Executive Director (IED) con 07/08/16 with NP that she was fluctuations in resident #9's was no concerns were identified.	this der for was titioner er was as written eight on P if weight rim firmed on s aware of	
	Review of the TAF record) for June 2 weights: "6/2/16 - 116.8 6/3/16 - 120.1 (a g 6/4/16 - 122.2 (a g			Criterion # 2 - How will the identify other residents hav potential to be affected by t practice?	ing the	
	6/7/16 - 109.9 6/8/16 - 121.0 (a g 6/15/16 - 120.9 6/16/16 - 123.0 (a			Residents with orders containing notification parameters have the potential to be affected by this	ne	

		IDENTIFICATION ALLIADED.		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 157	the TAR did not re notification of the or nurse practition. Review of the TA following weights "5/3/16 - 118.3 5/4/16 - 120.6 (a Review of the number of the TAR did not renotification of the physician or nurs. The comprehens updated on 3/10/Resident is at ris related to Hx (his infection), Hx of rethan normal concluded) (1)" The "part, "Weight as	rse's notes and the reverse of eveal any documentation of the above weight gains to physician ner. R for May 2016 documented the : gain of 2.3 lbs.)" rse's notes and the reverse of eveal any documentation of the weight gain above to the expractitioner. sive care plan dated, 12/8/15 and 16, documented, "Problems: k for alteration in fluid balance story) of UTI (urinary tract recurrent hyponatremia (lower centration of sodium [salt] in the Approaches" documented in per protocol. Notify MD/NP er) and family of significant	F 15	F 157 Continued from Page 7 An audit was completed by Unit Managers (UM) on 07/25/16 to ca list of residents with orders that contain physician notification parameters for physician orders win the last 60 days, with an emphaweight gain notification parameters. Beginning on 07/28/16, the Direct Nursing (DON) reviewed the Tree Administration Record (TAR) of residents with orders containing physician notification parameters. June and July 2016 to identify an occurrences of missing required notifications. The audit was comon 07/29/16 and identified concewere compiled on a list, reviewe Medical Director and no new ord were received.	vritten asis on ers. etor of eatment s for ny other enpleted erns d by the	
	practical nurse) # #4 was asked to order. When asl the order, LPN # weights, you che previous day and (name of NP) if i An interview was manager; on 7/7 asked to review	s conducted with LPN (licensed #4 on 7/7/16 at 12:36 p.m. LPN review the above physician's ked what the nurse is to do with 44 stated, "If they have daily eck the weight. Look at the d notify (name of doctor) or t's above 2 pounds." s conducted with LPN #3, the unit 1/16 at 1:00 p.m. LPN #3 was the above physician's order. at the nurse is to do with that		Criterion #3 - What measures put in place or systematic charmade to ensure the deficient pwill not reoccur. Education starting on 07/26/16 by Interim Executive Director (Staff Development Coordinator and/or DON to Licensed Nurse regarding proper documentation physician notification related to	provided IED), (SDC) s	

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F 253	daily. You comparday and notify the ordered." An interview was a staff member (ASI on 7/7/16 at 1:08 porder was reviewed what the nurse is a "You check the wellook at the previor You notify the document of the executive dire and ASM #2 were findings on 7/7/16 requested. No further information of the executive directly and ASM #2 were findings on 7/7/16 requested. No further information of the executive directly and ASM #2 were findings on 7/7/16 requested. No further information of the executive directly and ASM #2 were findings on 7/7/16 requested. The facility must maintenance serior of the executive directly and the executive	ed, "You weigh the resident e the weight to the previous doctor or (name of NP) as conducted with administrative M) #2, the director of nursing, o.m. The above physician's ed with ASM #2. When asked expected to do, ASM #2 stated, eight daily. You document it. us day's weight and before. tor or NP if there is a reason." The above of the abov	F	157	F 157 Continued from Page 8 changes when orders have set parameters. This education will be completed by 08/05/16 and the same education will be included in oriental for new hires Being on 07/25/16, the DON (Direct of Nursing) or Unit Manager (UM) v audit the Treatment Administration Record (TAR) 5 days a week for 4 weeks, then 3 times a week for 4 weeks, then 3 times a week for 4 we then weekly for 4 weeks to ensure physician notification occurred as indicated per physician order. Criterion #4 – How will the facilit monitor the corrective plan to ens the deficient practice was correcte and not reoccur? Results of audits for documentation physician notifications for weight changes per parameters will be repo for review and recommendations to Quality Assurance/Performance Improvement Committee (QA/PI) b DON or UM for 3 months or until 1 compliance is achieved.	tor will ty sure ed of orted the by the	08/05/16
	by: Based on obser document review was determined	Vation, staff interview, facility or and clinical record review, it that the facility staff failed to lichair in good repair for one of 25	F 25	53	F253 Criterion #1 - How will the corre action be accomplished for those		

Facility ID: VA0145

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTIO	/N	(X3) DATE SURVEY COMPLETED	
ND PLAN OI	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING				
		495139	B. WING			07/08/2016	
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	01100011	DEFICIENCY)		
F 253		ırvey sample, Resident #6.		253 F253 C	Continued from Page 9		
	A torn area approximately four inches long by one inch wide was observed on the back of Resident #6's wheelchair. Cloth and hard plastic were exposed. The findings include: Resident #6 was admitted to the facility on 6/26/09. Resident #6's diagnoses included but were not limited to: pain, anxiety and dementia (1). Resident #6's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/6/16, coded the resident's cognition as being severely impaired. Section G documented the resident required extensive assistance of one staff with locomotion and was totally dependent on two or more staff with transfers. Resident #6's comprehensive care plan with an onset date of 1/15/15 documented, "Approaches: Provide adaptive/safety equipment such as wheelchair			residents by the de	found to have been affect ficient practice?	ed	
			1	practice. 6 wheelcha by the Di therapy s appropria resident s Criterio identify	# 6 was identified in this On 07/07/16, the back of ir for resident # 6 was repa rector of Rehab (DOR) and creen was completed for the wheelchair. On 07/08/1 # 6's wheelchair was replace on # 2 - How will the facilit other residents having the ld to be affected by the sand?	ty e	
	wheelchair with 7/7/16 at 2:12 p observations, a inches long by the back of Reshard plastic were On 7/7/16 at 4:1 conducted with #6 regarding with the maintenance.	Resident #6 sitting in a specialize a raised back was conducted or m. and 4:00 p.m. During the torn area (approximately four one inch wide) was observed on ident #6's wheelchair. Cloth and re exposed. O5 p.m., an interview was CNA (certified nursing assistant heelchair repairs. CNA #6 states to department inspects reeded repairs but CNAs and	i)	Beginn all resid started Manag	dents with wheelchairs have all to be affected by this prac- ing on 07/07/16, a 100% au- dent wheelchairs in use was by the DON and Nurse ers. The audit was complete 16. All issues identified	otice. dit of	

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	SURVEY
TATEMENT (ND PLAN OF	OF DEFICIENCIES CORRECTION					07/08/2016	
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	Continued From pand inspect wheel was shown the tor wheelchair. CNA area before and the reported to the man of the wheelchair Resident #6's who cleaned during the on Fridays. On 7/7/16 at apprinterview was commember) #3 (the #3 stated torn are if the maintenance area. OSM #3 stated torn are if the maintenance area. OSM #3 stated torn are if the maintenance area. OSM #3 stated torn are if the maintenance area. OSM #6 stated, that." On 7/7/16 at 5:2 member) #1 (the director of nursi above findings. The facility policing and Maintenance properation of all wheelchairs us upon arrival to increation of all wheelchairs us upon arrival to increasing of all wheelchairs us		a n f	253	regarding wheelchair maintenant written up on a maintenance slip detailed report and provided to maintenance department. Identification repairs needed to wheelchairs we completed by 08/05/16. Criterion #3 - What measures put in place or systematic chain made to ensure the deficient pwill not reoccur? Education starting on 07/25/16 provided by IED, SDC, and/or all Licensed Nurses, C.N.A's, housekeeping and maintenance regarding correct procedure for reporting identified repairs neewheelchairs. Education will be completed by 08/05/16 and sate education will be included in off or new hires. Starting on 07/25/16, the Main Director or Maintenance assis audit 2 resident rooms daily Maintenance assis audit 2 resident rooms daily Maintenance assis audit 2 resident equipment is repair.	with fied ill be will be nges oractice was DON to e staff reded to e me orientation ntenance tant will Monday nonthly for	

PRINTED: 07/19/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS	S FOR MEDICARE	& WEDICAID SERVICES				WAL DATE	CLIDVEV
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE	PLETED
		495139	B. WING			07/0	08/2016
	ROVIDER OR SUPPLIER			31	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 278	(rehabilitation) sendepartment upon a Quarterly inspectic scheduled for all comaintenance department of the properties o	will be inspected by rehabilities or the maintenance arrival to the facility. 2. In and cleaning will be hairs by the in-house artment. 3. Chairs which are ken or missing parts or are in be taken out of use exported to the maintenance ab services for repair. 4. If the made and / or parts ken chairs. Wheelchair eat bottoms and seat backs are orn, or otherwise in need of the name for a group of the by disorders that affect the pecific disease. People with the able to think well enough to be able to think we		253	Criterion # 4 – How will the facilimonitor the corrective plan to enthe deficient practice was correct and not reoccur? Results of weekly and monthly author wheelchair maintenance will be reported for review and recommendations to the Quality Assurance/Performance Improver Committee (QA/PI) by the Interine Executive Director (IED) or Maintenance Director for 3 month until 100% compliance is achieve Ongoing quarterly audit results where the presented to QA/PI committee quarterly. F278 Criterion #1 - How will the correction be accomplished for those residents found to have been after by the deficient practice? Resident's # 6, #12, #10, #3 and were identified to be affected by practice.	nsure ted dits be ment hs or ed. vill also rective se ffected	08/05/16

Facility ID: VA0145

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495139	B. WING			07	/08/2016
	PROVIDER OR SUPPLIER			31	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844		
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F 278	assessment must that portion of the Under Medicare a willfully and knowi false statement in subject to a civil m \$1,000 for each a willfully and knowi to certify a materiaresident assessment. Clinical disagreen material and false. This REQUIREM by: Based on staff in review, it was det failed to maintain data set) for 5 of sample, Resident #6's an with an assessment. 1. The facility stare Resident #6's an with an assessment would be developed. 2. Resident # 12 set) assessment incorrectly codes.	no completes a portion of the sign and certify the accuracy of assessment. Ind Medicaid, an individual who ngly certifies a material and a resident assessment is noney penalty of not more than assessment; or an individual who ngly causes another individual all and false statement in a ent is subject to a civil money re than \$5,000 for each		278	 Resident #6 was identified as affected by this practice. Section V0200 on Resident #6's annual MDS with an ARI of 07/15/15 was corrected an MDS submitted on 07/25/16 reflect there is not a check beside the Care Planning Decision area for the dental care area in section V20015I. Resident #12 was identified a affected by this practice. Section V0200 on Resident 12's annual MDS with an A of 06/15/16 was corrected at MDS submitted on 07/25/16 reflect there is not a check beside the Care Planning Decision area for the dental care area in section V20015. Resident #10 was identified affected by this practice. Section V0200 on Resident 10's quarterly MDS with an ARD of 04/13/16 was corrected and MDS submitted on 07/25/16 to reflect there is check beside the Care Plantak Care area for the dental care area in section V20015. 	d to 3. as # RD nd 5 to 6B. as # nected mot a ning l	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) ' /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 27	incorrectly coded as being: "Addres indicated that a d developed, when dental care plan was as "Care Planning I MDS with assess The coding indicated that a developed. 5. The facility star "Care Planning I MDS with assess The coding indicated that a developed.	I's MDS (minimum data set) was in Section V under column "B" ased in Care Plan." The coding ental care plan would be the staff had determined that a would not be developed. If miscoded Section V020015B Decision of Resident #3's annual ament reference date 8/5/15. The ated that a dental care plan bed, when the staff had a dental care plan would not be defined as a dental care plan would not be set of Resident #8's annual sment reference date 6/10/16. The ated that a dental care plan ped, when the staff had a dental care plan would not be affected that a dental care plan ped, when the staff had a dental care plan would not be		278	 Resident #3 was identified affected by this practice. Section V0200 on Reside 3's annual MDS with an of 08/05/15 was corrected MDS submitted on 07/25 reflect there is not a check beside the Care Planning Decision area for the dencare area in section V200 Resident #8 was identified affected by this practice. Section V0200 on Reside 8's annual MDS with an of 06/10/16 was corrected MDS submitted on 07/25 reflect there is not a check beside the Care Planning Decision area for the decare area in section V20 	d as ent # ARD d and 6/16 to ek ent # O15B. ed as ent # ARD ed and 5/16 to ek g ntal	
	Resident #6's ar with an assessm The coding indic would be developed. Resident #6 was 6/26/09. Resident	aff miscoded Section V0200 of annual MDS (minimum data set) nent reference date of 7/15/15. Cated that a dental care plan uped, when the staff had a dental care plan would not be a sadmitted to the facility on ent #6's diagnoses included but to: pain, anxiety and dementia			Criterion # 2 - How will the faction identify other residents having potential to be affected by the spractice? All Residents have the potential affected by the practice regarding checking Column B in section V	the same to be	

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COM	PLETED
		495139	B. WING			07/	08/2016
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LIFE CA				INE	PROVIDER'S PLAN OF CORRECT	TION	(X5)
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F 278	data set), a quarte (assessment referesident's cognition of the cognition	rage 14 s most recent MDS (minimum orly assessment with an ARD rence date) of 4/6/16, coded the on as being severely impaired. Resident #6's annual MDS with documented, "V0200. CAAs sments) and Care Planning: 1. If Care Area is triggered. 2. For are Area, indicate whether a new an revision, or continuation of is necessary to address the fied in your assessment of the care Planning Decision columned within 7 days of completing assessment instrument) (MDS leck column B if the triggered essed in the care plan" A documented in section Area Triggered" and V020015B lecision" for the dental care area est date of 1/15/15 failed to reveal egarding dental care. 5 p.m., an interview was LPN (licensed practical nurse) #1 stated the MDS lecrates the care area triggers for #1 stated the MDS coordinators ent's chart and compares the dent's current diagnoses, status clioning. LPN #1 stated the plan the triggered area of dental care planning decision column for area) didn't necessarily mean the was care planned. LPN #1	or.	278	Criterion #3 - What measure put in place or systematic chamade to ensure the deficient will not reoccur. Education, reviewed and appropriate Division Clinical Reimbursems Specialist, will be provided to coordinators and Social Service RN MDS Coordinator on proprofront of column B in section V0200 RAI manual. Education will completed by 08/05/16. Starting on 07/25/16, MDS nurprovide the Director of Nursina printed copy of section V for MDS completed for 3 months DON will audit this informatic confirm that care plans are defor all concern areas identified checkmarks in column B and plan is not needed, that column checked.	s will be anges practice oved by ent all MDS es staff by her coding per the be arses will en (DON) reach and veloped d by if a care	

PRINTED: 07/19/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING _ AND PLAN OF CORRECTION 07/08/2016 B. WING 495139 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 315 EAST LEE HIGHWAY NEW MARKET, VA 22844 LIFE CARE CENTER OF NEW MARKET (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F278 Continued from Page 15 F 278 F 278 Continued From page 15 stated the check mark indicated the MDS coordinators created a care area worksheet and made a decision whether or not to care plan the Criterion # 4 – How will the facility dental care area. LPN #1 stated the MDS monitor the corrective plan to ensure coordinators reference the RAI manual when the deficient practice was corrected completing MDS assessments. At this time, LPN #1 was asked to provide the corresponding dental and not reoccur? CAA worksheet for Resident #6's annual MDS with an ARD of 7/15/15. Results of DON's audit for correct The corresponding CAA worksheet for the dental coding of Column B in section V0200 care area documented, "Care Plan Y/N (yes/no): will be reported for review and No. Care Plan Considerations: Oral status recommendations to the Quality 08/05/16 stable. No current issues noted. Assurance/Performance Improvement Committee (QA/PI) by the RN MDS The CMS (Centers for Medicare and Medicaid Services) RAI manual documented the following: coordinator or Director of Nursing (DON) for 3 months or until 100% "Coding Instructions for V0200A, CAAs compliance is achieved. Facility staff are to use the RAI triggering mechanism to determine which care areas require review and additional assessment. The triggered care areas are checked in Column A 'Care Area Triggered' in the CAAs section. For each triggered care area, use the CAA process and current standard of practice, evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the

and documentation.

care area. Document relevant assessment information regarding the resident's status. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning,

For each triggered care area, Column B 'Care Planning Decision' is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The 'Care Planning Decision' column

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	COM	COMPLETED		
		495139	B. WING			/08/2016		
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F 278	must be completed the RAI, as indicated the RAI, as indicated which is the dated decision(s) were resident's care in the control of the contr	page 16 ted within 7 days of completing lated by the date in V0200C2, at that the care planning ecompleted and that the plan was completed" 55 p.m., ASM (administrative staff e administrator) and ASM #2 (the large) were made aware of the large staff expecific disease. People with large staff expecific disease expecific disease expecific disease expecific disease. People with large staff expecific disease expecific disease. People with large staff expecific disease expecific disease. People with large staff expection was obtained from the large staff expection was obtained from the large staff expection of the large staff expecti	t d	78				

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION		COMPLETED	
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F 278	Resident # 12's m set), an annual as (assessment referesident # 12 as to understand oth as scoring 15 of a Interview for Men Cognitive Pattern cognitively intact. A review of "Section annual MDS asserevealed that "# 1 under column "A" documented as: Resident # 12's replan with a revisitient evidence any documented as: During an intervity LPN (licensed previewed ander column B care Plan." LPN (Bart Plan) depends or reviewed Reside under column B Care Plan." LPN "B. Care Planning and care Planning B Care Planning B Care Planning Set Planning Se	n/health/topics/bipolar-disorder/i nost recent MDS (minimum data assessment with an ARD rence date) of 6/15/16, coded understood by others and able ers. Resident # 12 was coded a possible 15 on the Brief tal Status in Section C, s, indicating the resident was	s 1	278			

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		405420	B. WING			07/	08/2016
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F 278	plan or not. Wher for completing the stated she used the Instrument manual. During an intervier RN (registered nurses, they were stated she used the RN # 2 was shown Dental Care and a Planning Decision that if that is check evaluate the Resistant care plan. RN # 2 worksheet # 15 Decision documented that reviewed and that care plan dental care p	en decide if they will do a care in asked what resource they use MDS assessments LPN # 1 in RAI (Resident Assessment al. W on 7/7/16 at 2:55 p.m. with rse) # 2, an MDS coordinator, in Resident # 12's MDS for asked what it meant if "B. Care I" was checked. RN # 2 stated ked then they must go and dent and decide whether to do a 2 provided a copy of the CAA PENTAL CARE; this worksheet Resident # 12's record was the MDS staff decided to not care. RN # 2 was asked what es to complete the MDA d RN # 2 stated that she uses At this time RN # 2 was asked if and copy of the instructions	9	278			
	incorrectly code as being: "Addre	d in Section V under column "B" essed in Care Plan." The coding					

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The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date of 4/13/16 coded the resident as having a six out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring the assistance of staff for all activities of daily living. In section L 0200 the resident was coded as having no teeth. Section V0200 of Resident #10 's admission MDS with an ARD of 1/8/16 documented, "V0200. CAAs (care area assessments) and Care Planning: 1. Check column A if Care Area is triggered. 2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (resident assessment instrument) (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan..." A

1/8/16 with diagnoses that included but were not

limited to: arthritis, dementia, high blood pressure, kidney disease and diabetes.

check mark was documented in section V020015A "Care Area Triggered" and V020015B "Care Planning Decision" for the dental care area. Review of the comprehensive care plan initiated on 1/8/16 did not evidence documentation of a dental plan of care.

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findings.

On 7/7/16 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the

No further information was provided prior to exit.

4. The facility staff miscoded Section V020015B "Care Planning Decision" of Resident #3's annual MDS with assessment reference date 8/5/15.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		ICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE C	(X3) DAT	(X3) DATE SURVEY COMPLETED		
		495139	B. WING			07	/08/2016	
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F 278	would be develo determined that developed. Resident #3 was 2/19/15 and readiagnoses include a stroke with one enlarged prostat kidney disease. (minimum data assessment refibeing moderate decisions. A review of Resident assessment reficheck mark in the "Care Planning directions on the triggered care aplan." A review of Resident and the plan dated 8/9/dental care plan. On 7/7/16 at 1: nurse) #1 confibated a dental care plan decording to the worksheets daintend to develobeing without the strong to the plan without the strong to the plan without the strong to the strong without t	ated that a dental care plan ped, when the staff had a dental care plan would not be admitted to the facility on dmitted on 3/29/16 with ding, but not limited to: history of e-sided paralysis, depression, the with obstruction, and chronic On the most recent MDS set), a quarterly assessment with erence date, he was coded as by cognitively impaired for making dident ##3's annual MDS with an erence date 8/5/15 revealed a he box for section V020015B Decision". According to the embox has addressed in the care sident #3's comprehensive care 15 revealed no evidence of a notation. 30 p.m., LPN (licensed practical read that Resident #3 did not care plan. She stated that e CAA (care area assessment) ted 8/5/15, the facility staff did not op a care plan due to Resident #3		278				

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F 278	"Care Planning D MDS with assess The coding indica would be developed determined that a developed. Resident #8 was 6/27/13 with diag to: chronic obstrohronic back pair most recent MDS assessment date coded as being decisions. Further review or revealed a check V020015B "Care to the directions the triggered carplan." A review of Resiplan dated 3/23/dental care plan. On 7/7/16 at 1:3 nurse) #1 confir have a dental care care dental c	aff miscoded Section V020015B Decision" of Resident #8's annual ament reference date 6/10/16. The ated that a dental care plan bed, when the staff had a dental care plan would not be admitted to the facility on proses including, but not limited uctive pulmonary disease, and anxiety disorder. On the 6 (minimum data set), an annual ed 6/10/16, Resident #8 was cognitively intact for making daily on the MDS, "Check column B if the area is addressed in the care dent #8's comprehensive care dent #8 did not are plan. She stated that ac CAA (care area assessment) ac CAA (care area assessment) ac CAA (care plan due to Resident #8 did not are plan due to Resident #8		78				

Facility ID: VA0145

TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	The resident has the incompetent or othe incapacitated under participate in plant changes in care and A comprehensive within 7 days after comprehensive as interdisciplinary terphysician, a regist for the resident, and disciplines as deter and, to the extent the resident, the relegal representative and revised by a treach assessment. This REQUIREMED by: Based on staff in and clinical record the facility staff far comprehensive cain the survey same.	ne right, unless adjudged herwise found to be en the laws of the State, to hing care and treatment or and treatment. Care plan must be developed the completion of the sessment; prepared by an arm, that includes the attending ered nurse with responsibility and other appropriate staff in ermined by the resident's needs, practicable, the participation of esident's family or the resident's re; and periodically reviewed eam of qualified persons after early and for two of 28 residents aple, Residents #27 and #7. If failed to review and revise the are plan for Resident #27 after all altercation with another	F	280	F280 1.) - Resident # 27 Criterion #1 - How will the correaction be accomplished for those residents found to have been affeby the deficient practice? Resident # 27 was identified in this practice. The care plan for resident was reviewed and revised on 07/07 by the DON, Social Services Director (SSD) and the LPN Unit Manager to reflect resident's behaviors on 06/14/16.	ected s t # 27 7/16 ctor	
	2. The facility stat	ff failed to review and revise the					

TATEMENT	OF DEFICIENCIES F CORRECTION	(XI) ENGLISHED TO SELECTION OF THE PROPERTY OF	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	
		495139	B. WING		07/08/2016
	PROVIDER OR SUPPLIER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 15 EAST LEE HIGHWAY IEW MARKET, VA 22844	
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
con	Continued From pa comprehensive ca Resident #7's diet	re plan for a change in	F 280	F280 Continued from Page 24 Criterion # 2 - How will the face	ility
	The findings include: 1. The facility staff failed to review and revise the comprehensive care plan for Resident #27 after		identify other residents having potential to be affected by the s practice?	the ame	
	comprehensive care plan for Resident #27 after she had a physical altercation with another resident on 6/14/16. Resident #27 was admitted to the facility on 8/19/14 and most recently readmitted on 10/14/15 with diagnoses including, but not limited to: Alzheimer's disease, coronary artery disease, and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 5/18/16, Resident #27 was coded as being severely cognitively impaired for making daily decisions, having scored six out of 15 on the BIMS (brief interview for mental status). She was coded as not having demonstrated any behaviors directed toward			All residents who reside in the fall have the potential to be affected practice. On 07/25/16, the Social Services Director, Unit Manager completed an 100% audit of all reare plans to ensure any resident resident altercations within the plant were appropriately updated behavioral care plans. Care Plant been revised to reflect any concidentified.	by this c, DON resident t to past 3 ated on ans have erns
	A review of the not revealed a note of approximately 1:10 be wheeling hers hallway when she Resident stated to were you are got then smacked [Find Resident has no Resident will be that area. Resident power this altercal	look back period. urses' notes for Resident #27 vritten 6/14/16 at 3:14 p.m.: "At 30 p.m., resident was noted to elf in her wheelchair up the [sic] a ran into another resident. To her, 'I wish you would watching. I know you can see me.' She Resident #27] in the right forearm s/s of bruising to that area. monitored for any discoloration then the tide of the tide of the tide. Will continue to monitor." vrote this note was not available ing the survey.	e o	Criterion #3 - What measures put in place or systematic charmade to ensure the deficient provide and the provide of the provid	ractice , SDC tion to rvice tion of cluding This

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495139	B. WING			07/08/2016	
	PROVIDER OR SUPPLIER	MARKET		31	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE IATE	(X5) COMPLETION DATE
F 280	F 280 Continued From page 25 A review of the care plan dated 4/15/16 revealed no information regarding this altercation. On 7/8/16 at 9:10 a.m., LPN #4 was interviewed.		F 280		F280 Continued from Page 25 The DON, Unit Managers (UM) and	d/or	
	residents are involother, she stated sand keep them awas possible. When members would knapart, she stated: out for. Everybody She stated she would tag both resid stated this was the	should be done when two ved in an altercation with each the would split the residents up ray from each other for as long in asked how other staff how to keep these residents "Everyone knows who to look y knows everybody up here." build fill out an incident report, ents for "alert charting." She e facility's process for close			Social Services will audit orders, incident reports and 24 hour reports daily Monday through Friday during clinical IDT meeting to ensure care plans are reviewed and revised as needed. Audits will be completed d Monday through Friday for 3 month	g the	
	monitoring of residents for any reason. She stated alert charting happens for three days on every shift following any sort of major event or change. When asked if the care plan should be updated, she stated: "We normally don't update the care plan. We notify the doctor or the family. But it is understood. Everyone knows which residents to keep apart."				Criterion # 4 – How will the facili monitor the corrective plan to ensithe deficient practice was correct and not reoccur? Results of audits for care plans being updated after all incidents will be	sure ed	
	staff member) #1, ASM #2, the direct these concerns. A review Resident # sure there were n	D a.m., ASM (administrative the executive director, and stor of nursing, were informed of ASM #2 stated she would 27's care plan again to make o updates. She stated the care been updated with this incident.			reported for review and recommendations to the Quality Assurance/Performance Improveme Committee (QA/PI) by the MDS coordinator, Director of Nursing (Dor Unit Manager (UM) for 3 month until 100% compliance is achieved.	OON) is or	08/05/16
	Care Plan" reveal "Review of the ca and as needed to	cility policy entitled "Resident led, in part, the following: re plan is done at least quarterly reflect the resident's current goals, care, treatment and	/				

Facility ID: VA0145

PRINTED: 07/19/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		495139	B. WING			07/0	8/2016
	PROVIDER OR SUPPLIER RE CENTER OF NEW	MARKET	STREET ADDRESS, CITY, STATE, ZIP COI 315 EAST LEE HIGHWAY NEW MARKET, VA 22844				
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Basic Nursing, Ess (Potter and Perry, reference for care a written guideline promoting continui criteria to be used care. The written nursing care priori professionals. The coordinates resour care. A correctly feasy to continue of the patient's state nursing diagnosis no longer approprian. An out of da compromises the 2. The facility staff comprehensive care Resident #7's diet Resident #7 was a with diagnoses that to: anxiety, dysuring dementia, edema depression, and of the most recent lassessment, a quassessment refer resident as being cognitive daily decoded as requiring more staff members.	tion was provided prior to exit. Sentials for Practice, 6th edition, 2007, pages 119-127), was a plans. "A nursing care plan is for coordinating nursing care, ty of care and listing outcome in the evaluation of nursing care plan communicates ties to other health care e care plan also identifies and roes used to deliver nursing ormulated care plan makes it are from one nurse to another. The task changed and the and related interventions are interested interventions. If failed to review and revise the are plan for a change in requirements. In admitted to the facility on 6/8/15 at included but were not limited a, high blood pressure, pain, hypothyroid disease, osteoporosis. MDS (minimum data set) userterly assessment, with an rence date of 5/13/16, coded the severely impaired to make cisions. The resident was gextensive assistance of one overs for all of her activities of dailing in which she required limited		280	F280 2.) Resident #7 Criterion #1 - How will the coraction be accomplished for thorresidents found to have been at by the deficient practice? Resident # 7 was identified as be affected in this practice. The nutroare plan for resident # 7 was revand revised on 07/07/16 by the E of Nursing (DON), Food Service Director (FSD) and the LPN Unit Manager to reflect correct diet.	ing ritional viewed Director	

Facility ID: VA0145

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF		MULTIPLE CONSTRUCTION UILDING		SURVEY PLETED
		405400	B. WING		10	07/	08/2016
		495139	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	1 017	00,2010
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET				31	5 EAST LEE HIGHWAY EW MARKET, VA 22844		
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 280	"DIET: Regular." The orders were s 6/29/16. Review of the care reviewed on 5/23/ "Problems: Reside by abnormal labs fluctuation, leaves for most meals, cl problem." A dietary commundocumented, "Pleand dysphagia (d. An interview was practical nurse) # at 9:58 a.m. Whethickened liquids, you asking that?" responsible for upstated, "Nursing." An interview was staff member (As on 7/7/16 at 12:3 responsible for upstated, "The floor basically all nurs should be up to a above was share. The facility policy documented in proper at least quitable and the stage of	ders July 2016" documented, his order was dated 10/14/15. igned by the physician on e plan dated, 6/8/15 and 16, documented in part, ent is at nutrition risk, evidenced (laboratory test results), weight 25 % or more of food uneaten hewing problem, swallowing nication form dated 10/10/15, ease change diet to thin (liquids) iet texture)." conducted with LPN (licensed 2, the unit manager, on 7/7/16 in asked if Resident #7 was on LPN #2 stated, "No, why are When asked who is podating the care plans, LPN #2 conducted with administrative SM) #2, the director of nursing, 3 p.m. When asked who is podating the care plans, ASM #2 r nurses, MDS, unit managers, es." When asked if the care plan date, ASM #2 stated, "Yes." The ed with ASM #2 at this time. by, "Resident Care Plan" overt, "Review of the care plan is arterly and as needed to reflect the problems, goals, and the care plans, goals, and the care plans, goals, problems, goals, g		280	Criterion #2 - How will the faidentify other residents having potential to be affected by the practice? All residents who reside in the f have the potential to be affected practice. On 07/25/16, the Unit Managers, DON and/or Food Sc Director completed an 100% au resident nutrition care plans to ediets are correct and any change the past 3 months were approprupdated. As of 07/26/16, all nucare plans for residents in house been reviewed and reflect curredietary problems and approached. Criterion #3 - What measure put in place or systematic characteristic plans for the deficient will not reoccur. Beginning on 07/25/16, the IE and/or DON will provide educ licensed nurses and Food Serv Director and Assistant Food Sc Director related to review and of care plans after any dietary communication slips or order of This education will be comple 08/05/16.	racility by this ervice dit of all ensure all es within iated atritional e have ent es. s will be anges practice CD, SDC ation to ices ervices revision change.	

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES				3) DATE	SURVEY
STATEMENT AND PLAN OI	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION (X:	COMPL	
		495139	B. WING			07/0	8/2016
	ROVIDER OR SUPPLIER	MARKET		31	TREET ADDRESS, CITY, STATE, ZIP CODE 15 EAST LEE HIGHWAY EW MARKET, VA 22844		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT 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)	E NTE	(X5) COMPLETION DATE
F 280	Williams and Wilki documented, "A will communication too members that help	age 28 amentals of Nursing Lippincott ns 2007 pages 65-77 ritten care plan serves as a bl among health care team as ensure continuity of care plan is a vital source of	F2	280	F280 Continued from Page 28 The DON, Unit Managers and/or Food Services Director will audit orders, 2 hour reports and dietary communicat forms daily, Monday through Friday during the clinical IDT meeting to ensure care plans are reviewed and	tion	
	information about and goals. It contractiving the goal and is used to directly revise and update there are changes with new orders	the patient's problems, needs, ains detailed instructions for s established for the patient ect careexpect to review, the care plan regularly, when in condition, treatments, and			revised as needed. Audits will be completed daily, Monday through Friday for 3 months. Criterion # 4 – How will the facilit monitor the corrective plan to enst the deficient practice was correcte and not reoccur?	sure ed	
F 281 SS=D	p.m. 483.20(k)(3)(i) SE PROFESSIONAL The services proving must meet profes This REQUIREM by: Based on observents	RVICES PROVIDED MEET	F	281	Results of audits for care plans being reviewed and updated after dietary changes will be reported for review recommendations to the Quality Assurance/Performance Improveme Committee (QA/PI) by the Director Nursing (DON), Food Service Director or MDS Coordinator for 3 months of until 100% compliance is achieved	ent r of ector, or	08/05/16
	was determined to follow profession clarification for or sample, Residen The facility staff to suprapubic cathe	hat the facility staff failed to al standards of practice for orde ne of 28 residents in the survey			F281 Criterion #1 - How will the correaction be accomplished for those residents found to have been affe by the deficient practice? Resident # 3 was identified in this	•	

Facility ID: VA0145

TATEMENT OF BEHOLES		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		495139	B. WING			07/0	8/2016
	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY		
LIFE CAF	RE CENTER OF NEW	MARKET		NI	EW MARKET, VA 22844		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	Resident #3 was a 2/19/15 and readn diagnoses including a stroke with one-enlarged prostate kidney disease. Of (minimum data sea an assessment re #3 was coded as impaired for making a suprapulation of the following of was observed in his suprapublic cathetage, encased in a p.m. and at 3:10 p.m.	Ide: Indmitted to the facility on inited on 3/29/16 with ag, but not limited to: history of sided paralysis, depression, with obstruction, and chronic on the most recent MDS at), a quarterly assessment with ference date, 5/4/16, Resident being moderately cognitivelying decisions. He was coded as pic catheter in place. Itates and times, Resident #3 are draining in to a collection aprivacy cover: 7/6/16 at 12:35 a.m.; 7/7/16 at 8:10 a.m. and all observations, the urine in the sclear yellow. In a.m.: "Resident noted to have allood in urine this a.m. (morning) are urine after going out for " To p.m.: "Cath (catheter) bag use to a blood clot. Urine is red in There has been no c/o in or discomfort." In clotting, draining mostly pure to the order to flush cath X 3 (three each shift) and that she would		281	practice. The PRN catheter flush of dated 06/19/16 was discontinued a 07/13/16. A new PRN catheter flush order was written on 07/13/16 white contained clarified orders regarding frequency, volume and type of flust solution. Criterion #2 - How will the facility other residents having the potential to be affected by the sampractice? All residents residing in the facility the potential to be affected by this practice. On 07/13/16, a LPN Unit Manage completed a 100% audit of all cather flush orders written in the last 30 and reviewed Urinary Catheter can plans for residents identified with catheters. All orders were completed a 100% and orders were identified to flush orders were identified as not complete, licensed nurse notified the Physic clarification. This review will be completed by 08/01/2016.	ss of ash ach ag shing lity the ame by have a start and ssues affect. Charge ers to r any a	

STATEMENT OF DEFICIENCIES		(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED		
		495139	B. WING			07/	08/2016
	ROVIDER OR SUPPLIER			ST 31	IREET ADDRESS, CITY, STATE, ZIP CODE IS EAST LEE HIGHWAY EW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 281	revealed the follow (suprapubic) cath for BPH (benign p prostate) with obset (three times a day the following order practitioner: "Flust (every shift) due to practitioner] will for A review of the TA record) for Reside that his suprapubic ordered on 6/19/1. A review of the condered	ysician's orders for Resident #3 ving order, written 3/29/16: "SP (catheter) to bed side drainage rostatic hyperplasia - enlarged (obstructive) uropathy TID)." The review also revealed r, written 6/19/16 by the nurse th cath X 3 (three times) q shift o clots. [Name of nurse ollow up in am (morning)." AR (treatment administration ent #3 for June 2016 revealed dic catheter was flushed as 6, 6/20/16 and 6/21/16. Imprehensive care plan for d 3/29/16 revealed, in part, the ollow up) with urology as te Foley per order. If unable to logy." I p.m., LPN (licensed practical gularly cares for Resident #3, LPN #4 was asked to review TAR referenced above (which dials) for flushing Resident #3's as asked what kind of solution of the catheter, and how much of used. LPN #4 stated: "I couldn' loesn't say. I probably did about), but I don't know. I am sure I ne." When asked if the order cified the amount and type of LPN #4 stated: "Definitely. It in clarified."	t:	281	Criterion #3 - What measures wiput in place or systematic changemade to ensure the deficient prawill not reoccur. Beginning on 07/25/16, the IED, Sand/or DON will provide education licensed nurses, the Nurse Practiticand the Attending Physician/Medi Director regarding specifics require a complete Physicians order with emphasis on catheter flush orders. Catheter flush orders must include frequency, volume and type of soft to be used. The education will also include that any changes related to flushes must be updated in the resurrance Catheter care plan. This education will be completed by 08/05/16. The DON and/or Unit Managers will audit orders and 24 hour report daily, Monday through Friday duthe clinical IDT meeting to ensur orders are complete when writter clarified when identified by the IUM to not be complete. Audits completed daily, Monday through Friday for 3 months.	es ctice SDC on to oner ical red for lution so o sident's (UM) orts iring re all and/or DON or s will be	
1	On 7/7/16 at 2:4	5 p.m., LPN #2, a unit manager,					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		E SURVEY PLETED
		495139	B. WING			07/0	08/2016
	PROVIDER OR SUPPLIER	MARKET		315	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844		
(X4) ID PREFIX TAG	(FACH 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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	was interviewed. A referenced order a nurses should have nurse practitioner of flushing solution. On 7/7/16 at 5:30 member) #1, the ethe director of nurse concerns. On 7/8/16 at 12:30 professional stand for catheter irrigations its own policy. A review of the fact Irrigations revealed provide for and madrainage and to accompany of care must addrainage and to accompany of the fact Orders/Transcript related to the request and the request to the request through a small had catheter because (leakage), urinary urinate), surgery for another health taken from the wear through through a small had catheter flushing.	When shown the above and TAR, LPN #2 stated the e clarified the order with the regarding amount and type of p.m., ASM (administrative staff executive director, and ASM #2, sing, were informed of these open., ASM #2 was asked what lard of practice the facility uses fon. She stated that the facility years are constant urinary definition constant urinary deminister medicationThe planessthe type of solution, uency of the irrigation." Collity policy entitled "Physician's ion" revealed no information uired contents of the order for eation was provided prior to exit. Catheter (tube) drains urine to the inspect of		281	Criterion # 4 – How will the facimonitor the corrective plan to enthe deficient practice was correct and not reoccur? Results of audits for order comple and necessary care plan updates were ported for review and recommendations to the Quality Assurance/Performance Improvem Committee (QA/PI) by the MDS coordinator, Director of Nursing (or Unit Manager (UM) for 3 montuntil 100% compliance is achieved.	teness vill be nent DON)	08/05/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
AND PLAN OF	ONNEOTION	HT-TAM				07/0	8/2016
		495139	B. WING		EET ADDRESS, CITY, STATE, ZIP CODE	1 0770	0/2010
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET				315	EAST LEE HIGHWAY W MARKET, VA 22844		
(X4) ID PREFIX TAG	/CACH DESIGNENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 281 F 309 SS=D	and Perry, 6th edi physician's order irrigation solution sterile solution in 483.25 PROVIDE HIGHEST WELL Each resident mu provide the neces or maintain the h	damentals of Nursing, Potter tion, page 1362: "Assess for type of irrigation and to usePrepare prescribed sterile graduated cup." CARE/SERVICES FOR BEING ast receive and the facility must essary care and services to attain ighest practicable physical, thosocial well-being, in the comprehensive assessment		309	F309 Criterion #1 - How will the caction be accomplished for tresidents found to have been by the deficient practice?	those	
	by: Based on staff is and clinical reconstruction the facility staff of for one of 28 research #9. The facility staff order to notify the facility staff or the facility staff o	nterview, facility document review of review, facility document review of review, it was determined that ailed to follow physician's orders sidents in the survey sample, failed to follow the physician of a daily weight gain or more in one day for Resident stude: It admitted to the facility on 3/3/12 that included but were not limited high blood pressure, low back pain, hypothyroid disease, and	2		Resident # 9 was identified in practice. On 07/08/16, the ordaily weights for resident # 9 reviewed with the Nurse Practice (NP) and the daily weight ord discontinued. A new order was follows: "obtain weekly we Monday and notify MD or N gain exceeds 4 pounds". Into Executive Director (IED) con 07/08/16 with NP that she we fluctuations in resident #9's no concerns were identified.	der for was etitioner der was vas written veight on P if weight erim nfirmed on as aware of weight and	f

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				CONSTRUCTION	(X3) DATE SURVEY COMPLETED
TATEMENT O ND PLAN OF	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		AMIRO 1004C
		495139	B. WING		07/08/2016
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET			315	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY 5 W MARKET, VA 22844	
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD DC
F 309	Continued From p	age 33	F 309	F309 Continued from Page 33	
	The most recent assessment, a quassessment refer resident as being cognitive decision requiring extensions staff members for living. Resident limited assistance	MDS (minimum data set) parterly assessment, with an ence date of 6/14/16, coded the severely impaired to make daily as. The resident was coded as we assistance of one or more or most of her activities of daily 49 was coded as requiring e of one staff member for eating		Criterion # 2 - How will the far identify other residents having potential to be affected by the practice? Residents with orders containing notification parameters have the potential to be affected by this parameters have the potential to be affected by University of the process of the pro	g g g g g g g g g g g g g g g g g g g
	"Daily weight if g day or 4 lb. or m doctor) daily." Review of the Tarecord) for June weights:	ders dated, 5/1/16, documented, ains 2lbs (pounds) or more in a ore in a week, notify MD (medicated) when the second streament administration are 2016 documented the following	al	Managers (UM) on 07/25/16 to a list of residents with physicia notification parameters with an emphasis on weight orders for physician orders written in the days. Beginning on 07/28/16, the Di	all last 60
	6/3/16 - 120.1 (6/4/16 - 122.2 (a gain of 3.3.lbs) a gain of 2.2 lbs.)		Nursing (DON) reviewed the Administration Record (TAR) residents with orders containing	of
	6/15/16 - 120.9	a gain of 11.1 lbs.)		physician notification parame June and July 2016 to identify occurrences of missing requir	ters for any other
	Review of the the TAR did no notification of physician or n	nurse's notes and the reverse of of reveal any documentation of the above weight gain to the urse practitioner. TAR for May 2016 documented this:		notifications. The audit was on 07/29/16 and identified co were compiled on a list, review Medical Director and no new were received.	completed incerns weed by the

5/4/16 - 120.6 (a gain of 2.3 lbs.)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
1101 111101		405420	B. WING			07/0	8/2016
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET		B. WIITO	STF 315	REET ADDRESS, CITY, STATE, ZIP CODE S EAST LEE HIGHWAY W MARKET, VA 22844			
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309 Continued I	Poview of the nur	age 34 se's notes and the reverse of eveal any documentation of	F	309	F309 Continued from Page 34		
	notification of the physician or nurse physician or nurse updated on 3/10/7 Resident is at risk related to Hx (his infection), Hx of related to Hx of related to Hx (his infection), Hx of related to Hx of r	above weight gain to the epractitioner. ve care plan dated, 12/8/15 and 16, documented, "Problems: for alteration in fluid balance tory) of UTI (urinary tract ecurrent hyponatremia (lower tentration of sodium [salt] in the Approaches" documented in per protocol. Notify MD/NP er) and family of significant			Criterion #3 - What measures we put in place or systematic changemade to ensure the deficient provided by Interim Executive Director (IED), Staff Development Coordinator (SDC) and/or DON Licensed Nurses regarding proper documentation of physician notificated to weight changes when chave set parameters. This education will be included in orie for new hires Beginning on 07/25/16, the DON Unit Manager (UM) will audit the Treatment Administration Reconsection (TAR) 5 days a week for 4 weeks 3 times a week for 4 weeks, therefor 4 weeks to ensure physician notification occurred as indicated physician order.	ges actice n will ent to or fication orders ion will he same entation N or he rd ks, then h weekly	

order was reviewed with ASM #2. When asked

STATEMENT (S FOR MEDICARE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A, BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495139	B. WING			07/08	/2016
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET				315	EET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY W MARKET, VA 22844		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Continued From p what the nurse is "You check the we Look at the previo You notify the doo In "Fundamentals Patricia A. Potter Inc; Page 419. "I directing medical obligated to follow believe the order clients." The executive dia and ASM #2 wer findings on 7/7/1		F	309	F309 Continued from Page 35 Criterion # 4 – How will the fact monitor the corrective plan to extend the deficient practice was corrected and not reoccur? Results of audits for documentation physician notifications per paramovella be reported for review and recommendations to the Quality Assurance/Performance Improved Committee (QA/PI) by the DON for 3 months or until 100% compilis achieved.	ility ensure ected ion of neters ement or UM	08/05/16
F 31 SS=I	(1) Barron's Dict Non - Medical R Chapman, page 483.25(a)(2) TR IMPROVE/MAIN A resident is giv services to main specified in para This REQUIRE by: Based on obse document reviewas determine	EATMENT/SERVICES TO	d es	F 311	Criterion #1 - How will the coaction be accomplished for the residents found to have been a by the deficient practice? Resident # 4 was identified in the practice. An order to disconting restorative dining services for re	his nue resident #	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMPLETED
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	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO 315 EAST LEE HIGHWAY NEW MARKET, VA 22844				
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F 311	The facility staff facility staff facility staff facility staff facility staff facility staff for Resident The findings included Resident #4 was with diagnoses in chronic kidney diagnoses in chronic	for one of 28 residents in the esident #4. ailed to provide restorative as recommended by the therapy #4. ade: admitted to the facility on 2/9/16 acluding, but not limited to: sease, diabetes, congestive high blood pressure. On the 6 (minimum data set), a quarterly assessment reference date is coded as being severely red for making daily decisions, ree out of 15 on the BIMS (brief of the status). She was coded as ensive assistance of staff for bed g, personal hygiene and bathing. Resident #4 during the survey	F 311	Criterion # 2 - How will the facilidentify other residents having to potential to be affected by the sapractice? All residents on restorative case to have the potential to be affected by practice. A 100% audit of residents with or for restorative services, including restorative dining was performed Unit Manager/Restorative Nurse 07/21/16, to ensure restorative prowere documented, and care plant reflect improvement, decline, continuation or discontinuation or restorative programs. No other is were identified.	he ame Dad y this ders by on ograms ed to
	wheelchair beside attempting to fee at feeding; close times; at 2:50 p. in bed with eyes - 7/7/16 at 8:10 wheelchair beside attempting to fee at feeding; close times; at 11:15 bed with eyes cl	D p.m Resident #4 in the her bed, eating lunch, and herself. Resident #4 was slowed her eyes between bites four m Resident #4 was lying supine closed. a.m Resident #4 seated in the her bed; eating breakfast, and herself. Resident #4 was slowed her eyes between bites nine Resident #4 was lying supine in osed; at 2:35 - Resident #4 was led with eyes closed.	e	Criterion #3 - What measures we put in place or systematic changemade to ensure the deficient provided in the	ges actice ided by to all sistants

Facility ID: VA0145

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	OF PROVIDER OR SUPPLIER CARE CENTER OF NEW MARKET		J	315	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844		
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	Continued From There was no ev services for dinin during these obs A review of Resid a document entit Referral" dated 6 revealed, in part would benefit fro improve attention improve meal pa (maximum) verb swallowing and manner. Recomper week; 2X/da diet but is requir meals. To begin The form was si nurse) #2, the re A review of Res administration restorative serv and that Reside services since to A review of the evidence regard services. A review of the 4/29/16 failed to	page 37 idence of any restorative nursing g being provided to Resident #4 ervations. dent #4's clinical record revealed led "Restorative Nursing 6/1/16. A review of this document the following: "Pt (patient) metorative assistance to not task while eating and to acing. Pt. requires max all cueing to take bites after to chew and swallow in a timely mended Frequency 7 X (times) by. Patient is tolerating a regular ing an hour or more to complete a Sat. (Saturday) June 4, 2016." gned by LPN (licensed practical estorative nursing coordinator. ident 4's TARs (treatment lecords) revealed that the inces were stopped on 6/22/16, and #4 had not received restorative.		311	Beginning on 07/25/16, the Unit Manager (UM), restorative nurse of DON will audit 100% of restorative load weekly for 3 months to ensure restorative services are being comper physician orders. Criterion # 4 – How will the faci monitor the corrective plan to extend the deficient practice was correct and not reoccur? Results of audits for documentation restorative services per physician will be reported for review and recommendations to the Quality Assurance/Performance Improver Committee (QA/PI) by the DON, Restorative Nurse or Unit Manage (UM) for 3 months or until 100% compliance is achieved.	ility nsure cted on of orders ment	08/05/16
	manager, was restorative service check the char	50 p.m., LPN #3, the unit asked if Resident #4 was receivir vices. She stated that she would t and speak with LPN #2, the sing coordinator.	ng				

PRINTED: 07/19/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 07/08/2016 B. WING 495139 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 315 EAST LEE HIGHWAY LIFE CARE CENTER OF NEW MARKET **NEW MARKET, VA 22844** (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG F 311 F 311 Continued From page 38 On 7/7/16 at 5:30 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. On 7/8/16 at 10:45 a.m., LPN #2 was interviewed. LPN #2 stated that she was not working during the week of 7/22/16 when the restorative services for Resident #4 were discontinued. LPN #2 stated that she was told that Resident #4 had achieved maximum benefit from the services. She stated when she returned from her vacation, she instructed her staff members that they needed an order to discontinue the services, and that documentation needed to be gathered and

A review of the facility policy entitled "Restorative Dining Overview" revealed, in part, the following: "Establish goals to be achieved by the resident through the program and include the information for care planning. Assure that the resident is assisted by the assigned restorative aide at each meal...Periodic assessment of any progress, offering the opportunity to reassess and modify the program to further enhance the resident's quality of life. Establish an individual maintenance program after the resident has reached their highest level of functioning. Continue to monitor the resident for signs of regression and continue to document for the maintenance program."

verified before restorative services could stop.

No further information was provided prior to exit. F 315 483.25(d) NO CATHETER, PREVENT UTI, SS=D RESTORE BLADDER

F315

Criterion #1 - How will the corrective F 315 action be accomplished for those residents found to have been affected by the deficient practice?

ATFMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY
		495139	B. WING			07/0	8/2016
	ROVIDER OR SUPPLIER			315	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY 5 W MARKET, VA 22844		
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F 315	assessment, the faresident who enter indwelling catheter resident's clinical of catheterization was who is incontinent treatment and ser infections and to refunction as possible. This REQUIREMI by: Based on observed document review was determined to provide care and catheter (1) for our catheter was determined to catheter (1) for our catheter individuals.	dent's comprehensive acility must ensure that a rs the facility without an r is not catheterized unless the condition demonstrates that is necessary; and a resident of bladder receives appropriate vices to prevent urinary tract restore as much normal bladder ole. ENT is not met as evidenced ration, staff interview, facility and clinical record review, it hat the facility staff failed to services for a suprapubic ne of 28 residents in the survey		315	Resident # 3 was identified in the practice. On 06/30/16, based of assessment, LPN charge nurse resident # 3 to be evaluated by Urologist. When contacted for appointment, the Urologist was available for an office visit and instruction was received from the Urologist's office to send resident the emergency room via non-entransport for super pubic cather replacement. The Nurse Practiverified that she was aware resident was being sent to ER for the cather change on 06/30/16. Resident	his n requested his an s not l the ent #3 to mergency ter tioner ident # 3 antheter t returned	
	timely manner of bag of Resident assessment(s) of events leading to the emergency of the em	railed to notify the physician in a bloody urine in the collection #3's suprapubic catheter. On ity staff transferred Resident #3 y room to have the suprapubic d, but failed to document of the suprapubic catheter and to the transfer of Resident #3 to oom.	f		Criterion # 2 - How will the identify other residents havi potential to be affected by the practice? All residents with catheters have potential to be affected by the On 07/25/16, LPN Unit Mana and/or DON completed a 100 all nurse's notes, Urinary Cather Plans and orders for the last of residents identified with cather other issues were identified.	facility ng the ne same ave the s practice. agers 0% audit of theter Care	f

TATEM	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION	COMPLETED
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F3	assessment refebeing moderatel decisions. He was catheter in place. On the following was observed in suprapubic catheter and at 3:10 2:40 p.m. At all collection bag was a review of the revealed the fol (suprapubic) catheter times at the revealed, in part of the revealed at 10	set), a quarterly assessment with strence date, he was coded as y cognitively impaired for making as coded as having a suprapubic as coded as having a suprapubic at the strence date and times, Resident #3 his room, and to have a seter draining in to a collection a privacy cover: 7/6/16 at 12:35 p.m.; 7/7/16 at 8:10 a.m. and observations, the urine in the ras clear yellow. The physician's orders for Resident #3 to lowing order, written 3/29/16: "SF th (catheter) to bed side drainage a prostatic hyperplasia - enlarged bs (obstructive) uropathy TID day)." Thurses notes for Resident #3 to the following: The physician of the strength of the strengt		Criterion #3 - What is put in place or system made to ensure the dwill not reoccur. Beginning on 07/25/16 and/or DON will provall licensed nurses regdocumentation related change in condition, it assessments needed a required when sending the facility for unplant treatment. Education notifying the Nurse Pattending Physician party of resident's chand proper document medical record. Educompleted by 08/05/ The DON and/or Unaudit orders and 24 famough Fridations were mupdated, and orders will be completed dathrough Friday for 3	measures will be natic changes eficient practice 6, the IED, SDC ride education to garding proper I to a resident's including and documentation in ga resident out of ined evaluation and also includes fractitioner, and responsible lange of condition tation in the cation will be 16. In Managers will incour reports daily lay during the to ensure changes or residents with rly assessed, ade, care plans are are written. Audits aily, Monday

TATEMENT	OF DEFICIENCIES OF CORRECTION	TATI THOUSE TO SEE THE	, ,		CONSTRUCTION	OMPL	
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	Continued From prinsertion site" - 6/30/16 at 10:22 ER (emergency refiname of nurse) at that sp cath was replacement. Urine Further review of evidence of assergarding Reside assessment or hir room on 6/30/16. A review of the concept regarding Resident #3 date following: "Report to nurse. F/U (for scheduledObst symptoms of UT physician." Further review of revealed no evid June 2016. On 7/7/16 at 2:1 nurse) #4 was in for Resident #3, done if she discountify the urolog noticed blood in bag, she stated blood or clots in changed. He gamonth in the doverify the date of prior to 6/30/16	rage 41 7 p.m.: "Resident returned from from) at 8:30 p.m. Report from t [name of local hospital] was replaced and x-ray to confirm is bloody in collection bag" the nurses notes revealed no sament or documentation in t#3's suprapubic catheter is transfer to the emergency	1	315	Criterion # 4 – How will the facility monitor the corrective plan to ensu the deficient practice was correcte and not reoccur? Results of audits regarding change in condition related to catheter care including proper notifications will be reported for review and recommendations to the Quality Assurance/Performance Improveme Committee (QA/PI) by the Director Nursing (DON) or Unit Manager (Uffor 3 months or until 100% compliations achieved.	n e ent cof	08/05/16

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concerns.

stated she could not find evidence of

should have been written."

assessment/documentation regarding the transfer to the emergency room on 6/30/16. She stated: "Assessments should have been done and notes

On 7/7/16 at 5:30 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these

11/	TATEMENT ND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DNSTRUCTION		MPLETED
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	F 315	A review of the factoringation" revealed provide for and madrainage and to accord to condition, e.g. swe output, amount, condition and the following: "Nuresponsible for no physician when: the resident's physician when record in accordance policies and process. No further information of the sediment, surgery or another health taken from the whole the surgery or another health taken from the whole the surgery intake will help to sediment, clots block the suprapintake will help to sediment or infections.	illity policy entitled "Catheter II, in part, the following: "To aintain constant urinary dminister medicationRoutine Changes in the resident's elling, discomfort, change in polor, any sediment" cility policy entitled "Changes in ion or Status" revealed, in part, arsing services will be atifying the resident's attending There is significant change in ion as been made to transfer or ident from the facilityAll sident's medical condition must ded in the resident's medical need in the resident's medical need with our documentation edures." ation was provided prior to exit. catheter (tube) drains urine at it is inserted into your bladder to leave you have urinary incontinence of that made a catheter necessary problem." This information is ebsite hih.gov/medlineplus/ency/patien	e ,	315			

TATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY
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	(intake and output appearance of urinfection." This in Fundamentals of edition, page 1365 483.25(h) FREE ON HAZARDS/SUPE The facility must be environment remains is possible; and	ist monitor the client 's I&O carefully, monitor the ne, and observe for signs of formation is taken from Nursing, Potter and Perry, 6th 5. DF ACCIDENT RVISION/DEVICES ensure that the resident ains as free of accident hazards d each resident receives sion and assistance devices to	F3	F323 Criterion #1 - How will the action be accomplished for residents found to have be by the deficient practice?	r those	
	by: Based on observed occument review was determined to implement a physic for 1 of 28 resider Resident #6. The facility staff to pressure chair all The findings included the resident #6 was 6/26/09. Resident #6 were not limited (1). Resident #6 data set), a quarter of the review	ENT is not met as evidenced vation, staff interview, facility and clinical record review, it that the facility staff failed to sician ordered safety intervention ints in the survey sample, failed to implement Resident #6's arm per a physician's order. admitted to the facility on int #6's diagnoses included but to: pain, anxiety and dementia its most recent MDS (minimum terly assessment with an ARD erence date) of 4/6/16, coded the	5	Resident # 6 was identified affected by this practice. Im upon notification of concert 07/07/16, Director of Nursi with the help of a Certified Assistant (C.N.A.), applied alarm to resident # 6. On LPN Unit Manager (LPN) history of falls, and the rescare plan for fall prevention LPN then notified the Nurs (NP) of findings and a veri discontinue the chair pad a written and approved.	nmediately n on ing (DON) Nursing I a chair pad 07/08/16, a assessed ident's fall n approaches. se Practitioner bal order to	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
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F 323	Section G docume extensive assistan and was coded as more staff with trar Resident #6 had no prior assessment. Review of Resider fall risk evaluation the resident was a dated 6/7/16 document assistant) came to on the floor besider room and resident with knees bent lebed and right arm A physician order physician or 7/1/1 pressure alarm to (three times a day sure safety devices TID" Resident #6's component date of 1/15 related injury- As injury; Fall Risk Sweakness; Cognit mobility; Poor safe Pressure alarm to Observation of Rethe nurse's station 2:12 p.m. and 4:0 observed.	n as being severely impaired. nted the resident required ce of one staff with locomotion totally dependent on two or nsfers. Section J documented ot sustained a fall since the at #6's clinical record revealed a dated 6/7/16 that documented t risk for falls. A nurse's note mented, "CNA (certified nursing this nurse stating resident was bed. This nurse entered the was sitting oon (sic) bottom aning with right side against		323	Criterion # 2 - How will the facilidentify other residents having the potential to be affected by the sarpractice? Residents with orders for fall previous aftected by this practice. On 07/2: 100 % audit of medical records for prevention safety alarms was comby Unit Managers (UM) to identify residents with alarms. A list was compiled and verification that ord alarms were in place and working properly was completed. No othe concerns were identified. Criterion #3 - What measures we put in place or systematic changemade to ensure the practice will reoccur. Beginning on 07/25/16, education be provided by IED, SDC and/or to licensed nurses and certified in assistants (CNA) regarding follow physician orders for alarms and the responsibility to ensure fall previous after a larms are in place and working properly. Education will be comby 08/05/16 and same education included in orientation for new have	ention be 5/16, a r fall pleted by ered r will be ges I not DON ursing wing heir ention orking pleted will be	

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		495139	B. WING			07/08/	2016
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(X4) ID PREFIX TAG	(EACH DEEICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) OMPLETION DATE
F 323	Resident #6). CN made aware of sa each resident. CN and our nurses let Resident #6 was sthe bed and an althis time, CNA #6 #6 in the wheelch was present on the On 7/7/16 at 4:12 conducted with LI (the nurse caring asked how she winterventions requisitated safety interthe treatment bod was supposed to chair and bed. Light resident did not he on 7/7/16 at 5:25 member) #1 (the	age 46 NA #6 (the CNA caring for A #6 was asked how she was fety interventions required for NA #6 stated, "They have orders us know." CNA #6 stated supposed to have a mat beside arm on the bed and chair. At was asked to observe Resident air. CNA #6 confirmed no alarm the resident's wheelchair. p.m., an interview was PN (licensed practical nurse) #5 for Resident #6). LPN #5 was as made aware of safety uired for each resident. LPN #5 reventions were documented on oks. LPN #5 stated Resident #6 have a pressure alarm on the PN #5 was made aware the nave an alarm on the wheelchair. 5 p.m., ASM (administrative staff administrator) and ASM #2 (the g) were made aware of the		3323	Starting on 07/25/16, orders and 2 reports will be reviewed daily Mothrough Friday during the Clinical meeting to identify order changes related to fall prevention safety at A list of fall prevention safety at will be maintained by the Unit Managers (UM) and updated as a by the Physician. Beginning on 07/25/16, observational audits will be completed by unit managers (UM) and/or Director Nursing (DON) 5 times a week weeks, then 3 times a week for a then weekly for 4 weeks to veri compliance with Physician's or fall prevention safety alarms.	onday al IDT s alarms. arms ordered tion of for 4 4 weeks,	
	documented, "Prassessed through different parameter awareness, fall I medications, or that may contribute interdisciplinary implemented, represent to referencessary to refere	y titled, "Falls Management" blicy: Each resident will be hout the course of treatment for eters such as: cognition, safety history, mobility, sensory status, predisposing health conditions ute to fall risk. An plan of care will be developed, eviewed and updated as flect each resident's current safe eduction interventions"			Criterion # 4 – How will the famonitor the corrective plan to the deficient practice was cor and not reoccur? Results of audits for fall prevents afety alarms will be reported for the safety alarms will be report	o ensure rected	

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	() (0) 141 11 2	TIDL F	CONSTRUCTION (X:		SURVEY
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		495139	B. WING			07/0	8/2016
	RE CENTER OF NEW	MARKET		315	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844		
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F 323	(1) "Dementia is the symptoms caused brain. It is not a selection do normal activities eating" This influebrates https://www.nlm.nml	age 47 tion was presented prior to exit. The name for a group of the last by disorders that affect the pecific disease. People with the able to think well enough to es, such as getting dressed or formation was obtained from the lih.gov/medlineplus/dementia.ht MENT/CARE FOR SPECIAL		323	F323 Continued from Page 47 and recommendations to the Quality Assurance/Performance Improveme Committee (QA/PI) by the DON or for 3 months or until 100% complia is achieved.	ent UM	08/05/16
	proper treatment special services: Injections; Parenteral and et Colostomy, urete Tracheostomy catracheal suctioni Respiratory care; Foot care; and Prostheses. This REQUIREM by: Based on observecord review, it staff failed to enprovide for two comprovides for two comprovides ample, Resider	rostomy, or ileostomy care; are; are; are; are; are; are; are;			Criterion #1 - How will the correct action be accomplished for those residents found to have been affect by the deficient practice? Residents # 4 and # 3 were identified being affected by this practice. Of 07/07/16, the Nurse Practitioner was consulted by Nurse Unit Manager podiatry consult orders for resident and # 3 were discontinued. Neither resident was deemed by the Nurse Practitioner to have an immediate Podiatry concern. Both residents placed on Podiatry list, orders write and appointments made for in-how Podiatry visit scheduled on 08/01/10.	ed as on as and t # 4 er were tten use	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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TATEMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495139	B. WING			07/0	8/2016
	PROVIDER OR SUPPLIER			31	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844		
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F 328	Continued From p	age 48	F:	328	F328 Continued from Page 48	3	
	 The facility staft consult for Reside provided. The findings inclu 	f failed to ensure a podiatry nt #3 ordered on 3/29/16 was		;	Criterion # 2 - How will the faci identify other residents having t potential to be affected by the sa	the	
	1. Resident #4 w 2/9/16 with diagnor chronic kidney disheart failure and I most recent MDS assessment with 5/18/16), she was cognitively impair having scored the interview for mer requiring the externobility, dressing	as admitted to the facility on obses including, but not limited to: sease, diabetes, congestive high blood pressure. On the (minimum data set), a quarterly assessment reference date is coded as being severely red for making daily decisions, ree out of 15 on the BIMS (brief tall status). She was coded as ensive assistance of staff for bed g, personal hygiene and bathing.	1		practice? All residents residing in the facility the potential to be affected by this practice. On 07/29/2016, Nurse Unit Mana (UM) completed an observation of in-house resident's toe nails to id residents with Podiatry needs. A resident identified with a Podiatry has a scheduled appointment to shouse podiatrist.	agers of all lentify any y need	
	of Resident #4's nurse) #3, a unit surveyor and per Resident #4's rig revealed the secondary of the prevention of the pr	toenails. LPN (licensed practical manager, accompanied the formed the assessment. In the foot was assessed first, and and third toenails were long fit foot revealed the third toenail at touched the first toenail on the escribed it as "a little overgrown." Only sician's orders for Resident # at, the following order, written on the try consult with [name of ainful, thick, mycotic nails abetes and arterial insufficiency."	j. e ''		Criterion #3 - What measures put in place or systematic charmade to ensure the deficient pwill not reoccur. Education, starting on 07/25/16 provided by IED, SDC and/or I licensed nurses, the Health Info Manager (HIM) and assistant H manager regarding proper procreferring a resident to Podiatry admission, readmission and as	oractice will be OON to ormation HIM bedure for upon	

regarding the resident's toenails.

CENTER	S FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	COMPLE	TED
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		495139	B. WING		TID CODE	07/08/	2016
	PROVIDER OR SUPPLIER			315	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY 5 W MARKET, VA 22844		
LIFE CAP	RE CENTER OF NEV		ID		PROVIDER'S BLANCE CORRECTION	e C	(X5) OMPLETION
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	Continued From particles of the TA review of the TA records) and nurse that Resident #4 as ordered by the A review of the care records of the care records of the care records of the director of nurse records. Policipodiatry services on 7/8/16 at 8:3 facility did not his services.	Page 49 ARs (treatment administration as notes revealed no evidence had been referred to a podiatrist physician. In proper to physician physician physician physician. In proper to physician physicia	ed.	328	Education will be completed by 08/05/16 and the same education wi included in orientation for new hires on-going referral list will be compil by the HIM Director or HIM assistated based on communication in the clin IDT meeting held Monday through Friday. Podiatry appointments will scheduled upon identification of neand MD order obtained at that time. The HIM director will maintain the going audit of podiatry consults neidentifying both in-house and exterpodiatry consults. This audit will when referrals are made, orders are written and when Podiatry service performed to ensure compliance.	s. An led ant lical l be leed le. leed leed	
	podiatrist. LPN make those list on 7/8/16 at 10 was interviewed like that, and nappointment sithis was done have been dor records/transponsults need Medical record orders and charage pended.	#4 stated: "Floor hurses don't	er d		Criterion # 4 – How will the fact monitor the corrective plan to exthe deficient practice was correand not reoccur? Results of HIM audits for podiate services referred, ordered and convil be reported for review and recommendations to the Quality Assurance/Performance Improve Committee (QA/PI) by the DON HIM Director for 3 months or un 100% compliance is achieved.	ensure ected try completed rement	08/05/1

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		E SURVEY MPLETED
		495139	B. WING		07	/08/2016
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F 328	On 7/8/16 at 10:30 member) #2, the interviewed. OSN role with the podia nurse indicates the add that resident to include podiatry screening process. No further information in Fundamentals Patricia A. Potter Inc; Page 419: "Indirecting medical obligated to follow believe the order clients." 2. Resident #3 verification in the control of the control o	o a.m., OSM (other staff medical records clerk, was M #2 stated: "I do not have a latrist with admission orders. If a lat a podiatrist is needed, then I to the list. I've never been told y consults in any kind of son admission." ation was provided prior to exit. of Nursing, 6th edition, 2005, and Anne Griffin Perry, Mosby, he physician is responsible for treatment. Nurses are w physician's orders unless they are in error or would harm was admitted to the facility on ling, but not limited to: history of e-sided paralysis, depression, e with obstruction, and chronic. On the most recent MDS set), a quarterly assessment with erence date, he was coded as y cognitively impaired for making was coded as requiring the ance of two staff members for insfers and personal hygiene. He eing dependent on staff member		328		

DENTIFICATION NI IMPER		\ ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 315 EAST LEE HIGHWAY NEW MARKET, VA 22844	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 328	revealed, the third long nails. LPN # getting a little long. A review of the phrevealed, in part, 3/29/16: "Podiatr toe nails." A review of the addated 3/29/16 revealed 3/29/16 revealed, in part, 3/29/16 revealed, in part, 3/29/16 revealed, in part toe nails." A review of the Threcords) and nurse that Resident #3 as ordered by the A review of the CR Resident #3 date information related On 7/7/16 at 5:30 member) #1, the the director of nurconcerns. Policie podiatry services. On 7/8/16 at 8:30 facility did not has services. On 7/8/16 at 10: She stated unit in generating the lispodiatrist. LPN # make those lists	d, fourth and fifth toes contained 3 stated: "I'd say they are g. Especially the big one." Inysician's orders for Resident #3 the following order, written on y consult for long thick painful dmission nursing assessment realed no documentation ident's toenails. ARS (treatment administration sees notes revealed no evidence had been referred to a podiatrist exphysician. Imprehensive care plan for d 3/29/16 failed to reveal ed to podiatry services. In p.m., ASM (administrative staff executive director, and ASM #2, rsing, were informed of these es and procedures regarding were requested. In a.m., ASM #2 stated that the executive director is a podiatry. In a.m., LPN #4 was interviewed managers are responsible for sets of residents to be seen by the executive. "Floor nurses don't		228		

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TATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	COMPLETED	
		495139	B. WING			07/0	8/2016
	ROVIDER OR SUPPLIER	MARKET		315	EET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY V MARKET, VA 22844		
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F 328	like that, and not p appointment shoul this was done as a have been done the records/transportate consults needed with Medical records grounders and checks are needed. She makes the appoint On 7/8/16 at 10:30 member) #2, the reinterviewed. OSM role with the podianurse indicates the add that resident to include podiatry screening process. No further informated that the include podiatry screening process. No further informated at 10:30 member with the podianurse indicates the add that resident to include podiatry screening process. No further informated at 10:30 member with add that resident to include podiatry screening process. No further informated at 10:30 member with add that resident in include podiatry screening process. No further informated with a service indications for its adverse consequent indications for its adver	LPN #2 stated: "If it's ordered rn (as-needed), then an d be scheduled. It looks like in admission order. It should be a scheduled. It looks like in admission order. It should be a scheduled. It should be a scheduled ition. I don't generate a list of a when someone is admitted. It is someone is admitted. It is shown that a scheduled it is shown it is shown in a scheduled it is shown i	F		F329 Criterion #1 - How will the coraction be accomplished for the residents found to have been at by the deficient practice? Resident #9 was identified in this practice. A behavioral monitoring sheet was put into place on 07/09. Director of Nursing (DON) for	se ffected s ng flow	+
	Based on a compresident, the faci	the reasons above. orehensive assessment of a lity must ensure that residents ed antipsychotic drugs are not			documenting effectiveness of PF medication. Resident # 9's Comprehensive Care Plan was reby DON, Unit Managers (UM),	eviewed	

Event ID: 8PM911

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495139	B. WING			07/0	08/2016
	PROVIDER OR SUPPLIER	MARKET		31	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844		
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F 329	therapy is necessal as diagnosed and record; and resided drugs receive grade behavioral interver contraindicated, in drugs. This REQUIREME by: Based on staff interview, and clinical determined that the use of a hypnopromote sleep) for survey sample, Resident staff for the medication, (1)) was monitored. The findings included the received many contraints in the received many contraints and th	unless antipsychotic drug ry to treat a specific condition documented in the clinical nts who use antipsychotic ual dose reductions, and ntions, unless clinically an effort to discontinue these ENT is not met as evidenced erview, facility document I record review, it was e facility staff failed to monitor offic (medication used to r one of 28 residents in the esident #9. illed to ensure the effectiveness Restoril (used to treat insomnia d for Resident #9.		329	F329 Continued from Page 53 Services Director (SSD) and MDS coordinators on 07/19/16 and upd include the problem of insomnia a approaches. On 07/27/16, a medireview was completed by Medica Doctor (MD) to ensure current medications were still appropriate continued use. No new orders we obtained relating to the hypnotic medication. Criterion #2 - How will the faction in the identify other residents having potential to be affected by the practice? Residents who have orders for Phypnotic medications have the pto be affected. An audit of in-hor resident's MAR's was completed Unit Managers (UM) on 07/21/16 identify other resident's with PR orders for hypnotic medications. UM also verified behavior monits sheets for residents were in place indicated and effectiveness was be monitored and documented	ated to and cation and cation at the state of the state o	

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TATEMENT	OF DEFICIENCIES		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
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F 329	staff members for living. Resident # limited assistance The physician ord "Restoril 7.5 mg (age 54 e assistance of one or more most of her activities of daily 9 was coded as requiring of one staff member for eating. ers, dated, 5/1/16, documented, milligram) capsule PO (by y bedtime) prn (as needed); 1 mouth nightly as needed."	F 329	F329 Continued from Page 54 appropriately. Care plans for a residents identified on PRN hypwere reviewed and updated accept DON, MDS Nurse, or UM of 07/25/16.	all pnotics cordingly
	administration recadministration of 5/2/16, 5/4/16, 5/ Three of the above the reverse of the effectiveness doc Review of the nureveal any documented, "The "Behavior/Indocumented, "The for the following (check if applica Antipsychotic, So "Behavior/Intervented May 2016 documented the behaviors. The review of the administration of the administration of the serview of the nurevented the service of the nurevented the nurevente	Itervention Monthly Flow Record his monitoring form is to be used drug classes when appropriate ble). Antianxiety Agent, edative/Hypnotic." The ention Monthly Flow Record for mented, "Anxiety and Yelling" as there was no documentation for		Criterion #3 - What measure put in place or systematic charmade to ensure the deficient will not reoccur. Beginning on 07/25/16, educate be provided by SDC and/or DC Licensed nurses and Social Sestaff related to following physorders, including verifying documentation of effectiveness medication and use of behavior monitoring sheets. Education include updating the resident Psychotropic Medication care regarding changes identified. will be completed by 8/05/16 education will be included in for new hires. Starting 07/27/2016, a UM operform 5 observations per wweeks, then 3 observations for	anges practice tion will ON to crvices dician's ss of or n will also e plan Education . Same orientation or DON will week for 4

effectiveness of the Restoril administration.

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '			OMPLETED
		495139	B. WING			7/08/2016
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F 329	for June 2016 do as the behaviors for insomnia/sleed. The review of the the administratio dates: 7/3/16 and the reverse of the effectiveness do 2016, nurse's not as the second control of the control of the feetiveness do 2016, nurse's not as the second control of the second control of the control of the second control of the sec	tervention Monthly Flow Record" cumented, "Anxiety and Yelling" . There was no documentation	F	329	F329 Continued from Page 55 then weekly observations for 4 weeks for residents on PRN hypnotic medication to ensure behavior monitoring sheets are complete, effectiveness was documented and carplans were appropriately reviewed and updated.	е
	revised on 3/16/ problem: The re and night." The part, "Administe and side effects physician's orde An interview wa practical nurse) regarding reside needed) medica fever. LPN #4 of the MAR and all PRN medica documented, Li be effectivenes know if the feve away or they side An interview wa manager, on 7/ process follows	s conducted with LPN (licensed #4 on 7/7/16 at 12:36 p.m. ents requests for a PRN (as ation for pain, sleep, anxiety or stated, "You sign it out on the bact the effectiveness." When asked tions require effectiveness PN #4 stated, "Yes, there should so for all of them. You'd want to be came down, or the pain went	k if		Criterion # 4 – How will the facility monitor the corrective plan to ensur the deficient practice was corrected and not reoccur? Results of PRN hypnotic MAR, behavior monitoring sheet observation including documentation of effectiveness and care plan updates where the provided for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the DON or Utfor 3 months or until 100% compliant is achieved.	08/05/10 11 11

STATEMENT OF DEFICIENCIES (X1 ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IG	COMPLETED	
		495139	B. WING		07	/08/2016
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(FACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	medication to tre If so you adminis the front of the M reverse of the M the pain flow she Restoril for inson effectiveness of #3 stated, "Yes, An interview was staff member (A When asked how of a PRN medica see if there is a l complaining abo available, they si information on th was and should asked if that app as Restoril, the o stated, "Yes it sh nurse's note." The facility polic documented in can be considered been made to d for the inapprop be considered a sedative/hypnot possibilities sho psychotropic me risk meeting. M easily determine (for that individu of sleep with the medications as	at what they are complaining of ter the medication, sign it off on IAR and then put it on the AR except pain, which goes on set." When asked if the use of annia should have the the medication documented, LPN it should have effectiveness too." Sconducted with administrative SM) #2 on 7/7/16 at 1:04 p.m. or a nurse is to document the use ation, ASM #2 stated, "First they PRN for what the resident is used in the MAR and write the ne back of the MAR and write the ne back of the MAR as to what it write the effectiveness." When oblies to the use of a hypnotic such director of nursing, ASM #2 nould be on the MAR or in a setermine and correct the reason riate sleep pattern. They can also be chemical restraintUsage of ics and dose reduction uld be routinely reviewed in the edication meeting or resident at lonitoring for Efficacy: Efficacy is ed by a resumption of a normal real pattern of sleep. Monitor hours a use of sedative/hypnotic		29		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	COMP	LETED
		495139	B. WING			07/0	8/2016
	PROVIDER OR SUPPLIER	MARKET		315	EET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY W MARKET, VA 22844		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 386	Wilkins, page 565, for documenting the effects of any med. The executive dire aware of the above p.m. No further informat (1) Temazepam (F. basis to treat inso staying asleep). To medications called slowing activity in https://www.nlm.n.ds/a684003.html 483.40(b) PHYSIC CARE/NOTES/OF The physician multiprogram of care, treatments, at each of this section; write notes at each vision with the exception polysaccharide via administered per policy after an astronomy. This REQUIREM by: Based on staff in and clinical record the facility staff fawrote, dated and	d Hirnle, Lippincott, Williams & "Nurses also are responsible the therapeutic effects and side ication administered." actor and ASM #2 were made the findings on 7/7/16 at 5:28 ation was provided prior to exit. Restoril) is used on a short-term mina (difficulty falling asleep or emazepam is in a class of the benzodiazepines. It works by the brain to allow sleep. ith.gov/medlineplus/druginfo/me	F al	386	F386 Criterion #1 - How will the correaction be accomplished for those residents found to have been affeby the deficient practice? Residents #11, #3, #4, #8, #2, #12 #10 and #9 were cited as being affeby this practice. 1. Resident #11 - Notes frow visits on: 07/24/15, 09/22 11/27/15, 01/28/16, 04/06 were dictated on 07/07/16 placed in medical record 07/07/16.	e e e e e e e e e e e e e e e e e e e	

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STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		ONSTRUCTION		MPLETED
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		495139	B. WING				/08/2016
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F 38	#10 and #9. 1. Resident #11's sign and place precord for visits record for visits made on 3. 3. Resident #4's sign and place provisits made on 3. 4. Resident #8's sign and place provisits made on 6/18/16. 5. Resident #2 in the clinical record for the clinical	s physician failed to write, date, rogress notes on the clinical made on 7/24/15, 9/22/15,		386	 Resident # 3 – Handwrit notes for physician visit 03/30/16 and 06/16/16 wigned and dated by the Director and were place medical record on 07/26 Resident # 4 – Handwrit notes for physician visit 03/19/16, 04/15/16, 05/2 and 07/01/16 were signed dated by the Medical Diand placed on medical re 07/26/16. Resident # 8 – Handwrit notes for physician visit 11/13/15, 01/08/16, 02/2 06/18/16 were signed and by the Medical Director placed on the medical re 07/26/16. Resident # 2 - Handwrit dictated notes for physic visits on 02/01/16, 02/0 02/19/16, 04/29/16, 05/2 and 07/06/16 were signed dated by the Medical Drand placed on the medical record on 07/26/16. 	tten s on were Medical ed on the 6/16. tten s on 27/16 ed and frector ecord on tten s on 23/16, and dated and ecord on tten and cian 9/16, 27/16 ed and irector	

Facility ID: VA0145

TATEMENT	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	COMPLETED	
		495139	B. WING			8/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		(X5)
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F 386	9. There were no clinical record for The findings inclu 1. Resident #11's sign and place precord for visits in 11/27/15, 1/28/16 Resident #11 was 9/19/14. Resident were not limited blood pressure a recent MDS (mirchange in status (assessment refithe resident's concerned physician each required vi 7/24/15 through On 7/7/16 at 11: staff member) # confirmed Resident #11 recertification proclinical record and for Resident #11 recertification in seen by the phy 11/27/15, 1/28/ printed notes we physician until On 7/7/16 at 10 conducted with the resident with the resident with the resident #11 recertification in seen by the phy 11/27/15, 1/28/ printed notes we physician until On 7/7/16 at 10 conducted with the resident with the	physician progress notes in the Resident #9 since 12/7/15. de: physician failed to write, date, ogress notes on the clinical nade on 7/24/15, 9/22/15, and 4/6/16. s admitted to the facility on the #11's diagnoses included but to: chronic kidney disease, high and pain. Resident #11's most nimum data set), a significant assessment, with an ARD erence date) of 6/17/16, coded gnition as moderately impaired. ent #11's clinical record failed to recertification progress notes for sit during the time period of 4/6/16. 15 a.m., ASM (administrative to the director of nursing) dent #11's physician's rogress notes were not in the land had to be printed out. Review to the resident was sysician on 7/24/15, 9/22/15, 16 and 4/6/16; however, the large moderate in the large progress not electronically signed by	w the	6. Resident # 12 - Handictated notes for physists on 03/26/16 awere signed and da Medical Director at the medical record 7. Resident # 13 - Handictated notes for physists on 12/05/15, 05/24/16, and 07/2 signed and dated be Director and place medical record on 8. Resident # 10 - Handictated notes visits on 03/26/16, 07/27/16 were signed on the medical Diplaced on the medical motes of the medical motes for visits on 11/09/15 02/02/16, 04/07/14 and 05/15/16 were dated by the Medical Diplaced on the record on 07/26/16	adwritten and hysician and 05/27/16 ted by the and placed on on 07/26/16. Indwritten and physician 02/23/16, 7/16 were by the Medical don the 07/27/16. Indwritten for physician o5/26/16 and and dated rector and dical record on andwritten and physician of 12/07/15, 6, 05/05/16, we signed and ical Director and ical Dir	

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	3) DATE SURVEY COMPLETED	
		495139	B. WING			07/08/2016	
	PROVIDER OR SUPPLIER RE CENTER OF NEW SUMMARY ST	ATEMENT OF DEFICIENCIES	315 EAST LEE HIGHWAY NEW MARKET, VA 22844 ID PROVIDER'S PLAN OF COR FACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE	RRECTION (X5)	
PREFIX TAG	(EACH DEFICIENC REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	TE DATE	
F 386	(Resident #11's pheed to be seen for OSM #2 stated AS from each visit but typed and on the chas asked for help supposed to receive On 7/7/16 at 3:17 conducted with AS records had been he had been asking to "catch up and he stated his bosses to assist him until stated other physically enough information review of systems dictated the notes handwritten notes dictate his typed handwritten notes on the chart, ASM consider them particulated as made aware were electronical day (7/7/16). AS the notes this sabeen pulling toged dictated notes we clinical record assistant who is information into system would not system.	age 60 istrative staff member) #3 nysician) a list of residents who or recertification every week. SM #3 keeps handwritten notes t doesn't always get the notes chart. OSM #2 stated ASM #3 oregarding this matter and was ve help the following week. p.m., an interview was SM #3. ASM #3 stated medical a huge issue. ASM #3 stated ing his bosses for a solid week help to stay caught up." ASM #3 didn't have anyone authorized the following week. ASM #3 icians' notes didn't contain on but he (ASM #3) used the s, hand scribbled notes then s. ASM #3 stated his s were for his personal use to notes. When asked if his s were signed, dated and placed att of the permanent record." we was always behind on ially for routine visits. ASM #3 we Resident #11's printed notes ly signed by him on this same att of the permanent record." we was always behind on ially for routine visits. ASM #3 can always behind on ially signed by him on this same att of the permanent record." we was always behind on ially for routine visits. ASM #3 a Resident #11's printed notes and what a stated he had dictated the day. ASM #3 stated he had bether his handwritten notes and otes this day because the ere supposed to be on the and a stated he has an supposed to help enter the computer but the computer of allow his assistant to do so and (health insurance portability		386	Criterion #2 - How will the facility identify other residents having the potential to be affected by the same practice? All in-house residents hat the potential to be affected by this practice. A medical record audit was complete by the HIM director on 07/13/2016 to indicate last physician and/or nurse practitioner visit filed in the chart. Interim Executive Director (IED) and the Physician/Medical Director (ME) were notified of the results of the audin 07/13/2016 by the HIM director. The Interim Executive Director (IEI met with the Medical Director (MD) 07/18/2016 and a plan was put in plate correct all concerns identified by HIM audit. All concerns will be addressed by 07/29/2016. Criterion #3 - What measures with put in place or systematic change made to ensure the deficient practical process. The Medical Director, Nurse	e ve ed co dd D) ddit D) on acce the	

TATEMENT O	FOR MEDICARE F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIF 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		EW MARKET, VA 22844		
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1	On 7/7/16 at 5:25 administrator) and nursing) were made and additional that requisition the medical care of expensions that requisitioner assistant, clinical practitioner) per seach visit, the phoresident's total process and in Significant change in diagnicant change in diagnicant change in medical progress and prog	p.m., ASM #1 (the I ASM #2 (the director of de aware of the above findings. titled, "Physician Services mented, "Policy: Documentation cord must reflect supervision of ach resident in the facility. All uire physician judgement are lonly by the physician or his sentative (i.e., physician's nurse specialist, or nurse state guidelinesAt the time of sysician must review the rogram of care, medications, the care plan. A progress note signed, and dated at the time of clude the following.	kit. lity cal uld s	386	Practitioner and other Attending Physician were educated by the I Executive Director on 07/12/201 regarding policy and procedure if documenting physician visits. The properly document a physician with the chart there must be a written progress note placed on the median record at time of visit. This can written as progress note or a Physician or a brief notation rethe visit including date and sign with notation that dictation will A Physician's Visit /Recertification form was put in place for all via dictated note will not be comwithin 72 hours. The physician completing the visit will composite form, including signature and of the handwritten documentation given to HIM or HIM assistant the documentation audit and the on the medical record until dicavailable. Health Information Manager (HIM assistant will audit requirementation Manager (HIM assistant will audit requirementation).	interim 6 For 7 For 8 For 9 For 10 For	

STATEMENT				PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495139	B. WING			8/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 315 EAST LEE HIGHWAY NEW MARKET, VA 22844	ODE	
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD RE	(X5) COMPLETION DATE
F 386	receive your healt applies to all form information, wheth The Security Rule security for health This information whitp://www.hhs.go-materials-for-cor 2. Resident #3's sign and place provisits made on 3/ Resident #3 was 2/19/15 and read diagnoses include a stroke with one enlarged prostat kidney disease. (minimum data sassessment refected as being for making decis A review of the Resident #3 review of the	its on who can look at and h information. The Privacy Rule is of individuals' protected health her electronic, written, or oral. It is a Federal law that requires information in electronic form." was obtained from the website: ov/hipaa/for-individuals/guidance insumers/index.html physician failed to write, date, rogress notes on the record for 130/16 and 6/16/16. admitted to the facility on dimitted on 3/29/16 with ling, but not limited to: history of e-sided paralysis, depression, e with obstruction, and chronic. On the most recent MDS set), a quarterly assessment with erence date of 5/4/16, he was moderately cognitively impaired	of the s,	physician visits and keep a of physician documentation list of all visits documented the medical record or comwritten or dictated notes be HIM department for verific completeness and filed or record. Criterion #4 – How will monitor the corrective the deficient practice wand not reoccur? Results of audit regarding notes being placed on the record will be reported for recommendations to the Assurance/Performance Committee (QA/PI) by director, HIM assistant least 3 months or until compliance is achieved.	a running log on needed. A sed directly in apleted hand be given to lication of a the medical little facility plan to ensure as corrected lag physician e medical for review and a Quality a Improvement the HIM or IED for at 100%	08/05/16

		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495139	B. WING			08/2016
NAME OF PROVIDER OR SUPP	LIER	;	STREET ADDRESS, CITY, STATE, ZIP 315 EAST LEE HIGHWAY NEW MARKET, VA 22844	CODE	
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visit, then later the facility star record. On 7/7/16 at 5 member) #1, the director of concerns. On 7/8/16 at provided with notes for visit 6/16/16. No further into 3. Resident sign and play visits made. Resident #4 with diagnost chronic kidn heart failure most recent assessmen 5/18/16, she cognitively having scorinterview for the start of the start	r types the notes and gives them to for placement in the clinical s:30 p.m., ASM (administrative stafthe executive director, and ASM #2 nursing, were informed of these s:30 a.m., the surveyor was evidence of ASM #3's hand-writter to the executive director and ASM #3's to Resident #3 on 3/30/16 and formation was provided prior to exit stafth to the facility on 2/9/30 and 3/9/16, 4/5/16, 5/27/16 and 7/1/30 was admitted to the facility on 2/9/30 and high blood pressure. On the fact with assessment reference date and high blood pressure. On the fact with assessment reference date and high blood pressure. On the fact with assessment reference date and high blood pressure and high blood pressure. On the fact with assessment reference date and high blood pressure and high blood pressure. On the fact with assessment reference date and high blood pressure and high blood pressure. On the fact with assessment reference date and high blood pressure on the BIMS (bring the progress notes revealed three out of 15 on the BIMS (bring the progress notes revealed on notes since the resident was	f f f f f f f f f f f f f f f f f f f	6		

TATEMENT	S FOR MEDICARE OF DEFICIENCIES CORRECTION			IPLE CONSTRUCT	(X3) DATE SURVEY COMPLETED		
	ROVIDER OR SUPPLIER		B. WING	315 EAST LEE	SS, CITY, STATE, ZIP COD HIGHWAY ET, VA 22844		/08/2010
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PRO	OVIDER'S PLAN OF CORRI H CORRECTIVE ACTION SI- REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPLETION DATE
F 386	member) #3, Res and the facility me He stated he was typed and placed "a huge issue her required visits, bubehind in getting placed in the med acceptable? No. stated he keeps visit, then later ty the facility staff for record. On 7/7/16 at 5:30 member) #1, the the director of nuconcerns. On 7/8/16 at 8:30 provided with evenotes for visits to 5/27/16 and 7/1/10. No further information and place.	ident #4's attending physician edical director, was interviewed. aware that getting his notes in the medical record had been re." He stated that he makes the it is weeks, sometimes months, the progress note typed and dical record. He stated: "Is it But it's the best I can do." He hand-written notes from each pes the notes and gives them to or placement in the clinical of p.m., ASM (administrative staff executive director, and ASM #2, ursing, were informed of these of a.m., the surveyor was ridence of ASM #3's hand-written or Resident #4 on 3/9/16, 4/5/16,		386			
	Resident #8 wa 6/27/13 with dia to: chronic obs chronic back p	as admitted to the facility on agnoses including, but not limited structive pulmonary disease, ain and anxiety disorder. On the DS (minimum data set), an annulated 6/10/16, Resident #8 was				Airciahla	neet Page 65 of

TATEMENT OF DEFICIENCIES ((AI) PROVIDE OUT		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ID PLAN O	F CORRECTION	5 09-70 W. J. C. C.			0.7	/08/2016	
		495139	B. WING			/00/2010	
	PROVIDER OR SUPPLIER	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 65 Coded as being cognitively intact for making daily		IF CODE	2		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES	PREF	(EACH CORRECTIVE ACT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 386	coded as being codecisions. A review of the clie evidence of physic 7/13/15. On 7/7/16 at 3:15 member) #3, Resand the facility methes stated he was typed and placed "a huge issue her required visits, bubehind in getting placed in the metacceptable? No. stated he keeps visit, then later ty the facility staff for record. On 7/7/16 at 5:30 member) #1, the director of nuconcerns. On 7/8/16 at 8:3 provided with evinotes for visits to 1/8/16, 2/23/16. No further inform 5. Resident # 2 was and most record.	p.m., ASM (administrative stafficial record failed to reveal cian recertification visits since p.m., ASM (administrative staffident #8's attending physician edical director, was interviewed. aware that getting his notes in the medical record had been re." He stated that he makes the at is weeks, sometimes months, the progress note typed and dical record. He stated: "Is it But it's the best I can do." He hand-written notes from each pes the notes and gives them to be placement in the clinical D. p.m., ASM (administrative stafficexecutive director, and ASM #2, arsing, were informed of these O. a.m., the surveyor was idence of ASM #3's hand-written or Resident #8 on 11/13/15,		386			

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		STRUCTION	(X3) DAT	E SURVEY MPLETED
		495139	B. WING				/08/2016
	ROVIDER OR SUPPLIER			315 EA	raddress, city, state, zip coi st lee highway Market, va 22844	DE	
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 386	Continued From p hypertension, hype hypothyroidism, at Resident # 2's mo set), a quarterly a (assessment refe Resident # 2 as u understand others scoring 11 of a po for Mental Status Patterns, indicatir cognitively impair	age 66 erlipidemia, dementia, trial fibrillation, and depression. est recent MDS (minimum data essessment with an ARD erence date) of 4/27/16, coded enderstood by others and able to es. Resident # 2 was coded as essible 15 on the Brief Interview in Section C, Cognitive eng the resident was moderately ed.	F	386	DEFICIENCY)		
	physician. During an intervious (other staff OSM # 2 reveals makes a list of a by the physician the list to the physician the list to the physician then takes then 2 further stated get on the chart During an intervial ASM (administration physician, reveastating, "I've beto do all the papweek. I'm alway written notes ar note that you can problem. I have	ew on 7/7/16 at 11:50 a.m. with member) # 2 (medical records), at that every week she (OSM # 2) Il residents that need to be seen. OSM # 2 stated that she gives ysician each week; OSM # 2 hysician does handwritten notes otes and types them up. OSM # that the typed notes don't always liew on 7/7/16 at 3:17 p.m. with ative staff member) # 3, the aled that records are a problem en asking for help for some time betwork. I'm getting help next ys behind in dictation. My hand e not acceptable - what use is a an't read. I recognize that it is a e handwritten notes for each not consider my notes a part of	± 3				

CENTERS FOR ME ATEMENT OF DEFICIENC ID PLAN OF CORRECTION	CIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	COM	E SURVEY IPLETED 708/2016
	ME OF PROVIDER OR SUPPLIER 315 EA		STREET ADDRESS, CITY, STATE, ZIP 315 EAST LEE HIGHWAY NEW MARKET, VA 22844			
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# 3 was a 3 respond During th p.m. with executive nurses, v physiciar was made On 7/8/1 visit for ethe exect ASM # 3 3/5/16, 4 corresponding and as / dated. During a ASM # I have." No furth 6. Responde is signed. Reside 6/20/1 with direct chronoge.	d so I do asked if we ded that we ded that we ded that we ded that we de director were made for the form of the fo	age 67 not date and sign them." ASM we could see his notes. ASM # we could. day interview on 7/7/16 at 5:30 dministrative staff member) # 1, 7, and ASM # 2, director of de aware of the missing is issue. At this time a request facility policy. 6 a.m. a list of the dates for each dent was provided by ASM # 1, 29/16, and 5/27/16. The notes of these dates were also provided stated they were not signed or stated they were not signed or siew on 7/8/16 at 8:32 a.m. with # 2 stated, "I presented everything that included but were not limited	ng t.	36		

		E & MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION	ON	(X3) DAT	E SURVEY IPLETED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			33	
		495139	B. WING				08/2016
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F 386	Resident # 12's set), an annual a (assessment ref Resident # 12 a to understand or as scoring 15 of Interview for Mc Cognitive Patter cognitively intact *Bipolar disorder manic-depressicauses unusual levels. www.nimh.nih.sndex.shtml Review of the physician programming an interest to the stated that the stated that the stated that the 2 further stated get on the children in the children in the stated in the children in the ch	most recent MDS (minimum data assessment with an ARD ference date) of 6/15/16, coded s understood by others and able thers. Resident # 12 was coded f a possible 15 on the Brief ental Status in Section C, rns, indicating the resident was etc. er, also known as ive illness, is a brain disorder that all shifts in mood, energy, activity gov/health/topics/bipolar-disorder/clinical record revealed no ress notes by the attending rview on 7/7/16 at 11:50 a.m. with aff member) # 2 (medical records alled that every week she (OSM # f all residents that need to be seen an. OSM # 2 stated that she gives physician each week; OSM # 2 e physician does handwritten note anotes and types them up. OSM ed that the typed notes don't alway.), 2) ns s,#	386			

TATEMENT OF DEFICI ND PLAN OF CORREC	ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		NSTRUCTION	COMPLETED		
		495139	B. WING				/08/2016	
NAME OF PROVIDER				315 E/	T ADDRESS, CITY, STATE, ZIP CODE AST LEE HIGHWAY MARKET, VA 22844			
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week. written note th proble reside the rec # 3 wa 3 resp During p.m. w execu nurse physic was n On 7/ visit for docur on 12 one r provie not si During ASM I hav No for 7. R note sign	notes are rest you can't m. I have heat you can't m. I have heat you can't m. I have heat you can't wonded that you can't was asked if you onded that you can progress hade for the secutive director each resident decentive director each resident decent was also an intervity and an intervity and an intervity arther information of the clinical signal sig	behind in dictation. My hand not acceptable - what use is a tread. I recognize that it is a andwritten notes for each of consider my notes a part of not date and sign them." ASM we could see his notes. ASM # we could. day interview on 7/7/16 at 5:30 dministrative staff member) # 1, and ASM # 2, director of de aware of the missing is issue. At this time a request a facility policy. a.m. a list of the dates for each dent was provided by ASM # 1, ector. A list of the dates for each dent was provided. This list ASM # 3 visited Resident # 12 16, 3/25/16, and 5/20/16. Only bonding to these dates was 6) and as ASM # 3 stated it was	g	386				

TATEMENT (S FOR MEDICARE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495139	B. WING _			/08/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 315 EAST LEE HIGHWAY NEW MARKET, VA 22844	CODE	
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 386	with diagnoses that to: congestive head diabetes, multiple gastroesophagear Resident # 13's met), a quarterly a (assessment refe Resident # 13 as to understand other as scoring 11 of a Interview for Men Cognitive Pattern moderately cognitive Pattern and	at included but were not limited art failure, hyperlipidemia, sclerosis*, and reflux disorder. In ost recent MDS (minimum data ssessment with an ARD rence date) of 6/1/16, coded understood by others and able ares. Resident # 13 was coded at possible 15 on the Brief stall Status in Section C, is, indicating the resident was stively impaired. In MS the body's immune myelin, which coats nerve cells. alth/multiple-sclerosis Inical record revealed no iss notes by the attending The won 7/7/16 at 11:50 a.m. with finember) # 2 (medical records at that every week she (OSM # all residents that need to be seen by sician each week; OSM # 2 onlysician does handwritten notes notes and types them up. OSM that the typed notes don't always.), 2) n s s, #	.86		

CENTERS FOR MEDICARE TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SUF COMPLET	
	495139	B. WING			08/2016
NAME OF PROVIDER OR SUPPLIER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 15 EAST LEE HIGHWAY IEW MARKET, VA 22844		
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week. I'm always written notes are in note that you can' problem. I have he resident but do not the record so I do # 3 was asked if v 3 responded that During the end of p.m. with ASM (and executive director nurses, were many physician progres was made for the was made for the control of the executive director visit for each residue that the executive director of the executive di	behind in dictation. My hand not acceptable - what use is a tread. I recognize that it is a nandwritten notes for each of consider my notes a part of not date and sign them." ASM we could see his notes. ASM # we could. I day interview on 7/7/16 at 5:30 dministrative staff member) # 1, r, and ASM # 2, director of de aware of the missing is issue. At this time a request	g		ontinuation sh	

CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 386	Imited to: arthritis pressure, kidney of the most recent of quarterly assessmere ference date of having a six out of for mental status) severely impaired. Review of the clir documentation of services note from A request was member) #2, the all of the physician #10. An interview was a.m. with OSM (medical records physician's program, with OSM #2 sasked the proce physician's visits every week and stated that the physician's visits every week	oses that included but were not a dementia, high blood disease and diabetes. MDS (minimum data set), a ment, with an ARD (assessment 4/13/16 coded the resident as a f 15 on the BIMS (brief interview) indicating the resident was	· · · · · · · · · · · · · · · · · · ·			

CENTERS	FOR WILDIONIL	& MEDICAID SERVICES			NOTOLICTION	(X3) DAT	E SURVEY
TATEMENT OF ND PLAN OF C	DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		495139	B. WING			07/	08/2016
	VIDER OR SUPPLIER	MARKET		315 E	ET ADDRESS, CITY, STATE, ZIP CODE AST LEE HIGHWAY MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
w all bore covered to the covered to	long and then dice hind in my dictarecerts." ASM #3 sompletes when however and written notes, ton't think it's part when asked if it was physician notes. No." On 7/7/16 at 5:15 and ASM #2, the caware of the finding on 7/8/16 at 8:30 physician's handword ocumented). Who ther notes, ASM you didn't get, we review of the fac Services Guideling Documentation in supervision of the in the facility. All of it is acceptable, progress note must be time of each is acceptable, progress note must be time of each in the facility and dates a progress note must be time of each in the facility. All of the facility is acceptable, progress note must be time of each in the facility. All of the facility is acceptable, progress note must be time of each in the facility. All of the facility is acceptable, progress note must be facility. There were noted that the facility is acceptable and dates a progress note must be facility. There were noted that the facility is acceptable and dates a progress note must be facility. There were noted that the facility is acceptable and dates a progress note must be facility. There were noted that the facility is acceptable and dates a progress note must be facility. The facility is acceptable and dates a progress note must be facility in the facility is acceptable. The facility is acceptable and dates a progress note must be facility in the facility is acceptable and dates a progress note must be facility in the facility is acceptable.	n't read. I scribble notes as I go tate my notes, I'm always tion. I keep a list of when I see showed the form that he e examines the residents. signed and dated his ASM #3 stated, "No, because I of the permanent record." was acceptable that there were son the chart, ASM #3 stated, p.m. ASM #1, the administrator director of nursing were made ngs. a.m. ASM #2 brought the written note dated 3/25 (no year nen asked if there were any #2 stated, "If there is something		386			

		(X1) PROVIDER/SUPPLIER/CLIA	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		67	10012016
		495139	B. WING	TREET ADDRESS, CITY, STATE, ZIP COI		/08/2016
	PROVIDER OR SUPPLIER		3.	15 EAST LEE HIGHWAY		
LIFE CAF	RE CENTER OF NEW	/ MARKET	N	EW MARKET, VA 22844	FCTION	(¥5)
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F 386			F 386			
	with diagnoses the	admitted to the facility on 3/3/12 at included but were not limited gh blood pressure, low back ain, hypothyroid disease, and				
	assessment, a quassessment refer resident as being cognitive decision requiring extensive staff members for this page 15 and 15	MDS (minimum data set) parterly assessment, with an ence date of 6/14/16, coded the severely impaired to make daily as. The resident was coded as we assistance of one or more or most of her activities of daily 49 was coded as requiring to of one staff member for eating.				
	documented phy-	nical record revealed the last sician visit to be 12/7/15. There tes by the nurse practitioner but sician for Resident #9.				
	member (OSM) and the physician. The horse in a pile in his of computer. He how things but I can be even contacted notes and then the horse in a physician.	conducted with other staff #2, the medical records 7/16 at 10:59 a.m. When asked ician visits, OSM #2 stated, "I expanded stating, "He handwritten sheets. He has them fice until he puts them in the as asked for help and it's coming we asked and asked for him to do to make him do something. I've my corporate person. He takes doesn't put it in the computer. By a physician service within our request was made to speak with				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495139	B. WING			/08/2016
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 386	physician for Resid ASM #3 stated, "It an (name of corposolid week to catch me coverage next notes. When some handwritten H & Punreadable. I hand dictate afterwards dictations. Especiwith too many care who was to help not they won't allow he when asked how stated, "I have a lifurther stated, "Is notes would be shreadable and have The routine stuff, (recertification's). Tuesday, Wednes around and scribb was aware of the physician visits ar stated, "Yes, I am I do a recert, I loo results, dose reducannot do the recent that's the time I rework." When ask something happe would be a messinformation that of But that's my profession putting together recomputer for the	dent #9, on 7/7/16 at 3:20 p.m. 's a huge issue here. I work for oration) affiliate. I wanted a hup. They have finally gotten week so I can dictate my seone comes in, I write a land (history and physical) but it's ad scribble notes and then. I am always behind in itially for ones who don't get seen the concerns. I have an assistant the put them in the computer but the reto put them in the computer." The knows who to see, ASM #3 this acceptable, no but my shorter. I want my notes to be all of the information on them. I keep a list of recerts The recerts usually are done on aday and Thursday. I run to be a note." When asked if he regulations regarding the and progress notes, ASM #3." ASM #3 further stated, "When the area of the information on the retres. When I do the recerts, eview the nurse practitioner the set what would happen if the total the used to follow the care, below; I want the notes to be and accurate. It's not good. I'm my handwritten notes into the ones you have requested." To p.m. ASM #3 brought a list of the progress of the context of the ones you have requested."		86		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN O	r CURRECTION	IDENTIFICATION NOINDER.	A. BUILDING _			
		495139	B. WING		07/0	8/2016
	PROVIDER OR SUPPLIER	MARKET	31	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENÇIES 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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	they were seen. As any list prior to Der Resident #7 was s 5/5/16. ASM #3 wa handwritten notes The executive dire of nursing, were m findings on 7/7/16 made to provide e for Resident #9 sir On 7/8/16 at 8:27 progress notes we and 5/5/16. No further informatical executive directions in the second sec	d handwritten notes of when SM #3 stated, "I do not have cember." The list documented een on 1/30/16, 4/7/16 and as requested to provide the for these visits. ctor and ASM #2, the director ade aware of the above at 5:28 p.m. A request was vidence of the physician visits	F 386			
SS=E	OF PHYSICIAN V The resident must once every 30 day admission, and at thereafter. A physician visit is not later than 10 or required. This REQUIREMINES Based on staff in and clinical record the facility staff favisits for 6 of 28 residence.	is be seen by a physician at least as for the first 90 days after least once every 60 days considered timely if it occurs lays after the date the visit was lays after the date the visit was enterview, facility document review a review, it was determined that ited to ensure timely physician esidents in the survey sample, #13, #1, #10 and #7		F387 Criterion #1 - How will the corraction be accomplished for thos residents found to have been af by the deficient practice? Residents # 6, # 8, # 13, # 1, # 10 7 were identified as being affected this deficient practice.	fected), and #	

Facility ID: VA0145

CENTERS FOR MEDICARI TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			07/08/2016	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET (X4) ID PREFIX FREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI. TAG	315 NE	REET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY W MARKET, VA 22844 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	CORRECTION (X ON SHOULD BE COMPL HE APPROPRIATE DA	
F 387 Continued From particles of the physician of the ph	ff failed to provide evidence Resident #6 was seen for recertification from 12/30/15 otal of 183 days). aff failed to provide physician #8 between 7/13/16 and eys); and between 2/23/16 and eys); and between 2/23/16 and eys). (per the physician's list of visits) Resident # 13 from 12/4/15 until dof 111 days). ailed to ensure that Resident #1 ician visit from 3/7/16 to 7/7/16. ailed to ensure that Resident #10 ician recertification for services is to 7/7/16.	en 5	387	Resident # 6 was seen by Medic Director on 07/27/16 for recertification is on the medical record. Resident # 8 was seen by Medic Director on 06/18/16 for recertification is on the medical record. Resident # 13 was seen by Medic Director on 07/27/16 for recertification is on the medical record. Resident # 13 was seen by Medic Director on 07/27/16 for recertification is on the medical record. Resident # 1 no longer resides facility. Resident # 10 was seen by Medic Director on 07/27/16 for recertification is on medical record. Resident # 7 was seen by Medic Director on 06/14/16 for recertification is on medical record.	cal affication the dical artification	

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	SURVEY
ND PLAN O	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		357	
		495139	B. WING			07/0	8/2016
	TO STATE OF CLUBBILIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER		1		5 EAST LEE HIGHWAY		
LIFE CAF	RE CENTER OF NEW	MARKET		NE	EW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DESICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	OFD RF	(X5) COMPLETION DATE
F 387	Continued From p	age 78 n as being severely impaired.	F	387	F387 Continued from Page 7	' 8	
	Review of Resider copies of physicia reveal documenta was seen by the co	nt #6's clinical record and n's progress notes failed to ition to evidence the resident ohysician for recertification from 0/16 (a total of 183 days).			Criterion # 2 - How will the faidentify other residents havin potential to be affected by the practice?	g the	
	conducted with O medical records of gives ASM (admir (Resident #6's phoned to be seen to OSM #2 stated A from each visit but typed and on the bas asked for he	7//16 at 10:55 a.m., an interview was ucted with OSM (other staff member) #2 (the cal records employee). OSM #2 stated she ASM (administrative staff member) #3 ident #6's physician) a list of residents who to be seen for recertification every week. #2 stated ASM #3 keeps handwritten notes each visit but doesn't always get the notes d and on the chart. OSM #2 stated ASM #3 asked for help regarding this matter and was loosed to receive help the following week.			A 100% audit of medical recornhouse residents was conducted director on 07/13/16. A list of who had not been seen by a Modern Doctor (MD) within the required days for short stay or 60 days for stay was compiled and provided Interim Executive Director and Director on 07/13/16.	by HIM f residents edical ed 30 for long ed to the d Medical	
	conducted with A records had been ask to "catch up and stated his bosse to assist him unt stated other phy enough informative eview of system dictated the note behind on dictate ASM #3 stated supposed to help computer but the allow his assistance.	7 p.m., an interview was ASM #3. ASM #3 stated medical in a huge issue. ASM #3 stated ting his bosses for a solid week help to stay caught up." ASM #s didn't have anyone authorized it the following week. ASM #3 sicians' notes didn't contain tion but he (ASM #3) used the ins, hand scribbled notes then es. ASM #3 stated he was alway ions, especially for routine visits he has an assistant who is the has an assistant who is the ecomputer system would not ent to do so because of HIPAA (25M #3 was asked to provide his es to evidence all of Resident #6	3 ys 2)		The Medical Director or other Credentialed Attending Physic will complete a recertification each resident identified to be a compliance as of the audit. The will be documented by signed progress note directly in the market form or dictated progress the chart within 24 hours of violation of National Physics (198/05/16, all residents in-house have a recertification visit with required time frame document medical record.	visit for out of hese visits and dated hedical fication a note on isit. As of se will hin the	

TATEMENT	S FOR MEDICARE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495139	B. WING			07/0	8/2016
	ROVIDER OR SUPPLIER			315	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY 5 W MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEEICIENG	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD RF	(X5) COMPLETION DATE
TAG	Continued From pstandard survey, make sense of mhandwritten notes. On 7/7/16 at 5:25 administrator) an nursing) were maregarding physici were asked to prnotes for Resider the last standard had been seen at On 7/8/16 at 8:30 "RESIDENTS Little documented Resphysician on 12/5/24/16. No evic handwritten notes ASM #2 stated stregarding physician on the medical response of the medical respons	page 79 ASM #3 stated, "You can't y notes." ASM #3 presented his for another resident. p.m., ASM #1 (the director of an visits. ASM #1 and ASM #2 ovide all of ASM #3's handwritten at #6 and other residents since survey to evidence the residents t each required visit. D a.m., ASM #2 provided a ST" dated 5/30/16 that sident #6 had been seen by the 8/15, 2/2/16, 3/29/16 and dence of these visits (including as) was provided. At this time, she had no further information can visits. By titled, "Physician Services umented, "Policy: Documentation accord must reflect supervision of	F	387	Criterion #3 - What measures put in place or systematic charmade to ensure the deficient pwill not reoccur. Health Information Manager (H HIM assistant will keep a running physician visits required and promote MD with recertification visits refor the upcoming week. Begin 07/13/16, the HIM director or H assistant will complete an audit determine if required visits from are documented in the medical A Physician Reminder letter we provided to the Medical Doctor any visits not completed by during Visits within 10 days of due do considered timely. The Medical	IIM) or ng log of ovide equired ming on HIM to m the list record. ill be r (MD) of e date. ate are cal	
	Guidelines" documented, "Policy: Documentation in the medical record must reflect supervision of medical care of each resident in the facility. All opinions that require physician judgement are signed and dated only by the physician or his designated representative (i.e., physician's assistant, clinical nurse specialist, or nurse practitioner) per state guidelines A physician must visit the resident at least every 30 days for the first 90 days after admission and at least every 60 days thereafter. Visits may alternate with a physician's assistant (PA), clinical nurse specialist (CNS) or nurse practitioner (NP). The facility is responsible for investigating any state regulations related to physician delegation to determine if state law is contrary. A visit is				Director and Interim Executive will be provided a copy the list overdue physician visits week beginning on 07/25/2016 for a correct compliance is achieved	st of ly 3 months	

OF DEFICIENCIES	IDENTIFICATION NUMBER:	A. BUILD			(X3) DATE SURVEY COMPLETED 07/08/2016		
	495139 / MARKET	STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY				07/08/2010	
(EACH DESICIENC	V MUST BE PRECEDED BY FULL			JEACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION DATE	
considered to be to days after the due No further information. (1) "Dementia is the symptoms caused brain. It is not a second onormal activitie eating" This in website: https://www.nlm.rml (2) Health Insural Act (HIPAA) - "More and other health be protected, and information. The gives you rights a sets rules and lin receive your hear applies to all form information, when The Security Rul security for health This information http://www.hhs.gmaterials-for-collections."	imely if it is made within 10 date" Intion was provided prior to exit. The name for a group of a by disorders that affect the pecific disease. People with the able to think well enough to es, such as getting dressed or formation was obtained from the hih.gov/medlineplus/dementia.ht The Portability and Accountability ost of us believe that our medical information is private and should do we want to know who has this Privacy Rule, a Federal law, over your health information and hits on who can look at and lith information. The Privacy Rule is a Federal law that requires the information in electronic form. Was obtained from the website: gov/hipaa/for-individuals/guidance on sumers/index.html Was admitted to the facility on gnoses including, but not limited ructive pulmonary disease,		387	Criterion # 4 – How will the formonitor the corrective plan to the deficient practice was corrand not reoccur? Results of audit regarding any of required physician visits incoverdue physicians visits will reported for review and recommendations to the Quality Assurance/Performance Improved (QA/PI) by HIM, I assistant or Interim Executive Director(IED) for at least 3 metrics.	acility o ensure rected tracking luding be ty ovement HIM	08/05/10	
	ROVIDER OR SUPPLIER E CENTER OF NEW SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From p considered to be to days after the due No further informat (1) "Dementia is the symptoms caused brain. It is not a selection of the security in eating" This in website: https://www.nlm.r. ml (2) Health Insurat Act (HIPAA) - "More and other health be protected, and information. The gives you rights of sets rules and lin receive your hea applies to all forr information, whe The Security Rul security for healt This information http://www.hhs.g. materials-for-co	ROVIDER OR SUPPLIER E CENTER OF NEW MARKET SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 80 considered to be timely if it is made within 10 days after the due date" No further information was provided prior to exit. (1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating" This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.ht ml (2) Health Insurance Portability and Accountability Act (HIPAA) - "Most of us believe that our medica and other health information is private and should be protected, and we want to know who has this information. The Privacy Rule, a Federal law, gives your rhealth information. The Privacy Rule, a Federal law, gives your health information. The Privacy Rule applies to all forms of individuals' protected health information, whether electronic, written, or oral. The Security Rule is a Federal law that requires security for health information in electronic form. This information was obtained from the website: http://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html 2. Resident #8 was admitted to the facility on 6/27/13 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, chronic back pain and anxiety disorder. On the most recent MDS (minimum data set), an annua sessessment dated 6/10/16, Resident #8 was	ROVIDER OR SUPPLIER E CENTER OF NEW MARKET SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 80 considered to be timely if it is made within 10 days after the due date" No further information was provided prior to exit. (1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. 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On the most recent MDS (minimum data set), an annual agreesment data 64 (10/16. Resident #8 was	

STATEMENT	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY MPLETED
		495139	B. WING	TOTAL STATE 7IP		/08/2016
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP 315 EAST LEE HIGHWAY NEW MARKET, VA 22844	CODE	
(X4) ID PREFIX TAG	SUMMARY S	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	HE APPROPRIATE	(X5) COMPLETION DATE
F 387	decisions. A review of the cophysician visit mourse of the surevidence of physician 2/23/16 and failed to produce between 7/13/16 between 2/23/16 On 7/7/16 at 3:1 member) #3, Reand the facility in the stated he will be the prioritizenew admission the highest prioritizenew admission the highest prioritizenew admission the director of concerns. On 7/8/16 at 5: member) #1, the director of concerns. On 7/8/16 at 1 member) #2 with the director of concerns. On 7/8/16 at 1 member) #2 with the director of concerns. On 7/8/16 at 1 member) #2 with the director of concerns.	dinical revealed evidence of a ade on 7/13/16. During the rvey, the facility staff provided sician visits made on 11/13/15; 16/18/16. However, the staff e evidence of a physician visit and 11/13/15 (120 days); and 6 and 6/8/16 (104 days). If p.m., ASM (administrative staff esident #8's attending physician medical director, was interviewed. as aware that he may have been e recertification visits. He stated es his time to see residents with and acutely ill residents receiving ority. 30 p.m., ASM (administrative staff executive director, and ASM #2 nursing, were informed of these calculated as a no documentation of the ced visits by the physician. 0:10 a.m., OSM (other staff vas interviewed. She stated that the physician a weekly list of visits are made. She stated: "That's all I yone knows this is a problem."	g f			
	3. The physic	cian (per the physician's list of visit	15)	Facility ID: VA0145	If continuation s	heet Page 82 of

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVE COMPLETED 07/08/201	
ND PLAN O	F CORRECTION	S-2	B. WING	90		
	RE CENTER OF NE		STI	REET ADDRESS, CITY, STATE, ZIP CO 5 EAST LEE HIGHWAY EW MARKET, VA 22844	DE	
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 387	did not examine 3/25/16 (a period 8/25/16 (a period 6/20/06 and mos with diagnoses the diabetes, multiple gastroesophage most recent MD assessment with date) of 6/1/16, understood by oothers. Resider of a possible 15 Status in Section the resident was *Multiple scleronervous system attacks nocih.nih.gov/h. Review of the ophysician programmer of the complexity of the com	Resident # 13 from 12/4/15 until	al d ll		Continuation sh	

TATEMENT	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIED IDENTIFICATION NUMBER 1		(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN O	CONNECTION		B. WING			07/	08/2016
	PROVIDER OR SUPPLIER		B. WINC	31	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 387	stating, "I've been to do all the paper week. I'm always written notes are roote that you can' problem. I have heresident but do not the record so I do # 3 was asked if v 3 responded that During the end of p.m. with ASM (and executive director nurses, were many physician progress was made for the continuous of the executive director visit for each residue executive director visit for each residue executive director visit for each residue executive director on 12/4/15, 3/25/25/25/25/25/25/25/25/25/25/25/25/25/	d that records are a problem asking for help for some time work. I'm getting help next behind in dictation. My hand not acceptable - what use is a tread. I recognize that it is a handwritten notes for each of consider my notes a part of not date and sign them." ASM we could see his notes. ASM # we could. day interview on 7/7/16 at 5:30 dministrative staff member) # 1, r, and ASM # 2, director of de aware of the missing as issue. At this time a request	g	387			

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				MPLETED
		495139	B. WING			07	/08/2016
	PROVIDER OR SUPPLIER RE CENTER OF NEW	MARKET	STREET ADDRESS, CITY, STATE, ZIP CO 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		AST LEE HIGHWAY MARKET, VA 22844	DDE	
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIEM (EACH CORRECTION OF THE APPROPRIEM OF T	ULD BE	(X5) COMPLETION DATE
F 387	kidney failure. The most recent Magnetic of the session of the clin documentation of a total of 121 days. A request was mandementation of a total of 121 days. A request was mandementation of a total of 121 days. A request was mandementation of a total of 121 days. A request was mandementation of a total of 121 days. An interview was a.m. with OSM (of medical records in the physician's progreshert, OSM #2 staked the procession of the physician's visits every week and estated that the physician's visits every week and estated that the physician's wisits every week and estated that the physician's visits every week and estated that the physician's every	MDS (minimum data set), a sent, with an ARD (assessment 5/18/16 coded the resident as 15 on the brief interview for cating the resident was sed cognitively. The resident uiring assistance from staff for	nd	387			

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		495139	B. WING			07/	08/2016
	PROVIDER OR SUPPLIER			31	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844		
(X4) ID PREFIX TAG	SUMMARY ST	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PROVIDERIS BLAN OF CORRECTION		DBE	(X5) COMPLETION DATE
F 387	along and then dibehind in my dictarecerts." ASM #3 completes when When asked if he handwritten notes don't think it's par When asked if it no physician note "No." On 7/7/16 at 5:15 and ASM #2, the aware of the find On 7/8/16 at 8:36 something you diphysician progres. Review of the faservices Guideli Documentation supervision of the in the facility. A lat least every 30 admission and a No further information for the facility of the facility of the faser every 30 admission and a No further information for the facility of the facility of the facility of the facility of the facility. A lat least every 30 admission and a No further information for the facility of t	an't read. I scribble notes as I go ctate my notes; I'm always ation. I keep a list of when I see showed the form that he he examines the residents. It is signed and dated his so, ASM #3 stated, "No, because I that there were son the chart, ASM #3 stated, was acceptable that there were son the chart, ASM #3 stated, so p.m. ASM #1, the administrator director of nursing were made ings. In a.m. ASM #2 stated, "If there is idn't get, we don't have it." No so notes were received. In the medical record must reflect the medical care of each resident only in the medical record must reflect the medical care of each resident only in the first 90 days after at least every 60 days thereafter. In atlied to ensure that Resident #10 sician recertification for services.	t	3387			

TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DAT COM	E SURVEY MPLETED
		495139	B. WING			/08/2016
	PROVIDER OR SUPPLIER	/ MARKET		STREET ADDRESS, CITY, ST 315 EAST LEE HIGHWAY NEW MARKET, VA 228		
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F 387	The most recent of quarterly assessmereference date of having a six out of for mental status) severely impaired coded as requiring activities of daily of the clindocumentation of services note from the Arequest was mander) #2, the all of the physician #10. An interview was a.m. with OSM (of medical records physician's program, oSM #2 sasked the procest physician's visited every week and stated that the pout had not put the notes were not a record. An interview was asking my boss asking my boss asking my boss.	lisease and diabetes. MDS (minimum data set), a nent, with an ARD (assessment 4/13/16 coded the resident as f 15 on the BIMS (brief interview indicating the resident was cognitively. The resident was g the assistance of staff for all	nd	87		

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CON	/08/2016
	PROVIDER OR SUPPLIEF		B. WING	STREET ADDRESS, CITY, STATE, Z 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		700/2010
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 387	along and then dibehind in my dictarecerts." ASM #3 completes when When asked if he handwritten noted don't think it's par When asked if it no physician note "No." On 7/7/16 at 5:13 and ASM #2, the aware of the find On 7/8/16 at 8:3 physician's hand documented). Wo other notes, ASI you didn't get, wo Review of the faservices Guidel Documentation supervision of the in the facility. A at least every 3 admission and No further information of the facility of th	an't read. I scribble notes as I go ctate my notes; I'm always ation. I keep a list of when I see showed the form that he he examines the residents. It is signed and dated his so, ASM #3 stated, "No, because it of the permanent record." It was acceptable that there were son the chart, ASM #3 stated, of p.m. ASM #1, the administrator director of nursing were made ings. 10 a.m. ASM #2 brought the written note dated 3/25 (no year then asked if there were any of #2 stated, "If there is somethin	g et	387		

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/08/2016		
	PROVIDER OR SUPPLIER		B. WING	STR 315	EET ADDRESS, CITY, STATE, ZIP CODI EAST LEE HIGHWAY W MARKET, VA 22844		10012010	
(X4) ID PREFIX TAG	SUMMARY ST	TATEMENT OF DEFICIENCIES SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION		IOULD BE	(X5) COMPLETION DATE	
F 387	The most recent I assessment, a quassessment refer resident as being cognitive daily de coded as requirin more staff memb living except eatin assistance of one Review of the clir physician progres physical dated 6/documented by the year. The nuthe facility. The lapractitioner note An interview was staff member (A 7/7/16 at 10:24 as she had seen Rehaven't seen her seen her for a with physician) saw her was the seen her for a with physician as well as the facility. An interview was member (OSM) employee, on 7/who tracks physician) has in a pile in his or a pile i	hypothyroid disease, steoporosis. MDS (minimum data set) sarterly assessment, with an ence date of 5/13/16, coded the severely impaired to make cisions. The resident was g extensive assistance of one or ers for all of her activities of dailying in which she required limited	n "	387			oot Page 89 o	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495139	B. WING		07	/08/2016
	PROVIDER OR SUPPLIER	MARKET	STREET ADDRESS, CITY, STATE, ZIP 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		CODE	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	SECON PERFORMANCE TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 387	things but I can't meven contacted my notes and then do He's employed by corporation." A reg the physician. An interview was on physician for Residus ASM #3 stated, "It an (name of corposolid week to catcome coverage next notes. When some handwritten H & Punreadable. I hand dictate afterwards dictations. Especiwith too many carwho was to help in they won't allow how stated, "I have a lifurther stated, "Is notes would be shreadable and have The routine stuff, (recertification's). Tuesday, Wednes around and scribt was aware of the physician visits and the stated, "Yes, I am I do a recert, I loo results, dose reducannot do the recent that's the time I results the time I r	asked and asked for him to do take him do something. I've or corporate person. He takes esn't put it in the computer. a physician service within our quest was made to speak with conducted with ASM #3, the dent #7, on 7/7/16 at 3:20 p.m. Is a huge issue here. I work for oration) affiliate. I wanted a hup. They have finally gotten week so I can dictate my deone comes in, I write a (history and physical) but it's and scribble notes and then. I am always behind in dially for ones who don't get seem the put them in the computer but the put them in the computer but the put them in the computer but the knows who to see, ASM #3 this acceptable, no but my norter. I want my notes to be all of the information on them. I keep a list of recerts The recerts usually are done or say and Thursday. I run to be a note." When asked if he regulations regarding the note progress notes, ASM #3 I." ASM #3 further stated, "When the say and the recerts, and the recerts, eview the nurse practitioner series. When I do the recerts, eview the nurse practitioner's ed what would happen if	1	387		

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION	COMPLETED
		495139	B. WING		07/08/2016
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		IP CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ODGGG DEFEDENCED TO	TION SHOULD BE THE APPROPRIATE DATE
E //31	would be a mess information that computer for the computer for formation for the computer for formation for the computer for the computer for formation for	age 90 ned to him, ASM #3 stated, "It but I feel there is enough ould be used to follow the care. olem; I want the notes to be d accurate. It's not good. I'm my handwritten notes into the ones you have requested." p.m. ASM #3 brought a list of nd handwritten notes of when ASM #3 stated, "I do not have eccember." The list documented seen on 11/28/15, 12/28/15, and 6/14/16. ASM #3 was vide the handwritten notes of rector and ASM #2, the director made aware of the above 6 at 5:28 p.m. A request was evidence of the physician visits since last survey. The provided prior to exit. The pro	f	F431 Criterion #1 - How w action be accomplish residents found to haby the deficient practice but was not for adversely affected by	ed for those ave been affected tice? antified in this been affected

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495139	B. WING			07/0	8/2016	
	PROVIDER OR SUPPLIER			ST 31	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844			
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 431	F 431 Continued From page 91 professional principles, and include the		F	431	F431 Continued from Page 9	1		
	appropriate access instructions, and the applicable. In accordance with facility must store locked compartments controls, and permanently affixed controlled drugs list control	sory and cautionary ne expiration date when all drugs and biologicals in ents under proper temperature nit only authorized personnel to e keys. Provide separately locked, ed compartments for storage of ested in Schedule II of the Orug Abuse Prevention and read other drugs subject to en the facility uses single unit tribution systems in which the minimal and a missing dose cared. ENT is not met as evidenced evation, staff interview and facility cure narcotics on one of six s, the Dogwood unit cart. failed to lock the narcotic box eation administration observation of the expiration of the care and care.			Immediately upon notification lid on the narcotic drawer of the identified medication cart was malfunctioning causing the draws to lock, the Director of Nursing contacted the pharmacy and a was sent out to change out the box. Repairs were made to the box on 07/07/16 by a pharmacy technician. On 07/07/16, 1:1 education we provided to LPN # 8 by the Strengarding the policy that all nurses the stored in a double lock system and reporting any protection the locking mechanisms immediately other residents have potential to be affected by the practice? All residents who are prescriptionarcotics have the potential to affected by this practice.	awer not g (DON) technician narcotic anarcotic expansion arcotic expansion arcotics exed blems with ediately to N).		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG	(X3) DATE COMP	PLETED
		495139	B. WING			8/2016
	PROVIDER OR SUPPLIER	MARKET		STREET ADDRESS, CITY, STATE, ZIP O 315 EAST LEE HIGHWAY NEW MARKET, VA 22844	CODE	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 431	and lung disease. The most recent Magnetic process of the medication who had requested (licensed practical narcotic box, the light the medication can be medication are processed by the medication can be marcotic box at the medication can be more processed by the medication can be marcotic box at the medication can be marcotic box.	arthritis, high blood pressure **IDS** (minimum data set), a ent, with an ARD (assessment 3/28/16 coded the resident as 15 on the BIMS (brief interview indicating the resident was make daily decisions. **IDS** (as made on 7/7/16 at 8:32 a.m.) **IDS** (as made on 7/7/16 at 8:32 a	F 4	Immediately upon notification issue with the identified meach LPN Unit Manager in other four (4) medication of the narcotic drawers were properly. No other issues Criterion #3 - What means put in place or systematic made to ensure the deficit will not reoccur? Beginning on 07/25/16, education of the provided by IED, SDC, to all licensed Nurses regasecurement of narcotics in locked system. Education include how to report issue medication carts, includin mechanisms. Education of the completed by 08/05/16 and information will be provided newly hired nurses. Beginning on 07/25/16, the UM will audit each medication medication and the provided will audit each medication of the complete of the provided nurses.	tion of the edication cart, aspected the carts to ensure locking were found. sures will be c changes ient practice ducation will, and/or DON arding a double a will also les with the log locking will be and same ded to all	
	narcotic box on the opened without the was pushed down asked why the nature LPN #8 stated, "It them safe and so into them." When	ne medication cart. The lide he use of the key. When the lidenth the box would lock. When the lidenth the box was usually locked, Because it's narcotics to keep on none of the residents can get a asked if the narcotic box should locked, LPN #8 stated, "Um, no	d	their assigned units to ensure properly secured in a dour system. This audit will be daily for 5 days a week for 3 times a week for 4 week weekly for 4 weeks and a documented on an audit	sure narcs are lible lock be completed for 4 weeks then leks, then once results will be	

PRINTED: 07/19/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE COI	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:				COMP	LETED
		495139	B. WING				8/2016
NAME OF P	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, Z AST LEE HIGHWAY	ZIP CODE	
LIFE CAR	RE CENTER OF NEW	MARKET		-	MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 431	a.m. with LPN #2, shown the unlocked why the narcotic b stated, "That's who because it has con On 7/7/16 at 5:15 member) #1, the a	age 93 conducted on 7/7/16 at 11:55 the unit manager. LPN #2 was ed narcotic box. When asked ox had a lock on it, LPN #2 at we are supposed to do ntrolled substances in it." p.m. ASM (administrative staff administrator and ASM #2, the g were made aware of the	F 4	C m tl a	Criterion # 4 – How woonitor the corrective he deficient practice wond not reoccur?	e plan to ensure was corrected	08/05/16
F 441 SS=D	Review of the faci Storage & Securit "NOTE: Schedule medicationsMe locked as required No further informate *Hydrocodone is https://www.nlm s.html> 483.65 INFECTION SPREAD, LINEN The facility must Infection Control safe, sanitary and to help prevent the of disease and in	edications are then double d. ation was provided prior to exit. used to relieve severe painnih.gov/medlineplus/medlineplu ON CONTROL, PREVENT S establish and maintain an Program designed to provide a d comfortable environment and ne development and transmission fection. trol Program	F	441	ncluding verification the functioning properly we view and recommend Quality Assurance/Perimprovement Committed DON or UM for 3 more compliance is achieved. F441 – Part 1 – Resident Criterion #1 - How we action be accomplished to happy the deficient praction to happy the deficient praction.	hat all locks are fill be reported for dations to the formance tee (QA/PI) by the other or until 100% d. lent # 28 vill the corrective ed for those two been affected tice?	
	The facility must	establish an Infection Control	S		Resident # 28 was ide affected by this practic gave resident # 28 me washing her hands pri	ce. The nurse that dication without	

Event ID: 8PM911

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	COMPL	
		495139	B. WING			3/2016
	AN OF CORRECTION A95139 OF PROVIDER OR SUPPLIER CARE CENTER OF NEW MARKET SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 441 Continued From page 94 (2) Decides what procedures, such as isolation should be applied to an individual resident; and (3) Maintains a record of incidents and correcti actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility musisolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for whand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread o infection. This REQUIREMENT is not met as evidence by: Based on observation, staff interview and face			STREET ADDRESS, CITY, STATE, ZIP COD 315 EAST LEE HIGHWAY NEW MARKET, VA 22844	Ē	
(X4) ID PREFIX TAG	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 441	(2) Decides what should be applied (3) Maintains a reactions related to (b) Preventing Sp (1) When the Infedetermines that a prevent the spreasisolate the reside (2) The facility mucommunicable diffrom direct contact will (3) The facility muchands after each hand washing is professional practical (c) Linens Personnel must transport linens serious relations and the same contact will (3) The facility muchands after each hand washing is professional practical (c) Linens Personnel must transport linens serious relations and the same contact which is the same con	procedures, such as isolation, to an individual resident; and cord of incidents and corrective infections. read of Infection ction Control Program resident needs isolation to do finfection, the facility must nt. ust prohibit employees with a sease or infected skin lesions ct with residents or their food, if transmit the disease. ust require staff to wash their direct resident contact for which indicated by accepted ctice.	F4	or after administration of the I was provided re-education by Development RN/Infection C Nurse (SDC) regarding prope washing and infection control to use during medication admon 07/07/16. On 07/07/16, Five (5) random observations of medication administration were complete SDC/Infection control Nurse proper hand washing practice infection control methods we utilized during medication prother issues were identified.	Medication the Staff ontrol r hand methods inistration ed by the to ensure e and ere being	
	by: Based on obser document review staff failed to fol two of 28 reside a. The facility st before and after Resident #18 ar			Criterion # 2 - How will to identify other residents has potential to be affected by practice? All residents refacility have the potential to by this practice.	aving the y the same esiding in the	
	h The facility st	aff was observed sitting on				

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPL	ETED
		495139	B. WING			07/08	3/2016
	PROVIDER OR SUPPLIER	MARKET		31	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844		
(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 CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Resident #18's becontact isolation for The findings include a. Resident #18 w 1/4/15 and readmit that included but w difficile*, diabetes, and lung disease. The most recent of quarterly assessmant reference date of having a 15 out of for mental status) cognitively intact the resident was code staff for activities coded as always bladder. Resident #28 was 12/17/12 with dianot limited to: eleanxiety. The most recent with an ARD of 6 sometimes under making self under as 00 out of 15 or resident was severe sident was severe sident was code staff for all activities and severe made on 7/1 was made on 7/1.	d. Resident #18 was on or clostridium difficile (c-diff).* de: as admitted to the facility on litted on 7/1/16 with diagnoses were not limited to: clostridium arthritis, high blood pressure	d	441	The SDC began performing 1:1 medication pass observations on 07/07/16 to ensure that staff wore awhen residents are on isolation precautions and that Licensed Nurscompleted hand washing before an after each medication pass. No ot issues were identified. Criterion #3 - What measures were identified. Criterion #3 - What measures were identified. The Director of Nursing (DON) Staff Development/Infection Con Nurse (SDC) began education to licensed nurses and Certified Nu Assistants (C.N.A.) on 07/07/16 regarding infection control with emphasis on medication administ and proper hand washing. This education will also be provided to all thires.	will be ges ractice and/ or ntrol o all arsing stration 08/05/16	

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(AI) FROVIDEIVOOI LEIEIVA		TIPLE CONSTRUCTION ING		COMPLETED	
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	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844	, ZIP CODE		
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F 441	FIGURATORY OR LSC IDENTIFYING INFORMATION)		e	F 441 F441 Continued from Page 96 The DON or SDC will maintain a loal infections, and track and trend monthly for education/re-education opportunities for staff. All newly hilicensed nurses will be educated on same topics and given competencie medication pass and infection contrupon hire, annually, and as needed. The DON, SDC or Nurse Unit Mar (UM) will observe and audit hand washing and infection control procedures during medication administration 5 times a week) x weeks then 3 Times a week for 4 vertical three tops of the times a week for 4 vertical traces.			
	A review of Resident #18s physician ' orders dated 7/1/16 documented, "Advair Diskus 250 mcg (microgram) -50 mcg/dose powder for inhalation. Per Inhaler BID (twice a day) 1 puff by inhalation BID for SOB (shortness of breath)."	,	Criterion # 4 – How monitor the correct the deficient practic and not reoccur?	tive plan to ensure			
	Review of the J administration r resident had re- 7/1-7/4/16 and	uly 2016 medication ecord documented that the ceived the Advair twice a day on	or	Results of Infection washing audits during Administration will review and recomme Quality Assurance/P Improvement Common DON, SDC or UM for the substitution of the su	ng Medication be reported for endations to the Performance nittee (QA/PI) by the	08/05/1	
		resident 's care plan initiated on		100% compliance is	achieved.		

TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495139	B. WING		·	07/	08/2016
	ROVIDER OR SUPPLIER			ST 31	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844		
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F 441	7/4/16 documented diagnosis of Clostr There was no evid to contact isolation. An interview was a.m. with LPN #8, their hands. LPN resident." When a hands before and medications to Re LPN #8 stated, "N gowns and gloves #8 stated she did knew Resident #1 #8 stated she did precautions she was c-diff infection, LP gloves. Then was water and use (now When asked what returning an inhal medication cart, Loff. Anything complete control practices medications, LPN when asked what returning an inhal stated, "It should why, LPN #2 state infection."	d, "PROBLEM Resident has idium difficile, (C-Diff-Toxin)." ence of documentation related		441	F441 — 2.) Resident # 18 Criterion #1 - How will the conaction be accomplished for the residents found to have been a by the deficient practice? Resident # 18 was identified as affected by this practice. The may provided re-education by the St Development RN/Infection Con (SDC). This education contained hand washing and infection commethods to use during medicate administration. The same nursualso educated on isolation precaution hand was identified. The C.N.A. that was identified sitting on the bed while assisting resident # 18 was educated on precautions and infection contains the strength of the precautions and infection contains the strength of the precautions and infection contains the precaution of the prec	being urse that was aff introl RN ad proper introl on e was autions solation to be ing isolation	

TATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION (X3	(X3) DATE SURVEY COMPLETED	
		495139	B. WING			07/08/2016	
	DF PROVIDER OR SUPPLIE	R		31	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844		
(X4) I PREF TAG	IX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETIC DATE	
F 4	wash their hands room they use hands care have to use staff needed to wasterial dis resident to reside	hen asked when staff should s, RN #1 stated, "Going into the and sanitizer going out of the sanitizer and after any personal the sanitizer. When asked why wash their hands, RN #1 stated, eases don't get spread from		441	Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice? All residents residing in the facility he the potential to be affected by this practice. Isolation carts are placed inside the resident room for those identified on contact or droplet precautions and resident on isolation precautions are listed on alert charting sheet. An autof all residents with current contact isolation precautions was compiled the SDC on 07/27/2016 and each rowas verified to contain an isolation as well as a magnetic sign on the doface that says "Stop - see nurse prior entering room". No other issues we found. On 07/07/16, the Director of Nursin (DON), Unit Managers (UM) and/or SDC/Infection Control Nurse began random observations of C.N.A.'s providing resident care to ensure no C.N.A.'s were sitting on resident be and that they were following infect control methods while providing caresident's on isolation precautions.	ave dit by bm cart or r to re eds ion are to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		495139	B. WING			07/0	8/2016
	PROVIDER OR SUPPLIER			315 E	ET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY V MARKET, VA 22844		
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Continued From pappetite, Nausea, https://www.nlm.difficileinfections.h ** 1.2 Maintenance Obstructive Pulmo DISKUS 250/50 is maintenance trea patients with chrodisease (COPD), and/or emphysem https://dailymed.fm?setid=f53cb2d b. An observation p.m. of CNA (cert on the foot of Resor gloves on. The wheelchair next to caring a plastic treating a plastic treating a plastic treating and plasti	age 99 Abdominal pain or tenderness. nih.gov/medlineplus/clostridium ntml> e Treatment of Chronic onary Disease. ADVAIR indicated for the twice-daily tment of airflow obstruction in nic obstructive pulmonary including chronic bronchitis	F 44	1	F441 Continued from Page 99 Criterion #3 - What measures was put in place or systematic changemade to ensure the deficient provided to ensure the deficient provided from Page 99 The Director of Nursing (DON) and Staff Development/Infection Con Nurse (SDC) began education to licensed nurses and certified nurses assistants (C.N.A.) on 07/07/201 regarding infection control inclusive proper hand washing and isolation proper hand washing and isolation precautions. This education will completed by 08/05/2016 and was be provided to all new hires. The DON or SDC will maintain all infections, and track and trensmonthly for education/re-education/portunities for staff. All newly licensed nurses will be educated same topics and given competer isolation precaution identification medication pass and infection cupon hire, annually, and as need.	will be ges eactice and/ or introl all sing 6 ding on l be ill also a log of id tion y hired l on incies for on, ontrol	
	An interview was p.m. with CNA# staff followed whroom, CNA#4 si hands with soap When asked wh CNA#4 stated,	s conducted on 7/7/16 at 2:40 4. When asked what process then going into Resident #18's tated, "Gown, glove and wash and water. Don't sit on the bed." by staff should not sit on the bed, "It may have BM (bowel the bed and you would get it on			newly hired C.N.A.'s will be ed on infection control program in isolation precautions, upon hire annually, and as needed.	lucated cluding	

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		495139	B. WING			7/08/2016
	PROVIDER OR SUPPLIER			31	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844	
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	An interview was p.m. with CNA #7 on the bed of a re CNA #7 stated, "I things. I shouldn't shouldn't sit on the It could get on my and I could spread Review of the facility. Contato enter the room caused by C. difficile if so resident or environg Gowns and glove the resident's roof following hand he on 7/7/16 at 5:1 member) #1, the director of nursing findings. No further inform 483.75(j)(1) ADMET	conducted on 7/7/16 at 4:10. When asked if staff should sit sident with a c-diff infection, sat for a moment to label her have." When asked why she e bed, CNA #7 stated, "It's dirty. It's clothes, I could take it home d it to the other residents." Willity's policy titled, "Clostridium had, "Purpose, to minimize the clostridium difficile (C-Diff) within at Precautions: Gloves are worn of a resident who has diarrhea icile. A gown is needed to entersident who had diarrhea caused abstantial contact with the commental surfaces is anticipated, are removed before leaving om and hands must be washed by giene guidelines." Deput. ASM (administrative staff administrator and ASM #2, the new ere made aware of the mation was obtained prior to exit.	F	= 502	The DON, SDC or Nurse Unit Manager (UM) will perform observations for residents on isolation precautions to ensure proper hand washing and infection control procedures during resident care are being followed. These observations will occur 5 times a week 4 weeks then 3 times a week for 4 weeks, then weekly x 4 weeks. Criterion #4 — How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur? Results of infection control, hand washing and isolation precaution audit will be reported for review and recommendations to the Quality Assurance/Performance Improvement Committee (QA/PI) by the DON, SDC or UM for 3 months or until 100% compliance is achieved. F502 Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	e x x 8 08/05/10 C, ve

Facility ID: VA0145

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING	COMPLETED		
		495139	B. WING		07/08/2016	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COI 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		DE	
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F 502	by: Based on staff ir and clinical recor the facility staff falaboratory tests for sample, Resident 1. a. The facility sordered fasting listest for Resident 1. b. The facility sordered thyroid sesident #6 ordered liver fundable. 2. The facility staff facility staff facility staff facility staff function panel blaborator depends for the physician ordered fasting listes function test (2) 2015. Resident #6 was 6/26/09. Reside were not limited	nterview, facility document review of review, it was determined that ailed to obtain physician ordered or 3 of 28 residents in the survey its #6, #8, and #7. Staff failed to obtain a physician pid panel test and liver function #6 in December 2015. Staff failed to obtain a physician stimulating hormone level for ered on 3/8/16. Staff failed to obtain a physician ction test for Resident #6 in June aff failed to perform a stool ry test ordered for Resident #8 on aff failed to complete a liver ood test in December 2015, per der, for Resident #7.	F 503	Resident's # 6, #8 and #7 were identified in this practice. 1. Resident # 6's physician was notified on 07/12/16 of ordered fasting lipid panel test and liver function test from December 20 not being collected as ordered. new order was written on 07/14 to perform fasting lipid panel to and liver function test. Reside was not adversely affected by a having blood work performed in December 2015. 2. Resident # 6's physician was notified on 07/08/16 of ordered thyroid stimulating hormone lettest ordered on 03/08/16 not be collected as ordered. The orded discontinued and not rewritten Resident was not adversely affeby not having blood work performed. 3. Resident # 6's physician was notified of ordered fasting live function test from June 2016 in being collected as ordered. A norder was written on 07/14/16 perform fasting liver function Resident was not adversely affeby not having blood work performed in June 2016.	A A/16 est nt not n l vel eing r was ected r ot new to test.	

Event ID:8PM911

STATEMENT OF DEFICIENCIES (X) ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495139	B. WING			07/	08/2016
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F 502	(assessment referesident's cognition Review of Resident Physician's order physician on 7/1/dated 9/19/15 for function test ever December. Furth clinical record failipid panel or live 2015. Resident #6's coonset date of 1/1 information regated on 1/1/16 at 1:20 conducted with Letter (the unit manager requested labsed documented on asked the facility ordered labs. Letter Laborder in manager writes day. LPN #3 state login sheet to donumbers, labsed lab personnel to obtained and the drawn. LPN #3 taken to the lab the facility and resident laborder in 1/2 laborder lab	erly assessment with an ARD rence date) of 4/6/16, coded the on as being severely impaired. ent #6's clinical record revealed a summary signed by the 16 that documented an order a fasting lipid panel and liver by six months in June and her review of Resident #6's led to reveal results of a fasting refunction test for December remprehensive care plan with an 5/15 failed to document reding the above lab tests. 5 p.m., an interview was LPN (licensed practical nurse) #3 er). LPN #3 stated the above could not be found and were not the "lab sheet." LPN #3 was a process for obtaining physician PN #3 stated nurses have lab unit. LPN #3 stated nurses put the lab book and the unit up lab sheets for the following lated the lab books contain a lab ocument residents' names, room ordered, dates and a place for the lab initial the date the labs are location where the blood is stated after labs are obtained an oratory, the results are faxed to reviewed by the physician.	d		4. Resident # 8's physician was notified on 07/08/16 that a sample laboratory test order 04/19/16 was not obtained ordered. Order was disconto 07/08/16. Resident was not adversely affected by not he stool sample lab test composition of ordered liver further panel blood test from Dece 2015 not being collected at The liver function panel test become 2015 was discoton 07/18/16. Liver function test had been performed of 06/08/16. Resident was not adversely affected by not December 2015 blood woth performed. Criterion # 2 - How will the identify other residents have potential to be affected by the practice? All residents who have labor orders have the potential to be by this practice.	vas stool cred on as attinued on ot naving the leted. cas nction ember s ordered. est from ontinued on panel n ot having rk	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	COMPLETED	
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	PROVIDER OR SUPPLIER	MARKET		STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
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F 502	Continued From page 103 director of nursing) were made aware of the above findings. The facility policy titled, "Laboratory Order Sheet" documented, "Standard: All laboratory work is ordered on a standardized laboratory order sheet to minimize errors and omissions. Policy: Department of nursing follows the laboratory order sheet policy. All laboratory work is ordered using the standardized two-ply laboratory order sheet. Laboratory order sheet is labeled with resident data information. Laboratory order sheet is placed in a consistent area for pickup by laboratory personnel. The carbon copy of the completed laboratory order sheet is discarded after the laboratory interim report is received.		F 50	A 100% audit of all labs ordered house residents and due since I 2015 was completed on 07/18/the Unit Managers (UM). Any laboratory test discovered during audit to not be completed was with the Nurse Practitioner or Director. New orders were wroneeded. This process was com 07/18/16.	ed for in- December 2016 by y ng the discussed Medical itten as	
	necessary informations sheet. 2. Unit secretary of space in front of the laboratory work is order sheet, the televal is a completed is placed in plastic.	en removed and placed in the notebook for interim laboratory rded only after the interim		Criterion #3 - What measure put in place or systematic chemade to ensure the deficient will not reoccur. Starting 07/25/16, education we provided by the IED, DON, and to all Licensed Nurses regarding procedures for ordering labs by laboratory books on each nurse.	practice vill be nd/or SDC ng proper by use of	
	No further informa	tion was presented prior to exit.				

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	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP 315 EAST LEE HIGHWAY NEW MARKET, VA 22844	CODE	
(X4) ID PREFIX TAG	SUMMARY S	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF C	ON SHOULD BE COMPLETED HE APPROPRIATE DATE	
F 502	as part of a card determine an ind and to help mak may be best if the This information https://labtestsoipid/tab/test (2) "A liver pane to screen for live has a condition the liver." This website: https://labtestsoiver-panel/tab/te (3) "Dementia is symptoms caus brain. It is not a dementia may do normal active eating" This website: https://www.nlmml	ofile (fasting lipid panel) is used iac risk assessment to help lividual's risk of heart disease e decisions about what treatment here is borderline or high risk." was obtained from the website: nline.org/understanding/analytes/l (liver function test) may be used or is taking a drug that may affect information was obtained from the nline.org/understanding/analytes/l	e	station. The education wi if a sample is unable to be the timeframe ordered, the bediscontinued and a new order should be received MD. On 07/26/16, the Li Managers (UM) were eduprocess of writing up lab that all lab tests were colordered and that results were viewed by the NP or Min the medical record. The LPN Unit Mangers will audit all laboratory results daily, Monday the ensure all laboratory test performed as ordered for months.	ill include that e obtained in at order should w clarified from the NP or PN Unit ucated on the slips, verifying lected as were received, MD and placed Education will 6. (UM) or DON orders and brough Friday to ts were	
	physician's ord stimulating hou tests to be cor of Resident #6	ident #6's clinical record revealed for dated 3/8/16 for a thyroid mone level in addition to other lab repleted on 3/15/16. Further reviews clinical record revealed the additional lab tests dated 3/15/16 veal results of a thyroid stimulatin.	N N	Criterion # 4 – How we monitor the corrective the deficient practice and not reoccur? Residocumentation of labor completed as ordered we monitor the completed as ordered we make the complete which is the correction of the cor	e plan to ensure was corrected ults of audits for ratory test	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495139	B. WING			07/	08/2016
	PROVIDER OR SUPPLIER	MARKET		31	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844	•	
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F 502	onset date of 1/15/information regards On 7/7/16 at 1:25 p conducted with LP (the unit manager) requested lab coul documented on the asked the facility p ordered labs. LPN books on each uni the lab order in the manager writes up day. LPN #3 state login sheet to docu numbers, labs ord- lab personnel to in obtained and the le drawn. LPN #3 sta taken to the labora the facility and rev On 7/7/16 at 5:25 member) #1 (the a director of nursing above findings. No further informa (1) "The thyroid-s is often the test of function and/or sy including hyperthy This information w https://labtestsonli sh/tab/test	prehensive care plan with an 15 failed to document ing the above lab test. D.m., an interview was N (licensed practical nurse) #3. LPN #3 stated the above d not be found and was not e "lab sheet." LPN #3 was rocess for obtaining physician I #3 stated nurses have lab t. LPN #3 stated nurses put e lab book and the unit lab sheets for the following of the lab books contain a lab ument residents' names, room ered, dates and a place for the itial the date the labs are obtained and atory, the results are faxed to iewed by the physician. p.m., ASM (administrative staff administrator) and ASM #2 (the lab ware of the itial the date the labs are obtained and atory, the results are faxed to iewed by the physician. p.m., ASM (administrative staff administrator) and ASM #2 (the lab ware of the labs are obtained from the website: obtained from the website: ine.org/understanding/analytes/taff failed to obtain a physician taff failed to obtain a physician and the labs are obtained from the website: ine.org/understanding/analytes/taff failed to obtain a physician taff failed to obtain a physician and the labs are obtained from the website: ine.org/understanding/analytes/taff failed to obtain a physician and taff failed to obtain a physician taff failed to obtain a physician and the labs are obtained failed to obtain a physician and taff failed to obtain a physician taff failed to obtain a physician and taff failed failed failed failed		502	F502 Continued from Page 105 for review and recommendations Quality Assurance/Performance Improvement Committee (QA/PI) DON, SDC or UM for 3 months 100% compliance is achieved.	to the	08/05/16

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(VI) LINGAIDEIGOSI I EILE	(X2) MULTIPLE CONSTRUCTION A. BUILDING				COMPLETED	
		495139	B. WING			07/08/2016		
	PROVIDER OR SUPPLIER	MARKET	STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844					
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE	
F 502	June 2016. Review of Resider physician's order sphysician on 7/1/1 dated 9/19/15 for a function test every December. Further clinical record faile function test for June Resident #6's composed date of 1/15 information regard. On 7/7/16 at 1:25 conducted with LI (the unit manager requested lab condocumented on the asked the facility ordered labs. LP books on each unthe lab order in the manager writes unday. LPN #3 stated login sheet to do numbers, labs or lab personnel to obtained and the drawn. LPN #3 staken to the laborate facility and results.	ion test (1) for Resident #6 in at #6's clinical record revealed a summary signed by the 6 that documented an order a fasting lipid panel and liver v six months in June and er review of Resident #6's ed to reveal results of a liver	d	502				

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			07/08/084/		
	<u>,</u>	495139	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	07	/08/2016	
	PROVIDER OR SUPPLIER				315 EAST LEE HIGHWAY			
LIFE CAP	RE CENTER OF NEW	MARKET			NEW MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 502	Continued From page 107			502	2			
	No further informa	tion was provided prior to exit.						
	to screen for liver has a condition or the liver." This inf website: https://labtestsonliver-panel/tab/test					34		
	6/27/13 with diagr to: chronic obstru chronic back pain most recent MDS	as admitted to the facility on noses including, but not limited active pulmonary disease, and anxiety disorder. On the (minimum data set), an annual d 6/10/16, Resident #8 was ognitively intact for making daily						
	the following ordersample (fecal cul-	ent #8's clinical record revealed er written 4/19/16: "Collect stool ture) (1) to r/o (rule out) C-diff tile bacteria) (2) and Norovirus						
	results and nurse	the record (including laboratory es notes) revealed no evidence ever performed for Resident #8						
	A review of Residual plan dated 3/23/related to laborate	dent #8's comprehensive care 15 revealed no information tory tests.						
	was interviewed laboratory test re was formed (not	5 p.m., LPN #3, a unit manager, regarding these missing esults. She stated: "If the stool runny), we would not have send any documentation for this						

		IDENTIFICATION NUMBER:	A, BUILDIN	NG		MPLETED
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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 108 resident on that day." When asked about the process for obtaining a laboratory test for a resident, she stated the nurse takes the order and writes it in the lab book. She stated that for stool sample, the facility staff collects the sample and places it in the lab refrigerator, where the personnel pick it up on the next lab day. When asked who is responsible for checking to make sure all ordered lab tests have been performed she stated: "Unit managers should be checking back to make sure it was done." On 7/7/16 at 5:30 p.m., ASM (administrative simember) #1, the executive director, and ASM the director of nursing, were informed of these concerns. No further information was provided prior to expansion in the stool (feces) that can cause gastrointestinal symptoms and disease." This information is taken from the website https://www.nlm.nih.gov/medlineplus/ency/artion/3758.htm. (2)"Clostridium difficile (C. difficile) is a bacterithat causes diarrhea and more serious intesting conditions such as colitis." This information is taken from the website https://www.nlm.nih.gov/medlineplus/clostridium fficileinfections.html. (3)"Noroviruses are a group of related viruses Infection with these viruses causes an illness			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 502	resident on that deprocess for obtain resident, she state and writes it in the stool sample, the and places it in the personnel pick it is asked who is responsed asked ask	ay." When asked about the hing a laboratory test for a sed the nurse takes the order lab book. She stated that for a facility staff collects the sample e lab refrigerator, where the lab up on the next lab day. When consible for checking to make ab tests have been performed, managers should be checking e it was done." p.m., ASM (administrative staff executive director, and ASM #2, rsing, were informed of these ation was provided prior to exit. It is a laboratory test to find stool (feces) that can cause symptoms and disease." This en from the website hih.gov/medlineplus/ency/article/ifficile (C. difficile) is a bacterium nea and more serious intestinal as colitis." This information is ebsite hih.gov/medlineplus/clostridiumdimal. The agroup of related viruses.	F 50	02		

TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
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F 502	https://www.nlm.ni ections.html. 3. The facility staff function panel bloom the physician order Resident #7 was a with diagnoses that to: anxiety, dysuring dementia, edema depression, and of The most recent I assessment refer resident as being cognitive daily de coded as requiring more staff memb living except eating assistance of one The "Physician Of "FLP (fasting lipid test) (2), TSH (the every 6 months of months." This of 10/4/15. Review of the cli TSH test results LFT test results LFT test results. An interview was practical nurse) at 9:58 a.m. The above were revi	taken from the website h.gov/medlineplus/norovirusinf failed to complete a liver od test in December 2015, per er, for Resident #7. admitted to the facility on 6/8/15 at included but were not limited a, high blood pressure, pain, hypothyroid disease, esteoporosis. MDS (minimum data set) parterly assessment, with an ence date of 5/13/16, coded the severely impaired to make cisions. The resident was g extensive assistance of one or ers for all of her activities of dailying in which she required limited estaff member. Orders July 2016" documented, d panel) (1), LFT (liver function yroid stimulating hormone) (3) JUNE - DEC (December) every for der was originally written on mical record revealed a FLP and dated, 12/1/15. There were no		502			

PRINTED: 07/19/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING B. WING 07/08/2016 495139 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 315 EAST LEE HIGHWAY LIFE CARE CENTER OF NEW MARKET **NEW MARKET, VA 22844** PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 502 F 502 | Continued From page 110 results in the clinical record. On 7/7/16 at 11:01 a.m. LPN #2 informed this surveyor that the LFT test results were not done in December 2015. An interview was conducted with administrative staff member (ASM) #2, the director of nursing. on 7/7/16 at 12:33 p.m. When asked if a physician orders a laboratory test, should it be completed, "ASM #2 stated, "It will be obtained unless if unable to attend or resident refuses, then the physician is to be notified." An interview was conducted with LPN #3, a unit manager, on 7/7/16 at 1:31 p.m. When asked the process for obtaining laboratory tests, LPN #3 stated, "You have to have a physician's order for them. Then they are to be completed per the order. If unable to obtain them you have to notify the doctor." When asked how they ensure that all laboratory tests are done per the physician order, LPN #3 stated. "We are to mark them off." When asked who marks them off, LPN #3 stated, "The unit manager is responsible for checking that they were done."

p.m.

No further information was provided prior to exit. F 504 483.75(j)(2)(i) LAB SVCS ONLY WHEN SS=D ORDERED BY PHYSICIAN

The executive director and ASM #2 were made aware of the above findings on 7/7/16 at 5:38

The facility must provide or obtain laboratory services only when ordered by the attending physician.

F 504

F504

Facility ID: VA0145

Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION	COMI	PLETED
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F 504	Continued From pa	age 111	F 5	04 F504 Continued from Pag	ge 111	
	by: Based on staff interest and clinical record the facility staff fair for a laboratory tersurvey sample, Resident #11 on 1 The findings inclusive Resident #11 was 9/19/14. Resident	illed to obtain a physician's lobin A1C (1) obtained from /12/16. de: admitted to the facility on t #11's diagnoses included but		Resident # 11 was identified practice. 07/08/16, resident physician was notified of as blood test, A1C being obtain 01/12/16 while an ordered completed as ordered. Not were received at that time, not adversely affected by hadditional blood work perfection.	# 11's dditional ined on BMP was new orders Resident was aving	
	were not limited to blood pressure ar recent MDS (mini change in status (assessment refe	o: chronic kidney disease, high and pain. Resident #11's most mum data set), a significant assessment, with an ARD rence date) of 6/17/16, coded unition as moderately impaired.		Criterion # 2 - How will t identify other residents he potential to be affected by practice?	aving the	
	a physician's orde metabolic panel (ent #11's clinical record revealed er dated 1/5/16 for a BMP (basic 2)) on 1/12/16. An order for a on 1/12/16 was not		All residents who have lab orders have the potential to by this practice. A 100% l lab tests ordered and due s December 2015 was comp	be affected ab audit for ince	
	revealed the result 1/12/16 and a he 1/12/16.	Resident #11's clinical record ults of a BMP obtained on moglobin A1C obtained on		07/18/16 by the Unit Mana No other occurrences of la being obtained without an identified.	agers (UM). boratory tests	
	onset date of 1/5	omprehensive care plan with an b/15 documented, "Resident is a tions associated with hyper or	t			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495139	B. WING		07/08/2016
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F 504	tests) as indicate at risk for alteration ordered and report of the unit manage process for obtain LPN #3 stated in unit. LPN #3 stated in unit. LPN #3 stated has books contain residents' names dates and a place the date the labs where the blood labs are obtained results are faxed the physician. Lest staff had to have lab test. LPN #3 without an order A1C obtained from documented to be communicated in laboratory. On 7/7/16 at 5:2 member) #1 (the director of nursing above findings. The facility policity documented, "Sordered on a state of the contains of the communicated in laboratory.	gh or low blood nes: Monitor labs (laboratory d and report resultsResident is on in fluid balanceLabs as		Criterion #3 - What measures we put in place or systematic chan made to ensure the deficient provided by the IED, DON, and/to all Licensed Nurses regarding procedures for ordering labs by a laboratory books on each nurse's station. The LPN Unit Managers educated on the process of writing lab slips, verifying that all orders were collected as ordered in a time manner and that results were recordered, reviewed by the NP or placed in the medical record. The education will include that if an additional laboratory test result received, the NP or MD should consulted upon receipt of results. Clarification orders will be obtain NP or MD verbally added an additional laboratory test results. Clarification orders will be obtain NP or MD verbally added an additab request after the specimen was delivered to lab. If there is no e that test was ordered after physical.	will be ges ractice be or SDC proper use of s s were ng up ed labs mely reived as MD and he is be s. ned if ditional as vidence

Facility ID: VA0145

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		COMPLETED
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F 504	order sheet policy. All laboratory work standardized two-p Laboratory order sheat information. Laboratory order sharea for pickup by The carbon copy or order sheet is discainterim report is reconstructed. Procedure: 1. Unit secretary or necessary informations sheet. 2. Unit secretary or space in front of the laboratory work is norder sheet, the test additional tests is a sheet. 3. The carbon is the front pocket of the reports. It is discallaboratory report had the completed of its placed in plastic then placed in a compersonnel" No further informations in the website:	is ordered using the ly laboratory order sheet. Heet is labeled with resident neet is placed in a consistent aboratory personnel. If the completed laboratory perded after the laboratory period after the laboratory order on the laboratory order on the laboratory order on the laboratory set(s) are written in the notebook for interim laboratory reded only after the interim as been received. Period only after the interim and onsistent area for pickup by laboratory order sheet bag with the specimen and onsistent area for pickup by laboratory order sheet bag with the specimen and assures your average blood sugar, level over the past 3		review, the laboratory will be notificial immediately regarding the discrepato determine why the test was performed. Education will be completed by 08/05/2016. The LPN Unit Mangers (UM) or D will audit all laboratory orders and results daily, Monday through Fridensure all laboratory tests were performed as ordered for at least 3 months. Criterion # 4 – How will the facing monitor the corrective plan to enthe deficient practice was correct and not reoccur? Results of audits for documentational laboratory test completed as order be reported for review and recommendations to the Quality Assurance/Performance Improvem Committee (QA/PI) by the DON, or UM for 3 months or until 100%	lity nsure eted on of ed will 08/05/16 nent SDC

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	ΓIPLE (CONSTRUCTION	(X3) DATE	SURVEY
ND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			
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F 504	meta?v%3Aproject medlineplus-bundl =1.187670888.130 (2) BMP (basic medicals in the bundle on the fluid (tests provide information the heart), bones, kidneys and liver. obtained from the https://vsearch.nlmmeta?v%3Aproject medlineplus-bundle A83.75(I)(1) RES RECORDS-COM LE The facility must resident in accord standards and praccurately docum systematically organization to ideresident's assess services provided preadmission scand progress not the resident of the progress not the resident of the progress not the resident of the preadmission scand progress not the preadmission scand pread	t=medlineplus&v%3Asources= e&query=hemoglobin+a1c&_ga 28579129.1468338746 etabolic panel) - "A metabolic f tests that measures different lood. These tests are usually plasma) part of blood. The mation about your body's and metabolism. They can give in about your muscles (including and organs, such as the "This information was website: in.nih.gov/vivisimo/cgi-bin/query- et=medlineplus&v%3Asources= lle&query=bmp PLETE/ACCURATE/ACCESSIB maintain clinical records on each dance with accepted professional actices that are complete; inented; readily accessible; and ganized. If must contain sufficient entify the resident; a record of the sments; the plan of care and diff; the results of any reening conducted by the State;	F	514	F514 Criterion #1 - How will the coaction be accomplished for the residents found to have been aby the deficient practice? Resident's # 11, #3, #4, #8, #2 # 13, # 10 and # 9 were listed affected by this practice. 1. Resident # 11 - Notes for visits on: 07/24/15, 09/11/27/15, 01/28/16, 04/16 were dictated on 07/07/16 placed in medical record 07/07/16.	affected 2, # 12, as being from 22/15, /06/16 16 and	

Facility ID: VA0145

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		MPLETED
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F 514	accurate clinical rethe survey sample #12, #13, #10 and 1. The facility staff clinical record connotes for visits that 11/27/15, 1/28/16 2. a. The facility for circumstances survey to the emergency b. The facility staff physician visits for record. 3. The facility staff physician visits for record. 4. The facility staff physician visits for record. 5. Resident # 2 or physician progres 3/5/16, 4/1/16	ed to maintain a complete and ecord for 9 of 28 residents in , Residents #11, #3, #4, #8, #2, #9. I failed to ensure Resident #11's tained physician's progress at occurred on 7/24/15, 9/22/15, and 4/6/16. A failed to document rrounding Resident #3's transfer		514	 Resident # 3 a.) Transfer to ER – nursed did not complete docume regarding events of emery room transfer on 06/30/1 received 1:1 education by DON on 07/26/2016. b.) Handwritten notes for physician visits on 03/30/06/16/16 were signed and by the Medical Director awere placed on the medicarecord on 07/26/16. Resident # 4 – Handwritten notes for physician visits 03/19/16, 04/15/16, 05/2/2 and 07/01/16 were signed dated by the Medical Director and placed on medical reformation of the medical reformation of the medical placed on the medical reformation of the medical placed on the medical reformation of the medical reformation. 	e who entation gency 6 y the /16 and dated and cal ren on 7/16 d and rector cord on ten on 3/16, d dated and .	

Facility ID: VA0145

PRINTED: 07/19/2016 FORM APPROVED OMB NO. 0938-0391

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F 514	9. There were no clinical record for The findings inclu 1. The facility staf clinical record cornotes for visits that 11/27/15, 1/28/16 Resident #11 was 9/19/14. Resider were not limited to blood pressure at recent MDS (min change in status (assessment refet the resident's cook Review of Resident's cook Review of Resident was a frequired vis 7/24/15 through for 7/7/16 at 11:15 taff member) #2 confirmed Resident #11's recertification proclinical record are of Resident #11's recertification no seen by the phys 11/27/15, 1/28/1	refailed to include a record of Resident #10 on the clinical physician progress notes in the Resident #9 since 12/7/15. de: If failed to ensure Resident #11's ntained physician's progress at occurred on 7/24/15, 9/22/15, and 4/6/16. Is admitted to the facility on at #11's diagnoses included but to: chronic kidney disease, high and pain. Resident #11's most imum data set), a significant assessment, with an ARD erence date) of 6/17/16, coded gnition as moderately impaired. Lent #11's clinical record failed to recertification progress notes for sit during the time period of		 F514 Continued from Pages Resident # 2 - Handwritted dictated notes for physicid visits on 02/01/16, 02/09 02/29/16, 03/05/16, 04/0 04/21/16, 04/29/16, 05/2 and 07/06/16 were signed dated by the Medical Din Nurse Practitioner and pon the medical record on 07/26/16. Resident # 12 - Handwrid dictated notes for physicid visits on 12/04/15, 01/29 03/25/16, 03/26/16, 05/2 and 05/27/16 were signed dated by the Medical Din Nurse Practitioner and pon the medical record on 07/26/16. Resident # 13 - Handwrid dictated notes for physicid visits on 12/04/15, 12/0 02/23/16, 03/25/16, 05/24/16, and 07/27/16 signed and dated by the Director or Nurse Practiand placed on the medical record on 07/27/16. 	en and an /16, 1/16, 1/16 d and rector or laced tten and ian 0/16, 20/16 d and rector or laced n itten and cian 8/15, 20/16, were Medical itioner	×

Event ID: 8PM911

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY PLETED
ND PLAN	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COM	
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
				315 EAST LEE HIGHWAY		
LIFE CA	RE CENTER OF NEW	MARKET		NEW MARKET, VA 22844	DECTION.	(VE)
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F 514	514 Continued From page 117 physician until 7/7/16. On 7/7/16 at 10:55 a.m., an interview was conducted with OSM (other staff member) #2 (the		F 5	8. Resident # 10 - Ha	ndwritten For physician	
	medical records e gives ASM (admir (Resident #11's pl need to be seen for OSM #2 stated AS from each visit but typed and on the has asked for help supposed to receive On 7/7/16 at 3:17 conducted with As records had been he had been asking to "catch up and stated his bosses to assist him until stated other physical processing to the stated other physical processing the processing the stated processing the processing the physical physical processing the physical	mployee). OSM #2 stated she histrative staff member) #3 hysician) a list of residents who or recertification every week. SM #3 keeps handwritten notes t doesn't always get the notes chart. OSM #2 stated ASM #3 p regarding this matter and was live help the following week. p.m., an interview was SM #3. ASM #3 stated medical a huge issue. ASM #3 stated in his bosses for a solid week help to stay caught up." ASM #3 is didn't have anyone authorized the following week. ASM #3 stated in his possible week.		visits on 03/26/16, 07/27/16 were sign by the Medical Dir placed on the medi 07/27/16. 9. Resident # 9 - Han dictated notes for p visits on 11/09/15, 02/02/16, 04/07/16 and 05/15/16 were dated by the Medicand placed on the record on 07/26/16	ed and dated ector and cal record on dwritten and ohysician 12/07/15, 5, 05/05/16, signed and cal Director medical	
	review of system dictated the note handwritten note dictate his typed handwritten note on the chart, ASI consider them particularly as made award were electronical day (7/7/16). ASI the notes this sail been pulling toged dictating typed in	on but he (ASM #3) used the s, hand scribbled notes then s. ASM #3 stated his s were for his personal use to notes. When asked if his s were signed, dated and placed #3 stated, "No because I don't art of the permanent record." he was always behind on sially for routine visits. ASM #3 a Resident #11's printed notes ally signed by him on this same SM #3 confirmed he had dictated the first handwritten notes and notes this day because the vere supposed to be on the		Criterion # 2 - How will identify other residents have potential to be affected by practice? All in-house residents have to be affected by this prace. A medical record audit we by the HIM director on 0' indicate last physician and practitioner visit filed in the second sec	re the potential tice. as completed 7/13/2016 to d/or nurse	

PRINTED: 07/19/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING 07/08/2016 B. WING 495139 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 315 EAST LEE HIGHWAY LIFE CARE CENTER OF NEW MARKET **NEW MARKET, VA 22844** PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F514 Continued from Page 118 F 514 F 514 | Continued From page 118 clinical record. ASM #3 stated he has an assistant who is supposed to help enter Interim Executive Director (IED) and information into the computer but the computer the Physician/Medical Director (MD) system would not allow his assistant to do so because of HIPAA (health insurance portability were notified of the results of the audit and accountability act) (1) regulations. on 07/13/2016 by the HIM director. The Interim Executive Director (IED) On 7/7/16 at 5:25 p.m., ASM #1 (the met with the Medical Director (MD) and administrator) and ASM #2 (the director of nursing) were made aware of the above findings. Director of Nursing (DON) on 07/18/2016 and a plan was put in place The facility policy titled, "Physician Services to correct all concerns identified by the Guidelines" documented, "Policy: Documentation in the medical record must reflect supervision of HIM audit. All concerns will be medical care of each resident in the facility. All addressed by 07/29/2016. opinions that require physician judgement are signed and dated only by the physician or his designated representative (i.e., physician's

Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.

The Medical Director, Nurse
Practitioner and other Attending
Physician were educated by the Interim
Executive Director on 07/12/16
regarding policy and procedure for
documenting physician visits. To
properly document a physician visit in
the chart there must be a written

assistant, clinical nurse specialist, or nurse practitioner) per state guidelines...At the time of

each visit, the physician must review the resident's total program of care, medications,

each visit and include the following. Significant change in condition...

mental/physical functional level...

Change in diagnosis

goals

indications...

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

Change in medications...

treatments, and the care plan. A progress note

Progress and problems in meeting care plan

Status of specialized treatments and medical

Documentation regarding advanced directives... "

No further information was presented prior to exit.

Measures taken to reach highest practical

must be written, signed, and dated at the time of

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		VIDER/SUPPLIER/CLIA ITIFICATION NUMBER: A. BUILDING A. BUILDING	PLETED
		495139	B. WING		07/0	8/2016
	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP C 315 EAST LEE HIGHWAY NEW MARKET, VA 22844	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	and other health be protected, an information. The gives you rights sets rules and lir receive your hea applies to all for information, who The Security for heal This information http://www.hhs.g-materials-for-contents.	page 119 ost of us believe that our medical information is private and should dive want to know who has this Privacy Rule, a Federal law, over your health information and nits on who can look at and lith information. The Privacy Rule and sof individuals' protected health other electronic, written, or oral. He is a Federal law that requires the information in electronic form." was obtained from the website: gov/hipaa/for-individuals/guidance onsumers/index.html #3 was admitted to the facility on admitted on 3/29/16 with uding, but not limited to: history one-sided paralysis, depression, ate with obstruction, and chronic as etc. On the most recent MDS a set), a quarterly assessment with ference date 5/4/16, he was code.	n f	progress note placed on the record at time of visit. This written as progress note or Visit/Recertification Form notation regarding the visit date and signature with not dictation will follow. A Physician's Visit/Recert was put in place for all visit dictated note will not be convithin 72 hours. The physicompleting the visit will completing the visit will complete handwritten documentation given to HIM or HIM assist the documentation audit a on the medical record untavailable. Health Information Mana HIM assistant will audit rephysician visits and keep of physician documentation is of all visits document the medical record or converted or dictated notes HIM department for veri completeness and filed or record.	medical s can be a Physician or a brief including ration that ification form its when a completed sician complete the and date. The in will be istant to update ind then placed il dictation is ger (HIM) or required a running log on needed. A ited directly in impleted hand be given to fication of	

PRINTED: 07/19/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 07/08/2016 B. WING 495139 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 315 EAST LEE HIGHWAY LIFE CARE CENTER OF NEW MARKET **NEW MARKET, VA 22844** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F514 Continued from Page 120 F 514 F 514 | Continued From page 120 making decisions. He was coded as having a suprapubic catheter in place. On the following dates and times, Resident #3 Beginning on 07/25/16, the IED, SDC was observed in his room, and to have a and/or DON will provide education to suprapubic catheter draining in to a collection all licensed nurses regarding proper bag, encased in a privacy cover: 7/6/16 at 12:35 p.m. and at 3:10 p.m.; 7/7/16 at 8:10 a.m. and documentation related to a resident's 2:40 p.m. During all observations, the urine in the change in condition, including collection bag was clear yellow. assessments needed and documentation required when sending a resident out of A review of the physician's orders for Resident #3 the facility for unplanned evaluation and revealed the following order, written 3/29/16: "SP (suprapubic) cath (catheter) to bed side drainage treatment. Education also includes for BPH (benign prostatic hyperplasia - enlarged notifying the Nurse Practitioner or prostate) with obs (obstructive) uropathy TID Attending Physician and the responsible (three times a day)." party regarding the change and proper documentation in the medical record of A review of the nurses notes for Resident #3 this notification. This education will be revealed, in part, the following: completed by 08/05/16. 6/20/16 at 5:53 p.m.: "Noted resident Foley bag and tubing with clear yellow urine." 6/23/16 at 3:37 a.m.: "...Supra pubic catheter intact draining bloody urine... - 6/23/16 at 10:36 p.m.: "Resident Supra Pubic catheter is intact and patent with bloody urine in Criterion # 4 – How will the facility baq...' monitor the corrective plan to ensure 6/24/16 at 10:02 a.m.: "Resident's catheter is

insertion site...!

noted to be leaking. Red tinged urine is noted..."

6/27/16 at 7:52 a.m.: "Catheter continues to

(continued) with suprapubic catheter and noted to

- 6/30/16 at 10:27 p.m.: "Resident returned from

ER (emergency room) at 8:30 p.m. Report from

leak. 250 ml (milliliters) of bloody urine in catheter bag. Reported to oncoming shift."

continue with bloody urine leaking around

- 6/30/16 at 3:26 a.m.: "Resident cont

and not reoccur?

the deficient practice was corrected

Results of audits regarding Complete

in the medical record as well as

Documentation of change in condition

Physician Visits being documented on

medical record will be reported for

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On 7/7/16 at 2:10 p.m., LPN (licensed practical nurse) #4 who regularly cares for Resident #3, was interviewed. When asked if she could find evidence that the physician had been notified of Resident #3's transfer to the emergency room on 6/30/16 or of the events surrounding the resident's transfer to the emergency room on 6/30/16, LPN #4 stated: "I don't know. There's nothing here to tell what happened. That nurse is on vacation this week. I would have written a note."

scheduled...Observe for and report any signs and symptoms of UTI (urinary tract infection) to

to nurse. F/U (follow up) with urology as

On 7/7/16 at 2:45 p.m., LPN #2, a unit manager, was interviewed. When shown the above referenced nurses notes, she stated she could not find evidence of assessment/documentation regarding the transfer to the emergency room on 6/30/16. LPN #2 stated: "The doctor should have been made aware of all of that. There should have been a note."

On 7/7/16 at 5:30 p.m., ASM (administrative staff

physician."

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Incredibly Easy, Lippincott Williams and Wilkins,

documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the

Philadelphia PA, page 23: "Nursing

health care team. Unless the content of

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On 7/7/16 at 5:30 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these

provided with evidence of ASM #3's hand-written notes for visits to Resident #3 on 3/30/16 and

On 7/8/16 at 8:30 a.m., the surveyor was

record.

concerns.

PRINTED: 07/19/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 07/08/2016 B. WING 495139 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 315 EAST LEE HIGHWAY LIFE CARE CENTER OF NEW MARKET **NEW MARKET, VA 22844** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 514 Continued From page 124 6/16/16. No further information was provided prior to exit. The facility staff failed to include a record of physician visits for Resident #4 on the clinical record. Resident #4 was admitted to the facility on 2/9/16 with diagnoses including, but not limited to: chronic kidney disease, diabetes, congestive heart failure and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 5/18/16), she was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). A review of physician progress notes revealed no recertification notes since the resident was admitted on 2/9/16. On 7/7/16 at 3:15 p.m., ASM (administrative staff member) #3, Resident #4's attending physician and the facility medical director, was interviewed. He stated he was aware that getting his notes typed and placed in the medical record had been "a huge issue here." He stated that he makes the

Facility ID: VA0145

record.

required visits, but is weeks, sometimes months, behind in getting the progress note typed and placed in the medical record. He stated: "Is it acceptable? No. But it's the best I can do." He stated he keeps hand-written notes from each visit, then later types the notes and gives them to the facility staff for placement in the clinical

PRINTED: 07/19/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 07/08/2016 B. WING 495139 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 315 EAST LEE HIGHWAY LIFE CARE CENTER OF NEW MARKET **NEW MARKET, VA 22844** (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 514 Continued From page 125 On 7/7/16 at 5:30 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns. On 7/8/16 at 8:30 a.m., the surveyor was provided with evidence of ASM #3's hand-written notes for visits to Resident #4 on 3/9/16, 4/5/16, 5/27/16 and 7/1/16. No further information was provided prior to exit. The facility staff failed to include a record of physician visits for Resident #8 on the clinical record. Resident #8 was admitted to the facility on 6/27/13 with diagnoses including, but not limited to: chronic obstructive pulmonary disease, chronic back pain and anxiety disorder. On the most recent MDS (minimum data set), an annual assessment dated 6/10/16, Resident #8 was coded as being cognitively intact for making daily decisions. A review of the clinical record failed to reveal evidence of physician recertification visits since

On 7/7/16 at 3:15 p.m., ASM (administrative staff member) #3, Resident #8's attending physician and the facility medical director, was interviewed. He stated he was aware that getting his notes typed and placed in the medical record had been "a huge issue here." He stated that he makes the required visits, but is weeks, sometimes months, behind in getting the progress note typed and

7/13/15.

TATEMENT	OF DEFICIENCIES F CORRECTION	(XI)	(X2) MULTIPLE C	CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		495139	B. WING			/08/2016
	PROVIDER OR SUPPLIER		315	EET ADDRESS, CITY, STATE, ZIP CODI EAST LEE HIGHWAY W MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 514	placed in the mediacceptable? No. stated he keeps his visit, then later typ the facility staff for record. On 7/7/16 at 5:30 member) #1, the endirector of nurconcerns. On 7/8/16 at 8:30 provided with evication of the provided with evication of the facility of the director of the concerns.	cal record. He stated: "Is it But it's the best I can do." He and-written notes from each es the notes and gives them to placement in the clinical p.m., ASM (administrative staff executive director, and ASM #2, sing, were informed of these a.m., the surveyor was dence of ASM #3's hand-written Resident #8 on 11/13/15,	F 514			
	physician progres 3/5/16 4/1/16, 4/2 record. Resident # 2 was and most recentl diagnoses that in hypertension, hy hypothyroidism, Resident # 2's m set), a quarterly (assessment ref Resident # 2 as understand other scoring 11 of a progression of the scoring 11	did not have copies of the ss notes for 2/9/16, 2/29/16, 29/16, and 5/27/16 on the clinical standard admitted to the facility on 1/4/16 by readmitted on 3/4/16 with accluded but were not limited to: perlipidemia, dementia, atrial fibrillation, and depression. The second most recent MDS (minimum data assessment with an ARD erence date) of 4/27/16, coded understood by others and able to see the second most recent # 2 was coded as possible 15 on the Brief Interview in Section C, Cognitive				

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3 responded that we could.

the record so I do not date and sign them." ASM # 3 was asked if we could see his notes. ASM #

On 7/8/16 at 8:25 a.m. a list of the dates for each visit for each resident was provided by ASM # 1, the executive director. This list documented that ASM # 3 visited Resident # 2 on 2/9/16, 2/29/16, 3/5/16 4/1/16, 4/29/16, and 5/27/16. The notes corresponding to these dates were also provided and as ASM # 3 stated they were not signed or dated and not part of the clinical record.

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Review of the clinical record revealed no physician progress notes by the attending

ndex.shtml

physician.

www.nimh.nih.gov/health/topics/bipolar-disorder/i

PRINTED: 07/19/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 07/08/2016 B. WING 495139 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 315 EAST LEE HIGHWAY LIFE CARE CENTER OF NEW MARKET **NEW MARKET, VA 22844** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 514 F 514 Continued From page 129 During an interview on 7/7/16 at 11:50 a.m. with OSM (other staff member) # 2, OSM # 2 revealed that every week she (OSM # 2) makes a list of all residents that need to be seen by the physician. OSM # 2 stated that she gives the list to the physician each week; OSM # 2 stated that the physician does handwritten notes, then takes the notes and types them up. OSM # 2 further stated that the typed notes don't always get on the chart. During an interview on 7/7/16 at 3:17 p.m. with ASM (administrative staff member) # 3, the physician, revealed that records are a problem stating, "I've been asking for help for some time to do all the paperwork. I'm getting help next week. I'm always behind in dictation. My hand written notes are not acceptable - what use is a note that you can't read. I recognize that it is a problem. I have handwritten notes for each resident but do not consider my notes a part of the record so I do not date and sign them." ASM # 3 was asked if we could see his notes. ASM # 3 responded that we could. During the end of day interview on 7/7/16 at 5:30 p.m. with ASM (administrative staff member) # 1,

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

executive director, and ASM # 2, director of nurses, were made aware of the missing

was made for the facility policy.

physician progress issue. At this time a request

On 7/8/16 at 8:25 a.m. a list of the dates for each visit for each resident was provided by ASM # 1, the executive director. A list of the dates for each visit for each resident was provided. This list documented that ASM # 3 visited Resident # 12 on 12/4/15, 1/29/16, 3/25/16, and 5/20/16. Only one note corresponding to these dates was

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		ONSTRUCTION	(/	IPLETED
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F 514	Continued From	page 130	F s	514			
	not signed or date clinical record.	ed and was not part of the					
	During an interview ASM # 2, ASM # 1 have."	ew on 7/8/16 at 8:32 a.m. with 2 stated, "I presented everything					
	No further inform	ation was provided prior to exit.					
	physician progres	did not have copies of the ss notes for 12/4/15, 3/25/16, ne clinical record.					
	6/20/06 and mos with diagnoses the to: congestive he diabetes, multiple gastroesophages most recent MDS assessment with date) of 6/1/16, of understood by of others. Residen of a possible 15 Status in Section	as admitted to the facility on trecently readmitted on 1/30/15 nat included but were not limited eart failure, hyperlipidemia, e sclerosis*, and al reflux disorder. Resident # 13's (minimum data set), a quarterly an ARD (assessment reference coded Resident # 13 as thers and able to understand trecent # 13 was coded as scoring 11 on the Brief Interview for Mental and C, Cognitive Patterns, indicating moderately cognitively impaired.					
	nervous system.	is (MS) is a disease of the centra In MS the body's immune nyelin, which coats nerve cells. alth/multiple-sclerosis	al				
		inical record revealed no ess notes by the attending					
	During an interv	iew on 7/7/16 at 11:50 a.m. with					

OLITICI	TO I DITTINEDICT IT	1						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 514	that every week shresidents that need OSM # 2 stated that physician each were physician does har notes and types that the typed note. During an interview ASM (administrative physician, revealed stating, "I've been to do all the paper week. I'm always written notes are note that you can't problem. I have heresident but do not the record so I do # 3 was asked if was responded that we buring the end of p.m. with ASM (adexecutive director, nurses, were mad physician progress was made for the On 7/8/16 at 8:25 visit for each resid documented that you 12/4/15, 3/25/1	nember) # 2, OSM # 2 revealed e (OSM # 2) makes a list of all it to be seen by the physician. At she gives the list to the ek; OSM # 2 stated that the indwritten notes, then takes the em up. OSM # 2 further stated is don't always get on the chart. You on 7/7/16 at 3:17 p.m. with we staff member) # 3, the id that records are a problem asking for help for some time work. I'm getting help next behind in dictation. My hand ot acceptable - what use is a read. I recognize that it is a andwritten notes for each it consider my notes a part of not date and sign them." ASM # we could. day interview on 7/7/16 at 5:30 ministrative staff member) # 1, and ASM # 2, director of e aware of the missing is issue. At this time a request		514				
	During an intervie	w on 7/8/16 at 8:32 a.m. with						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 514	ASM # 2, ASM # 2 I have." No further informa 8. The facility staf physician visits forecord. Resident #10 was 1/8/16 with diagnoral limited to: arthritis pressure, kidney	To further information was provided prior to exit. The facility staff failed to include a record of hysician visits for Resident #10 on the clinical		514	1		
	reference date of having a six out of for mental status severely impaired. Review of the clir documentation of	4/13/16 coded the resident as if 15 on the BIMS (brief interview indicating the resident was					
	member) #2, the	ade to ASM (administrative staff director of nursing, on 7/7/16 for in progress notes for Resident					
	a.m. with OSM (of medical records physician's progreshart, OSM #2 stasked the procesphysician's visits	conducted on 7/7/16 at 11:00 other staff member) #2, the staff. When asked if the ess notes were to be in the tated that they should. When as she followed to track the , OSM #2 stated, "I make a list give it to the doctor." OSM #2					

507 Incl. 9, 6: 5m-1	TO TOTAL THE DESCRIPTION							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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TAG	but had not put the notes were not avarecord. An interview was op.m. with ASM #3, about his notes, As for records it's a house asking my bosses then some help to write notes you car along and then did behind in my dictarrecerts." ASM #3 scompletes when how when asked if he handwritten notes, don't think it's part When asked if it was considered.	sician had handwritten notes im into the computer so the ailable in the resident's clinical conducted on 7/7/16 at 3:18 the physician. When asked SM #3 stated, "When asking uge issue here. I have been to give me a solid week off and keep up with it. Some doctors in tread. I scribble notes as I go state my notes, I'm always tion. I keep a list of when I see showed the form that he e examines the residents. signed and dated his ASM #3 stated, "No, because I of the permanent record."	F 5	14				
		p.m. ASM #1, the administrator director of nursing were made ags.						
	physician's handw documented). Wh	a.m. ASM #2 brought the ritten note dated 3/25 (no year en asked if there were any #2 stated, "If there is something don't have it."						
	Services Guideline Documentation in supervision of the in the facility. All o	lity's policy titled, "Physician es" documented, "Policy. the medical record must reflect medical care of each resident pinions that require physician and datedProcedure. A						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
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F 514	progress note must at the time of each is acceptable, pro- and dates a progranote was dictated No further information	st be written, signed and dated in visitA dictated progress note vided the physician writes, signs ess note that indicates that a and will be transcribed." ation was provided prior to exit.	F 5	514		
	clinical record for Resident #9 was a with diagnoses the to: pneumonia, his pain, dementia, po dysphagia. The most recent I assessment, a quassessment refer resident as being cognitive decision requiring extensive staff members for living. Resident # limited assistance Review of the clin documented phys were multiple not	physician progress notes in the Resident #9 since12/7/15. admitted to the facility on 3/3/12 at included but were not limited gh blood pressure, low back ain, hypothyroid disease, and MDS (minimum data set) arterly assessment, with an ence date of 6/14/16, coded the severely impaired to make daily as. The resident was coded as a eassistance of one or more of most of her activities of daily as coded as requiring a for one staff member for eating. Dical record revealed the last sician visit to be 12/7/15. There ees by the nurse practitioner but ician for Resident #9.				
	member (OSM) #	conducted with other staff \$2, the medical records \$716 at 10:59 a.m. When asked				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION DING		COMPLETED	
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F 514	do." She further et (physician) has hin a pile in his officomputer. He han next week. I have things but I can't even contacted motes and then derived he's employed by corporation." A rethe physician. An interview was staff member (AS on 7/7/16 at 11:1 physician's progredinical record, As An interview was physician for Res ASM #3 stated, "an (name of corposolid week to cat me coverage nemotes. When so handwritten H & unreadable. I had dictate afterward dictations. Espewith too many cay who was to help they won't allow When asked how stated, "I have a further stated, "Is notes would be streadable and had seen as the contact of th	cian visits, OSM #2 stated, "I expanded stating, "He andwritten sheets. He has them ce until he puts them in the s asked for help and it's coming e asked and asked for him to do make him do something. I've ny corporate person. He takes pesn't put it in the computer. I a physician service within our equest was made to speak with conducted with administrative GM) #2, the director of nursing, 7 a.m. When asked if the ess notes should be in the SM #2 stated, "Yes." conducted with ASM #3, the sident #9, on 7/7/16 at 3:20 p.m. It's a huge issue here. I work for coration) affiliate. I wanted a ch up. They have finally gotten at week so I can dictate my meone comes in, I write a P (history and physical) but it's and scribble notes and then s. I am always behind in cially for ones who don't get seem the put them in the computer but her to put them in the computer." I want my notes to be ve all of the information on them. I keep a list of recerts		514			

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F 514	(recertification's). Tuesday, Wedness around and scribb was aware of the physician visits and stated, "Yes, I am I do a recert, I loo results, dose reducannot do the recentlat's the time I rework." When asked something happer would be a messinformation that consulting together more readable and putting together more readable and	The recerts usually are done on aday and Thursday. I run alle a note." When asked if he regulations regarding the ad progress notes, ASM #3." ASM #3 further stated, "When k at the medications, lab actions. The nurse practitioner erts. When I do the recerts, eview the nurse practitioner's ed what would happen if ned to him, ASM #3 stated, "It but I feel there is enough ould be used to follow the care. Delem; I want the notes to be ad accurate. It's not good. I'm may handwritten notes into the ones you have requested." p.m. ASM #3 brought a list of and handwritten notes of when ASM #3 stated, "I do not have been on 1/30/16, 4/7/16 and was requested to provide the sof these visits. The director and ASM #2, the director made aware of the above at 5:28 p.m. A request was evidence of the physician visits	F 5	14			

Facility ID: VA0145