State of \	/irginia				FORM	APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION H	(X3) DATE SU COMPLE	
		VA0145	B. WING		na/n:	7/2018
	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA T LEE HIGHWAY RKET, VA 2284	1	03101	772010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
F 000	An unannounced bid Inspection was cond Corrections are required the Virginia Rules at Licensure of Nursing Code survey/report	ennial State Licensure Sucted 9/5/18 through 9/7/18, uired to be in compliance with and Regulations for the g Facilities. The Life Safety will follow.	F 000			
	103 at the time of th consisted of 39 curr (Residents #72, #6, #55, #1, #75, #74, # #30, #39, #37, #97, #29, #52, #65, #4, #	e survey. The survey sample ent resident reviews #73, #43, #70, #61, #42, #60, !62, #69, #2, #23, #48, #87, #26, #59, #17, #94, #40, #44, !58, #68, #88, #91, #95, #35, ed record reviews (Residents			137	
F 001	The facility was out following state licent following state licent This RULE: is not in 12VAC5-371-150. Refacility shall register Police to receive no reregistration of any or a contiguous zip is located pursuant Virginia. Based on staff interreview, it was determined to the state of the s	net as evidenced by: tesident rights. G. The nursing with the Department of State tice of the registration or sex offender within the same code area in which the facility to §9.1-914 of the Code of view and facility document mined that the facility staff	F 001	1. State licensure requires nursing facing registered with the Department of State to receive automatic notification of the registration or reregistration of any second area in which facility is located. The resident was determined to be affected identified concern. On 9/5/18 facility registered with the Department of State to receive automatic notification of the	te Police e x ous zip No d by	10/15/18
	failed to register to a from the Virginia Se	receive automatic notifications ix Offender Registry of any iders in the same or area of the facility.		registration or reregistration of any second area in which facility is located.	x ous zip	

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

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Execution Director

(X5) DATE

f continuation sheet 1 of

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State of Virginia						
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SI COMPLE	
		VA0145	B. WNG		00/0	7/2018
NAME OF D	ROVIDER OR SUPPLIER				1 03/0	112010
NAME OF P	KOVIDER OR SUPPLIER		DRESS, CITY, S' LEE HIGHWA			
LIFE CAR	E CENTER OF NEW MAS	RKET	RKET, VA 228			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
F 001	Continued From page	2 1	F 001	Continued from page 1		
				2. All residents residing within the fac	ility have	
	On 95/18 at approximately 12:00 p.m., during the entrance conference with the ASM #1, the Executive Director, (Administrative Staff Member), and ASM #2, the Director of Nursing.			the potential to be affected by the ider	ntified	
				concern. On 10/4/18, Social Services	will	
		2, the Director of Nursing, lity was registered with the		notify resident council that facility is	registered	
	Department of State Police (DSP) to receive notice of registration or reregistration of sex offenders in the same or contiguous zip code,			with the Department of State Police to	receive	
				automatic notification of any sex offer	nder	
was requested.	• • • • • • • • • • • • • • • • • • • •		registered in the same contiguous zip	code area		
	On 9/5/18 at 2:35 p.m., ASM #1 stated that the facility was not registered to receive automatic			in which facility is located. At that sa	me time	
				Social Services will inform residents t	hey may	
		sex offender registry. He ated the date of the survey		access Sex Offender Registry via inte	rnet	i
	(9/5/18), printed at 1:	56 p.m. (survey started at		access or view binder with printed not	tifications	
	11:45 a.m.), from the offender registry of a	Virginia State Police sex list of registered sex		by request through Social Services.		
	offenders for the one	zip code the facility was		3. Executive Director will remain regi	stered	
		Tounding areas, and stated nat they check every day.	-	with the Department of State Police to	receive	
	No evidence was pro	vided that it was in fact done		automatic notification of the registrati	on or:	
		also provided copies of a offender registry of people		reregistration of any sex offender with	nin the	
		admission, and stated that at they checked and did not		same or a contiguous zip code area in	which	
		dence of checking, printing		facility is located. Executive Director	will print	
	and retaining the doc residents. It was note	ument of any current		notifications and place in binder as the	ey are	
		uals that were checked, was		received. Social Services Director wil	l validate	
	printed from the Virgi	nia State Police website on		binder notifications weekly x4 weeks,	then one	
		5/18) at 1:14 p.m. and 1:28 evidence that residents are		time a month x 60 days.		,
	pre-screened prior to	admission, however they		4. Administrator will present findings	of audit	
	were not for any curre	ent residents.		accurate assessment findings to the Q	API	
		policy, "Protection of		committee for review and recommend		
		the Threat of Abuse and I, "Procedure for Screening		for 90 days.		
		espective residents, the				

6836

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If continuation sheet 2 of 8

State of Virginia				PRINTED: 09/18/2018 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:		(X3) DATE SURVEY COMPLETED
	VA0145	B. WING		09/07/2018
NAME OF PROVIDER OR SUPP	LIER STREE	ET ADDRESS, CITY, ST	ATE, ZIP CODE	
LIFE CARE CENTER OF N	EW MARKET	AST LEE HIGHWA MARKET, VA 2284		
PREFIX (EACH D	MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
the individual status; Medic Refer to the A Services Man regulations or residents." A review of a packet, titled Responsibilitit dated 6/7/200 passed by the that Long Ten receive inform offenders livin facility resident Virginia Sex 0 resident in ac admission to be screened the resident's accordance w 7/1/2007. (na all residents a that they may at (web addre register them the Social Se Director will p	orn page 2 It be reviewed: An assessment of so functional and mood/behavioral all acuity; and Special needs2. It drission Policy in the Social used and any State-specific laws regarding the screening of adocument from the admission and account from the admission and for Convicted Sex Offencer (sic): New as For Long Term Care Facilities. Account the facilities are for the control of the control of the control of the existence and use of the control of the existence and use of the control of the sex offender registry and the previous home address in a facility, all potential residents will artilizing the sex offender registry and previous home address in a facility is required to inform and/or responsible family members access the Sex Offender Registry ss). Resident s may access the selves at the facility by request to revices Director. The Social Services around internet services and assist the web side upon request. All		Continued from page 2 1. It is policy of Life Care to validate background check before associate atterfacility orientation. The policy states in has engaged an independent contractor CRA to perform certain background services in connection with prospective current Life Care Associates. Such employment screening conducted throw Vendor conforms to the mandates of the FCRA and other relevant federal and selaws. Virginia State Nursing Home Regulation requires nursing facility to criminal background check on new him within 30 days of employment and background checks must be obtained to Central Criminal Records Exchange for Virginia Department of State Police. No resident was determined to be affective identified concern. On 9/7/18, associate were reviewed, to verify background of were completed. 1. It is the policy of this facility to screen.	Life Care r as its creening e and/or ugh the ne tate obtain res using om the cted by the files checks

residents and/or responsible parties must sign

No further information was provided.

above information."

below to acknowledge that they have received the

2. Based on staff interview and facility document

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If continuation sheet 3 of 8

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for a history of abuse, neglect, exploitation,

or misappropriation of resident property in

exploitation of resident property. Screening components include but are not limited to attempting to obtain information from previous

order to prohibit abuse, neglect, and

State of \	/irginia					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDIŅG:		(X3) DATE SURVEY COMPLETED	
		VA0145	B. WING		09/07/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE. ZIP CODE		
		315 EAS	T LEE HIGHWAY			
LIFE CAR	E CENTER OF NEW MA	RKET NEW MA	ARKET, VA 2284	4		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
F 001	failed to ensure a criticheck was completed records reviewed (RI #2, CNA #3, CNA #4 CNA #8, OSM #2, OSM #7, and OSM # verification was obtain records reviewed (CI the laws of the State). The findings included Review of the state in documents "E. Persoprocedures shall inclied An accurate and comeach employee included certificate or complete training course; b. Critical Completes training course; b. Critical Completes of the complete training course; completes the complete training course; b. Critical Completes of the completes o	minal record background of for 16 of 25 employee N #1, RN #2, LPN #1, LPN , CNA #5, CNA #6, CNA #7, SM #4, OSM #5, OSM #6, i8), and a licensure med for 1 of 25 employee NA #8), in accordance with of Virginia. It: Regulation 12VAC5-371-140 employees and policies and ude, but are not limited to: 3. Explete personnel record for ding: a. Verification of license, registration, or ion of a required approved iminal record check."	F 001	Continued from page 3 employers and/or current employers, ar checking with appropriate licensing bor registries, and background checks. No read was determined to be affected by identification. 2. All residents residing within the facily have the potential to be affected by the identified concern. All new associates from 9/10/18 will have background chewithin 30 days of employment through Criminal Records Exchange from the Value Department of State Police. 2. All residents residing within the facily the potential to be affected by the identification completed as indicated on 19/10/18 forward will have licensure verification completed as indicated on 10 Care Centers of America Selection Proceed Centers of America Selection Proceeding Virginia State Nursing Homes Regulation to Human Resources Director regarding Virginia State Nursing Homes Regulation that requires nursing facility obtain criminal background check on a hires within 30 days of employment and background checks must be obtained us Central Criminal Records Exchange from Virginia Department of State Police.	ards, resident ified lity hired cks Central /irginia lity have ified re from Life cess or e y to new d sing	
	days of employment, employees an original with respect to convi- in this section or an o	obtain for any compensated al criminal record clearance ctions for offenses specified original criminal history ral Criminal Records		Human Resources Director will utilize hire tracking log to verify background using Central Criminal Records Exchai was completed within 30 days of hire. Executive Director will validate new hiracking log and completion of backgrounds.	check nge ire	

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If continuation sheet 4 of 8

OCT 0 1 2018
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING.	E CONSTRUCTION	(X3) DATE SUI COMPLET	
- H-H-00-1 -	VA0145	B. WNG		09/07	/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARK	ST 315 EAS	DDRESS, CITY, ST T LEE HIGHWA ARKET, VA 2284	Y		
OLIMATE OF THE				0000000000	
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES NUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
records check required; of license.) requires that home care or home heat hospice obtain a criminal check on new hires with employment. The law all background checks be of Criminal Records Exchat Department of State Police Copy of each law. On 9/7/18 a review of 2: conducted. The following identified: 1. For RN #1 (Registern 5/22/18, the 30-day criminal background check was not completed until 12/1/17. 3. For LPN #1 (License on 4/25/18, the 30-day of check was not completed until 8/10/18. 4. For LPN #2, hired on criminal background check was not completed until 8/10/18.	on and 32.1-162.9:1 Insation of persons Insess prohibited; criminal Is suspension or revocation It each nursing facility, Inth organization, and Is record background Is or requires that these Is obtained using the Central Is ange from the Virginia Ilice. See Appendix 2 for a 5 employee records was Ing concerns were ed Nurse), hired on Ininal background check Is 10/24/17, the 30-day Is eck was not completed ed Practical Nurse), hired Is or equires that these Is or each that these Is or equires that these Is or equ	F 001	Continued from page 4 check within 30 days one tidays. 3. Executive Director provied ucation to Human Resource are arrived in the policy of this staff for a history of abuse, or misappropriation of resident processes order to prohibit abuse, negexploitation of resident processes and/or current endecking with appropriate I registries, and background Human Resources Director Life Care Centers of American Checklist to ensure licensure pre-screening stage for all I for hire. Staffing Coordinat licensure verification one tidays. 4. Administrator will present accurate VSP criminal backwithin 30 days of hire and verification findings to the Performance Improvement review and recommendation.	ded written rces Director facility to screen neglect, exploitation dent property in glect, and perty. Screening e not limited to nation from previous imployers, and licensing boards, checks. will utilize ica Selection Process re verification in the licensed candidates tor will validate ime per week x90 int findings of audit kground checks licensure Quality Assurance committee for	

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State of Virginia

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TTE211

If continuation sheet 5 of 8

PRINTED: 09/18/2018 FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WNG VA0145 09/07/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY LIFE CARE CENTER OF NEW MARKET NEW MARKET, VA 22844 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY** F 001 12 VAC 5 - 371 - 250 A cross reference to F 001 Continued From page 5 Plan of Correction F 641 until 3/23/18. 12 VAC 5 - 371 - 250 C cross reference to 7. For CNA #5, hired on 6/19/18, the 30-day Plan of Correction F 657 criminal background check was not completed until 8/10/18. 12 VAC 5 - 371 - 200 B 1 does not cross reference to Plan of Correction F 658 8. For CNA #6, hired on 7/11/17, the 30-day criminal background check was not completed (past non-compliance: plan of correction not until 9/13/17. necessary) 9. For CNA #7, hired on 9/7/17, the 30-day 12 VAC 5 - 371 - 220 B 1 does not cross criminal background check was not completed reference to Plan of Correction F 760 until 12/1/17. (past non-compliance: plan of correction not 10. For CNA #8, hired on 10/24/17, the 30-day

necessary)

12 VAC 5 - 371 - 140 Policies and Procedures

12 VAC 5 - 371 - 280 A cross reference to

12 VAC 5 - 371 - 180 Infection Control cross

cross reference to Plan of Correction

F 622, F 623, F624, F 625, F 645

Plan of Correction F 679

references to F 695

14. For OSM #6, a laundry aide, hired on 11/8/17, the 30-day criminal background check was not completed until 3/23/18.

criminal background check was not completed until 8/10/18, AND the license verification was not

housekeeper, hired on 1/3/18, the 30-day criminal

11. For OSM #2 (Other Staff Member), a

background check was not completed until

12. For OSM #4, a housekeeper, hired on

was not completed until 8/10/18.

completed until 8/10/18.

5/22/18, the 30-day criminal background check

13. For OSM #5, a receptionist, hired on 6/9/18, the 30-day criminal background check was not

completed until 1/12/18.

3/23/18.

15. For OSM #7, a physical therapy assistant, hired on 11/29/16, the 30-day criminal background check was not completed until 2/3/17.

If continuation sheet 6 of 8

TTE211

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45	VA0145	B. WING		09/07/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	
LIFE CAR	E CENTER OF NEW MA	RKET	ARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETE
F 001	Continued From pag	e 6	F 001		
		physical therapist, hired on criminal background check until 3/23/18.			II
	#13, iluman Resour her "vires crossed a donewithin 90 days, licens verification for not have anything of	o.m., in an interview with OSM ces, she stated that she had and thought they had to be, not 30 days." Regarding the or CNA #8, she stated she did btained any earlier or closer to			
	Resiknts: Reducing Negkt" documente of the facility to scree policyfor a history of expitation, or misa proptly in order to expitation of reside comments include attenting to obtain empyers and/or complete.	ppropriation of resident prohibit abuse, neglect, and ent property. Screening but are not limited to information from previous urrent employers, and priate licensing boards,			
	(Admistrative Staff Direar) and ASM # theyrere made aw inforation was pro survy.	m. in a meeting with ASM #1 f Member - the Executive #2 (the Director of Nursing) are of the findings. No further vided by the end of the			
		0 C cross references to F 657 0 B 1 cross references to F			

6899

TTE211

If continuation sheet 7 of 8

State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING VA0145 09/07/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY LIFE CARE CENTER OF NEW MARKET NEW MARKET, VA 22844 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 001 F 001 Continued From page 7 12 VAC 5 - 371 - 220 B cross references to F 760 12VAC5-371-180. Infection Control cross references to F880. 12VAC5-371-140. Policies and Procedures cross references to F622, F623, F624, F625, F645 **Resident Activities** 12VACS-371-280A cross reference to F679

STATE FORM

6899

TTE211

If continuation sheet 8 of 8

OCT 0 1 2018
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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		SURVEY PLETED
	- 115 FO	495139	B. WING	No.	09/	/07/2018
	ROVIDER OR SUPPLIER E CENTER OF NEW MA	ARKET		STREET ADDRESS, CITY, STATE, ZIP CODE B15 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICENCY)	DBE	(X5) COMPLETION DATE
				The statements made in this plan of c	orrection	10.00
E 024 SS=C	survey was conduct 09/07/18. Correctio compliance with 42 Requirement for Lor Policies/Procedures CFR(s): 483.73(b)(6) [(b) Policies and procedure policies and procedure policies and procedure plan set forth in para assessment at para and the communication this section. The policies and update minimum, the policies of the policies and update minimum, the policies of the policies and update the policies and upda	CFR Part 483.73, ng-Term Care Facilities. i-Volunteers and Staffing iii) cedures. The [facilities] must ment emergency preparedness ures, based on the emergency agraph (a) of this section, risk graph (a)(1) of this section, tion plan at paragraph (c) of licies and procedures must be ed at least annually. At a es and procedures must	E 000		titute tes herein. e and ken or will of itutes the elop a on that e use of situation. ntified cility have	10/15/18
	volunteers in an emistaffing strategies, in for integration of Stahealth care profession during an emergence *[For RNHCIs at §40 procedures. (6) The emergency and other strategies to address emergency. This REQUIREMENT by: Based on staff interreview it was determined to have a compreparedness plan.	as noted above] The use of ergency or other emergency including the process and role ate and Federally designated onals to address surge needs by. D3.748(b):] Policies and use of volunteers in an er emergency staffing is surge needs during an ergency staffing and the surge needs during an ergency and facility document of the surge that the facility staff		3. Facility Safety Committee will devectomplete Emergency Preparedness Plancludes Policy and Procedure For the Temporary Staffing in a Emergency Staffing in a Emergency Staffing in a Emergency Staffity Committee will educate all staff the Emergency Preparedness Plan that includes Policy and Procedure For the Temporary Staffing in a Emergency Staffing in a Emergenc	an that e use of dituation. or and ff regarding t e use of dituation. ommittee thanges to I monthly iant. date	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be except from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing forlies, 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.

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

Event ID: WE1L11

Facility ID: VA0145

OCT continuated seet Page 1 of 141

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/18/2018 FORM APPROVED

		& MEDICAID SERVICES				. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING _	CONSTRUCTION	(X3) DATE : COMPI	
		495139	B. WING		09/6	07/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAR	E CENTER OF NEW	MARKET		15 EAST LEE HIGHWAY IEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUSY BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 024	The findings included to 00 09/07/18 at 12 facility's emergency interview was considerector. Review of preparedness plan procedures for the staffing strategies 1 stated that he diwould only rely on 00 09/07/18 at ap (administrative staffing strative staffing strategies 1 stated that he diwould only rely on 00 09/07/18 at ap (administrative staffing strative staffing strategies 1 stated that he diwould only rely on 00 09/07/18 at ap (administrative staffing strative staffing strations)	ailed to develop policies and a use of volunteers and others. de: 2:00 p.m. a review of the cy preparedness plan and ducted with ASM aff member) # 1, the executive of the facility's emergency in failed to evidence policies and a use of volunteers and other in the emergency plan. ASM # id not have volunteers. That he is staff. approximately 3:26 p.m., ASM aff member) # 1, the executive # 2, the director of nursing,	E 024	Continued from page 1 4. Executive Director will present the conferency Preparedness Plan that inclusively and Procedure For the use of Temporary Staffing in a Emergency Sit to the Quality Assurance Performance Improvement committee for review and recommendations for 90 days. The QAI committee consist of Executive Director Director of Nursing, Assistant Director Nursing, Social Services, Activities, Dietary Manager, Pharmacy consultant, Medical Director.	uation I PI r, of	
E 026 SS=C	Roles Under a War CFR(s): 483.73(b) [(b) Policies and procedure policies and procedure plan set forth in procedure	procedures. The [facilities] must be ment emergency preparedness edures, based on the emergency aragraph (a) of this section, risk aragraph (a)(1) of this section, cation plan at paragraph (c) of policies and procedures must be lated at least annually. At a scies and procedures must	E 026	E026 1.Facility Safety Committee will devel a complete Emergency Preparedness P includes Policy and Procedure describifacility's role in providing care and treat at altered care sites under a 1135 waive residents were affected by this identified concern. 2. All residents residing within the faci potential to be affected by this identified concern. 3. Facility Safety Committee will deve complete Emergency Preparedness Plaincludes Policy and Procedure describifacility's role in providing care and treaters.	lan that ing the atment er. No ed ility have ed clop a in that ing the	10/15/18

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

Event ID: WE1L11

Facility IO: VA0145

If continuation sheet Page 2 of 141

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROMOBY OR SUPPLIER LIFE CARE CENTER OF NEW MARKET SUMMARY STATEMENT OF DEPICIENCIES DIPPER MEMORY STATEMENT OF DEPICIENCY MARKET, VA 22844 DIPPER MEMORY ORLES DENTITING MY ORGANION) DIPPER MEMORY STATEMENT OF DEPICIENCY MEMORY MARKET, VA 22844 DIPPER MEMORY STATEMENT OF DEPICIENCIES DIPPER MEMORY STATEMENT OF DEPICE MEMORY MARKET, VA 22844 DIPPER MEMORY STATEMENT OF DEPICIENCY MEMORY MARKET, VA 22844 DIPPER MEMORY STATEMENT OF DEPICIENCY MEMORY MARKET, VA 22844 DIPPER MEMORY STATEMENT OF DEPICE MEMORY MARKET, VA 22844 DIPPER MEMORY STATEMENT OF DEPICIENCY MEMORY MARKET, VA 22844 DIPPER MEMORY STATEMENT OF DEPICE MEMORY MARKET, VA 22844 DIPPER MEMORY STATEMENT OF DEPICE MEMORY MARKET, VA 22844 DIPPER MEMORY STATEMENT OF DEPICE MEMORY MARKET, VA 22844 DIPPER MEMORY STATEMENT OF DEPICE MEMORY MARKET, VA 22844 DIPPER MEMORY STATEMENT OF DEPICE MEMORY MARKET, VA 22844 DIPPER MEMORY STATEMENT OF DEPICE MEMORY MARKET, VA 22844 DIPPER MEMORY MARKET, VA 22844 DIPPER MEMORY STATEMENT OF DEPICE MEMORY MARKET, VA 22844 DIPPER MEMORY STATEMENT OF DEPACEMENT OF DEP	STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE). <u>09</u> 38-0391 SURVEY PLETED
LIFE CARE CENTER OF NEW MARKET C41 0 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY OR IS.C IDENTIFYING INFORMATION) DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY OR IS.C IDENTIFYING INFORMATION DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY OR IS.C IDENTIFYING INFORMATION DEFICIENCY MUST SEE PRECEDED BY FULL REGULATORY OR IS.C IDENTIFYING INFORMATION DEFICIENCY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY ACTION SHOULD BE CROSS-REFERENCED ACTION SHOULD BE CROSS-REFERENCED ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TO THE APPROPRIATE DEFICIEN		mWater Colle	495139	B. WNG		09/	07/2018
E 026 Continued From page 2 [facility ander a waiver declared by the Secretary in accordance with section 1135 of the Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to develop policies and procedures in the emergency preparedness plan. The facility's role in providing care and treatment at altered care sites under a 1135 waiver. The findings include: On 09/07/18 at 12:00 p.m., a review of the facility's role in providing care and treatment at altered care sites under a 1135 waiver. Do 09/07/18 at 12:00 p.m., a review of the facility's role in providing care and treatment at altered care sites under a 1135 waiver. The findings include: On 09/07/18 at 12:00 p.m., a review of the facility's role in providing care and treatment at altered care sites under a 1135 waiver. The findings include: On 09/07/18 at 12:00 p.m., a review of the facility's role in providing care and treatment at altered care sites under a 1135 waiver. The findings include: On 09/07/18 at 12:00 p.m., a review of the facility's role in providing care and treatment at altered care sites under a 1135 waiver. E 026 Continued from page 2 at altered care sites under a 1135 waiver. By 10/87/18, Staff Develop Coordinator and Safety Committee will educate all staff regarding the Emergency Preparedness Plan that includes Policy and Procedure describing the facility's role in providing care and treatment at altered care sites under a 1135 waiver. Executive Director will lead Safety Committee and will review and make necessary changes to Emergency Preparedness Plan/Manuel annually thereafter. 4. Executive Director will present the complete Emergency Preparedness Plan flation to evidence policies and procedure describing the facility's role in providing care and treatment at altered care sites under a 1135 waiver of the Quality's role in p			MARKET		315 EAST LEE HIGHWAY		
[facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures in the emergency plan that describe the facility's energency preparedness plan and interview was conducted with ASM (administration staff member) # 1, the executive director. Review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan that describe the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan that describe director. Review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan that describe the facility is emergency preparedness plan failed to evidence policies and procedures in the emergency plan that describe the facility is emergency preparedness plan failed to evidence policies and procedures in the emergency plan that describe the facility is cole in providing care and treatment at altered care sites under a 1135 waiver. By 10/8/18, Staff Develop Coordinator and Safety Committee will educate all staff regarding the Emergency Preparedness Plan that includes Policy and Procedure waiver. Executive Director will lead Safety Committee and will review and make necessary changes to Emergency Preparedness Plan/Manuel annually thereafter. 4. Executive Director will review and treatment at altered care sites under a 1135 w	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	OULD BE	COMPLETION
#1 stated that he did not have it. On 09/07/18 at approximately 3:26 p.m., ASM (administrative staff member) #1, the executive	E 026	[facility] under a win accordance with provision of care a care site identified officials. *[For RNHCls at § procedures. (8) The waiver declared by with section 1135 of at an alternative care management officials. Based on staff interview it was deterfailed to have a compreparedness plant the facility's role in at altered care site. The findings included the facility's emergency interview was concuminated in the facility's emergency interview was concuminated in the facility's role in at altered care site. The findings included interview was concuminated in the facility's role in at altered care site.	aiver declared by the Secretary, a section 1135 of the Act, in the nd treatment at an alternate by emergency management 403.748(b):] Policies and a role role of the RNHCI under a role of Act, in the provision of care are site identified by emergency als. INT is not met as evidenced erview and facility document mined that the facility staff mplete emergency in the describe providing care and treatment is under a 1135 waiver. Ide: 100 p.m., a review of the expreparedness plan and ducted with ASM of the facility's emergency in failed to evidence policies and emergency plan that describe of the facility's emergency in failed to evidence policies and emergency plan that describe in providing care and treatment is under an 1135 waiver. ASM did not have it.	E 026	at altered care sites under a 1135 By 10/8/18, Staff Develop Coord Safety Committee will educate al regarding the Emergency Prepare that includes Policy and Procedur the facility's role in providing care treatment at altered care sites und waiver. Executive Director will lead Safe and will review and make necessa Emergency Preparedness Plan/Ma x90 days or until Plan is 100% co Safety Committee will review and Emergency Preparedness Plan/Ma annually thereafter. 4. Executive Director will present Emergency Preparedness Plan tha Policy and Procedure describing the facility's role in providing car treatment at altered care sites und waiver to the Quality Assurance I Improvement committee for revier recommendations for 90 days. Th committee consist of Executive E Director of Nursing, Assistant Di Nursing, Social Services, Activiti Dietary Manager, Pharmacy cons	inator and I staff dness Plan e describing e and er a 1135 ty Committee ary changes to anuel monthly empliant. d up date anuel t the complete at includes e and er a 1135 Performance ew and he QAPI Director, rector of ies,	

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

Event ID: WE1L11

Facility ID VA0145

If continuation sheet Page 3 of 141

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

OLIVICI	O TOTT WILDIONICE	WINTEDICTIO SERVICES			OIMB MO	. 0938-039 I
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LÉTED
		495139	B. WING		09/	07/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 001	0112010
LIFE CAR	E CENTER OF NEW M.	ARKET	3	15 EAST LEE HIGHWAY		
			1	NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	38	(X5) COMPLETION DATE
E 026	Continued From pa	ge 3	E 026			
	1	2, the director of nursing were				
	made aware of the			İ		
	No further information	on was provided prior to exit.				
E 039			E 039	E039		10/15/18
SS=C	CFR(s): 483.73(d)(2	2)		1. The Safety Committee will develop,	nlan	
	(2) Testing. The Ifac	cility, except for LTC facilities.		and implement a full-scale emergency	٠ ۱	
] must conduct exercises to		drill that requires activation of Emerge		
		plan at least annually. The		_	- 1	
	all of the following:	RNHCIs and OPOs) must do		Plan. No resident was affected by iden	unea	
	_			concern.		
		at §483.73(d):] (2) Testing.		2. All residents residing within the faci	. 1	
		st conduct exercises to test n at least annually, including		potential to be affected by identified co	1	
		drills using the emergency		3. Safety Committee will develop, plan	1	
		C facility must do all of the		and implement a full-scale emergency	1	
	following:]			drill that requires activation of Emerge	ncy	
		ull-scale exercise that is		Plan. The full scale exercises will be		
		or when a community-based		documented and facility's exercise ana	lysis and	
		essible, an individual, e [facility] experiences an		critique will be used to update emerger	юу	
	actual natural or ma	an-made emergency that		program based on the exercise analysis	;	
		of the emergency plan, the	1	when concerns are identified.		
	[facility] is exempt for community-based or	or individual, facility-based		Staff Development Coordinator and Sa	fety	
		or 1 year following the onset of		Committee will review the critique of	the full	
	the actual event.	iding ad assessing About as as		exercise with staff and educate all staff	fofany	
		itional exercise that may mited to the following:		changes in the emergency plan at month	· '	
	(A) A second full-	-scale exercise that is		staff in-services.	-,	
community-based or individu				Planning of the facilities full scale exer	rcise will	
		ercise that includes a group facilitator, using a narrated,		Begin immediately and documented in		
	clinically-relevant e	mergency scenario, and a set		Safety Committee monthly minutes eff	i	
	of problem stateme	nts, directed messages, or		October Safety meeting.	V0114E	
	1		1	October Salety meeting.	!	

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 4 of 141

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET O(4) ID SUMMAY STATEMENT OF DEFICIENCIES PRESTX AND CONTINUED From page 4 Departed questions designed to challenge an amergency plan. (iii) Analyze the [facility's] erengency plan, as needed. "[For RNHCIs at §403.748 and OPO's at least annually. A tabletop exercises at least annually. A tabletop exercise at least annually. A tabletop exercises, and emergency plan. (iii) Analyze the [RnHCl's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency plan. (iii) Analyze the [RnHCl's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency plan. (iii) Analyze the [RnHCl's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency plan. (iii) Analyze the [RnHCl's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency plan. (iii) Analyze the [RnHCl's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency plan. (iii) Analyze the [RnHCl's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RnHCl's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RnHCl's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RnHCl's and OPO's] response to an amergency events, and revise the [RnHCl's and OPO's] response to an amergency events, and revise the [RnHCl's and OPO's] response to an amergency events, and revise the [RnHCl's and OPO's] response to an amergency events, and revise the [RnHCl's and OPO's] response to an amergency events, and revise the [RnHCl's and OPO's] response to an amergency events, and revise the [RnHCl's and OPO's] response to an amergency events, and revise the gradual revised to the country of t		MODIAN OF COORECTION I INCURRED ATTOMATICAL TO A TOTAL TOTAL TO A			(3) DATE SURVEY COMPLETED		
LIFE CARE CENTER OF NEW MARKET LIFE CARE CENTER OF NEW MARKET STREET ADDRESS, CITY, STATE, ZP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844 PROVIDERS PLAND F CORRECTION COMMENTED REGULATORY OR LSC IDENTIFYING INFORMATION) E 039 Continued From page 4 prepared questions designed to challenge an emergency plan. (ii) Analyze the [facility s] emergency events, and revise the [facility] semengency plan. (iii) Analyze the [facility] semengency plan, as needed. "For RNHCIs at \$403.748 and OPOs at \$486.3501 (g/(2)) Testing. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency exertises, and emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency plan. (iii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency plan. (iii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency plan. (iii) Analyze the fine fine fine fine fine fine fine fin			495139	B. WING		09/07/2	018
PREFIX TAG ECULATORY OR LISC IDENTIFYING INFORMATION) E 039 Continued From page 4 prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and energency plan, as needed. Tifor RNHCI and OPO] must do the facility. The [RNHCI and OPO] must conduct exercises to test the emergency plan. (ii) Analyze the paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency plan. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide documented evidence of the full scale exercises analysis			ARKET		315 EAST LEE HIGHWAY	03/01/2	010
prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCls at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCl and OPO] must conduct exercises to test the emergency plan. The [RNHCl and OPO] must donduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCl's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide documented evidence of the full scale exercises and documentation of the facility's exercise analysis	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		MPLETION
emergency program based on the exercise analysis. The findings include:	E 039	prepared questions emergency plan. (iii) Analyze the [faci maintain documenta exercises, and emer [facility's] emergency *[For RNHCIs at §40 §486.360] (d)(2) Tes must conduct exerciplan. The [RNHCI ar following: (i) Conduct a paper-least annually. A tab discussion led by a folinically relevant emorganed questions emergency plan. (ii) Analyze the [RN to and maintain documergency plan. (iii) Analyze the [RN to and maintain documergency plan. The facility staff interreview it was determined to have a compreparedness plan. The facility staff faile evidence of the full stand response and hemergency program analysis.	designed to challenge an lity's response to and tion of all drills, tabletop gency events, and revise the y plan, as needed. 3.748 and OPOs at sting. The [RNHCl and OPO] ses to test the emergency and OPO] must do the response of the emergency scenario, and a set aletop exercise is a group facilitator, using a narrated, are gency scenario, and a set at directed messages, or designed to challenge an ementation of all tabletop gency events, and revise the selement of the emergency plan, as This not met as evidenced eview and facility document a single that the facility staff plete emergency and to provide documented scale exercises and the facility's exercise analysis ow the facility updated its abased on the exercise	E 039	4. Executive Director will present the S Committee minutes regarding the plant of the full scale Emergency plan exercito the Quality Performance Improveme committee for review and recommendary of days or until exercise is completed. QAPI committee consist of Executive I Director of Nursing, Assistant Director Nursing, Social Services, Activities, Di Manager, Pharmacy consultant, Medical	ting se, nt tions for The Director, of	

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 5 of 141

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495139	B. WING _		09.	07/2018
	ROVIDER OR SUPPLIER E CENTER OF NEW MA	ARKET		STREET ADDRESS, CITY, STATE, ZIP (315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
E 039	Continued From page	ge 5	EO	039		
F 000	emergency prepare conducted with ASM member) # 1, the exthe facility's emerge to evidence docume exercises and docu exercise analysis ar facility updated its ethe exercise analys facility was going to scale exercise but of "works." On 09/07/18 at 3:26 staff member) # 1, the direct aware of the finding No further informati INITIAL COMMENT	on was provided prior to exit. 'S ledicare/Medicaid standard	FC	000		
	Corrections are req CFR Part 483 Fede	ted 9/5/18 through 9/7/18. uired for compliance with 42 ral Long Term Care Life Safety code survey/report				
	103 at the time of the consisted of 39 curl (Residents #72, #6, #55, #1, #75, #74, #30, #39, #37, #97, #29, #52, #65, #4, #	118 certified bed facility was ne survey. The survey sample rent resident reviews #73, #43, #70, #61, #42, #60, #62, #69, #2, #23, #48, #87, #26, #59, #17, #94, #40, #44, #58, #68, #88, #91, #95, #35, sed record reviews (Residents				

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 6 of 141

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE : COMPI	
		495139	8. WING		09/0	7/2018
	ROVIDER OR SUPPLIER E CENTER OF NEW I	MARKET	3	TREET ADDRESS, CITY, STATE, ZIP CODE 15 EAST LEE HIGHWAY EW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584	CFR(s): 483.10(i)(s) §483.10(i) Safe End resident has a comfortable and hour not limited to resupports for daily. The facility must p §483.10(i)(1) A sathomelike environruse his or her perspossible. (i) This includes e receive care and sphysical layout of independence and (ii) The facility shat the protection of the fit. §483.10(i)(2) Houservices necessal and comfortable in §483.10(i)(4) Priving good condition; §483.10(i)(4) Priving sident room, as §483.10(i)(5) Adelevels in all areas.	protable/Homelike Environment (1)-(7) Invironment. In right to a safe, clean, comelike environment, including ecciving treatment and living safely. Invironment and living safely. Invironment and living safely. Invoide- If clean, comfortable, and ment, allowing the resident to sonal belongings to the extent exercises safely and that the structure facility maximizes resident to does not pose a safety risk. If exercise reasonable care for the resident's property from loss esekeeping and maintenance by to maintain a sanitary, orderly, interior; In bed and bath linens that are eate closet space in each specified in §483.90 (e)(2)(iv); If quate and comfortable lighting is a safe to the specified in §483.90 (e)(2)(iv);	F 000	F 584 1. How will the corrective action be accomplished for those residents for have been affected by the deficient practice? On 9/6/18 direct care staff were vereducated on policy to serve resident meals in a homelike environment it dining room during all meals; inclusifiest and second dining. 2. How will the facility identify of residents having the potential to be affected by the same practice? All residents that consume their meals that consume their meals affected by this practice. Social Services will notify resident by 10/4/18 that meals served in the room during first and second dining be served in a homelike environment include removing items from food placing them on the table for each 3. What measures will be put into or systematic changes made to ensure the systema	rbally nts their n the uding ther to be t council e dining g will ent to tray and resident place	
		nfortable and safe temperature nitially certified after October 1,		practice will not reoccur?	Y.	

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

Event ID; WE1L11

Facility ID: VA0145

If continuation sheet Page 7 of 141

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/18/2018 FORM APPROVED

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	CENTER	S FOR MEDICARE 8	MEDICAID SERVICES			OMB NO	0. 0938-0391
STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA. 22844 PROPORTIES PLAND FOR CREATEON RECOLLATORY OR LSC IDENTIFYING INFORMATION F 584 Continued From page 7 1990 must maintain a temperature range of 71 to 81°F; and \$483.10()(7) For the maintenance of comfortable sound levels. This RECUlREMENT is not met as evidenced by: Based on observations, staff interview and facility document review, it was determined that the facility failed to provide a homelike environment for residents during dinning. The facility staff failed to serve residents in a homelike manner in the main dining room. The findings include: A dining observation was conducted on 09/05/18 at 12:20 p.m. in the main dining room. There were nine residents seated at five tables; four residents at one table; two residents at another table and three residents at one table each. All of the residents were served their lunches on trays a.m. with CNA (certified nursing assistant) # 1. When asked what the facility was to the residents, CNA # 1 stated, "The second dinning is not fine dining; Second dinning is where we are to assist the resident or feed them." When asked if she tab her meals on tray on the table at home, CNA # 1 stated, "The second dinning is not fine dining; Second dinning is where we are to assist the resident or feed them." When asked what the facility was to the residents, CNA # 1 stated, "The second dinning is not fine dining. Second dinning is where we are to assist the resident or feed them." When asked what the facility was to the residents, CNA # 1 stated, "The neaked of the state her meals on a tray on the table at home, CNA # 1 stated, "No." When asked what the facility was to the residents, CNA # 1 stated, "No." When asked hat the facility was to the residents, CNA # 1 stated, "No."				1 .			
LIFE CARE CENTER OF NEW MARKET DISTRICT ADDRESS, CITY, STATE, JIP CODE 316 EAST LEE HIGHWAY NEW MARKET, VA 22844 PREFIX CACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR U.S.C IDENTIFYING INFORMATION) F 584 Continued From page 7 1990 must maintain a temperature range of 71 to 81°F; and §483.10(I)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and facility document review, it was determined that the facility failed to provide a homelike environment for residents during dinning. The facility staff failed to serve residents in a homelike manner in the main dining room. The findings include: A dining observation was conducted on 09/05/18 at 12:200 p.m. in the main dining room. There were nine residents seated at five tables; four residents at one table each, All of the residents were served their lunches on trays in the dining room, CNA# 1 stated, "No." An Interview was conducted on 09/06/18 at 8:43 a.m. with CNA (certified nursing assistant) # 1. When asked what the facility was to the residents, CNA # 1 stated, "No." When asked of she has the her meals on a tray on the table a thome, CNA # 1 stated, "No." When asked of eating off a tray was homelike, CNA #1 stated, "No." When asked of eating off a tray was homelike, CNA #1 stated, "No." When asked of eating off a tray was homelike, CNA #1 stated, "No." When asked of eating off a tray was homelike, CNA #1 stated, "No." When asked of eating off a tray was homelike, CNA #1 stated, "No."			495139	B. WING		09	/07/2018
F 584 Continued From page 7 1990 must maintain a temperature range of 71 to 81°F; and \$483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and facility document review, it was determined that the facility failed to provide a homelike environment for residents during dinning. The facility staff failed to serve residents in a homelike manner in the main dining room. The findings include: A dining observation was conducted on 09/05/18 at 12:00 p.m. in the main dining room. There were nine residents seated at five tables, four residents were served their lunches on trays. An Interview was conducted on 09/06/18 at 8:43 a.m. with CNA (certified nursing assistant) # 1. When asked with the facility was to the residents, CNA # 1 stated, "The their home." When asked if shat ach remeals on a tray on the table at home, CNA # 1 stated, "The their home." When asked what the facility was to the residents, CNA # 1 stated, "The their home." When asked if eating off a tray was homelike, CNA # 1 stated, "The their home." When asked if eating off a tray was homelike. CNA # 1 stated, "No."			ARKET		315 EAST LEE HIGHWAY		
1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and facility document review, it was determined that the facility falled to provide a homelike environment for residents during dinning. The facility staff failed to serve residents in a homelike manner in the main dining room. The findings include: A dining observation was conducted on 09/05/18 at 12:00 p.m. in the main dining room. There were nine residents seated at five tables; four residents at one table; two residents at one table and three residents are the ir unches on trays. An interview was conducted on 09/06/18 at 8.43 a.m. with CNA (certified nursing assistant) # 1. When asked why the residents at the termels on trays in the dining room, CNA # 1 stated, "The second dinning is where we are to assist the resident or feed them." When asked if seating off a tray was homelike, CNA # 1 stated, "The second dining is the meals on a tray on the table at home, CNA # 1 stated, "The second dining is the first facility was to the residents, CNA # 1 stated, "The second dining is a sked what the facility was to the residents, CNA # 1 stated, "The second dining is a sked what the facility was to the residents, CNA # 1 stated, "The second dining is a stated," The second dining is a stated, "The second dining is a stated," The second dining is the meals on a tray on the table at home, CNA # 1 stated, "The stated," The stated, "The stated," The stated,	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
CNA #1 stated, "No." on the table for each resident 5 times a week x30 days 1 time a	F 584	1990 must maintain 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMEN by: Based on observate document review, it facility failed to prove for residents during. The facility staff failed homelike manner in the findings included A dining observation at 12:00 p.m. in the were nine residents residents at one table and three residents were an interview was considered as when asked what the residents, CNA # 1	e maintenance of comfortable IT is not met as evidenced ions, staff interview and facility was determined that the vide a homelike environment dinning. ed to serve residents in a the main dining room. E: In was conducted on 09/05/18 main dining room. There is seated at five tables; four ole; two residents at another dents at one table each. All of served their lunches on trays. Inducted on 09/06/18 at 8:43 diffied nursing assistant) # 1. In residents ate their meals on oom, CNA# 1 stated, "The oot fine dining. Second dinning assist the resident or feed d if she ate her meals on a home, CNA# 1 stated, "No." the facility was to the stated, "It's their home."	F 58	By 10/8/18, Staff Dev will in-service Certific and Licensed Nurses of Dining Experience for meal to each resident to be served a meal in environment. Staff wi and place them on the Any Certified Nursing Nurse that has not bee 10/8/18 will not be all care until in-service is hired Certified Nursing Licensed Nurses will during orientation on Dining Experience for the meal to each resid like to be served a me environment by remorand placing them on the resident. Director of Nursing/U Development Coording Manager will evaluate environment in the director of first and sections.	elopment Coordinator ed Nursing Assistants on Creating a Positive Residents by serving just as they would like a home like II remove tray items table for each resident. Assistant or Licensed in in-serviced by owed to provide direct completed. All newly g Assistants and receive education Creating a Positive Residents by serving ent just as they would all in a home like ving tray items the table for each Init Manager/Staff nator or Dietary e home like ning room for all meals cond dining- to ensure	
		When asked if eating CNA #1 stated, "No	ng off a tray was homelike b."		associates remove trag	y items and place them resident 5 times a week	1

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

a.m. with CNA # 2. When asked why the

Event ID WE1L11

Facility ID: VA0145

week x30 days.

If continuation sheet Page 8 of 141

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		495139	B. WNG		09/07/2018
10	ROVIDER OR SUPPLIER E CENTER OF NEW MA	RKET		STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	1 1
F 584	residents ate their m room, CNA # 1 state been told to set them her meals on a tray of 2 stated, "No." When to the residents, CN/When asked if eating CNA #2 stated, "No." An interview was cor a.m. with ASM (admidirector of nursing. V residents ate their m room, ASM # 2 state taken off and placed The facility's policy "Experience for Residents ate their m room, ASM # 2 state taken off and placed The facility's policy "Remember: Serve to the room,	eals on trays in the dining d, "That's how I have always o up." When asked if she ate on the table at home, CNA # on asked what the facility was A # 2 stated, "It's their home." off a tray was homelike, Inducted on 09/06/18 at 10:50 inistrative staff member) # 2, When asked why the eals on trays in the dining d, "They (the food) should be in front of them."	F 584	Continued from page 8 4. How will the facility monitoring corrective plan to ensure the deficier practice was corrected and not reocci Director of nursing will present findings of audit accurate assessment findings to the Quality Assurance Performance Improvement committee for review and recommendations for days. The QAPI committee consist of Executive Director, Director of Nursing, Assistant Director of Nursing, Assistant Director of Nursing Social Services, Activities, Dietary Manager, Pharmacy consultant, Medical Director.	nt ur? t ee 90
F 622 SS=E	staff member) #1, the the director of nursin findings. No further information Transfer and Dischat CFR(s): 483.15(c)(1) \$483.15(c)(1) Facility (i) The facility must premain in the facility discharge the reside (A) The transfer or discountered for the discounte	o(i)(ii)(2)(i)-(iii) and discharge- y requirements- permit each resident to	F 622	F622 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? As of 9/21/18 patients #26, 40, 42, 588, 97, 94 have safely returned to face	

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 9 of 141

OCT 0 1 2018
VDH/OLC

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495139	B. WING		09/07/2018
	ROVIDER OR SUPPLIER	MARKET	3	TREET ADDRESS, CITY, STATE, ZIP CODE 15 EAST LEE HIGHWAY IEW MARKET, VA 22844	
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 622	cannot be met in to (B) The transfer of because the reside sufficiently so the services provided (C) The safety of endangered due to status of the reside (D) The health of otherwise be endangered to the status of the resident happropriate notice under Medicare of Monpayment applications while the necession payment or after the Medicare of M	the facility; In discharge is appropriate ent's health has improved resident no longer needs the by the facility; individuals in the facility is to the clinical or behavioral ent; individuals in the facility would langered; las failed, after reasonable and to, to pay for (or to have paid or Medicaid) a stay at the facility. lies if the resident does not eary paperwork for third party the third party, including caid, denies the claim and the to pay for his or her stay. For a tomes eligible for Medicaid after cility, the facility may charge a to wable charges under Medicaid; lases to operate. If y not transfer or discharge the appeal is pending, pursuant to chapter, when a resident er right to appeal a transfer or from the facility pursuant to § his chapter, unless the failure to eafer would endanger the health sident or other individuals in the ty must document the danger sfer or discharge would pose.	F 622	Continued from page 9 from facility initiated transfer to hospital. 2. How will the facility identify residents having the potential to affected by the same practice? Any resident transferred to the lands the potential to be affected by practice. •Director of Nursing/Unit manareview all residents currently at sent from our facility and send becopy of updated care plan. •Director of Nursing/Unit manareview all residents transferred since September 10, 2018 has porder for transfer. •Health Information Managemereview all residents transferred since September 10, 2018 to assume physician's note regarding transferred. 3. What measures will be put in or systematic changes made to a practice will not reoccur?	other be hospital by this ger will hospital hospital a ger will to hospital hysician's ent will to hospital sure efer is

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

Event ID: WE1L11

Facility IO. VA0145

If continuation sheet Page 10 of 141

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495139	B. WNG		09/07/2018
	ROVIDER OR SUPPLIER	MARKET		STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 622	section, the facility or discharge is do	must ensure that the transfer cumented in the resident's	F 622	•By 10/8/18, Staff Development	
		d appropriate information is he receiving health care		Coordinator will in-service Licens	sed
	institution or provid			Nurses on sending a copy of	
		in the resident's medical record		comprehensive care plan goals are	e sent
	must include: (A) The basis for the	ne transfer per paragraph (c)(1)		with resident upon a facility initia	1 1
	(i) of this section.			transfer to the hospital.	
	(B) In the case of p	paragraph (c)(1)(i)(A) of this ic resident need(s) that cannot			
		empts to meet the resident		•Staff Development Coordinator	
	needs, and the ser	vice available at the receiving		service Licensed Nurses on obtain	ing
	facility to meet the	need(s). ation required by paragraph (c)		physicians order regarding facility	y
	7 7	n must be made by-		initiated transfer to the hospital.	
	(A) The resident's	physician when transfer or		•Staff Development Coordinator	will in-
	discharge is neces (A) or (B) of this se	ssary under paragraph (c) (1)		service Medical Director on writing	
	, , , ,	en transfer or discharge is		physician's note regarding facility	
	1	paragraph (c)(1)(i)(C) or (D) of			′
	this section.	ovided to the receiving provider		initiated transfer to the hospital.	
		nimum of the following:		Any Licensed Nurse that has not	been in-
	, ,	ation of the practitioner		serviced by 10/8/18 will not be al	lowed to
		e care of the resident. sentative information including		provide direct care until in-service	e
	contact information	n		completed.	
	(C) Advance Direc			All newly hired Licensed Nurses	will
	ongoing care, as a	ructions or precautions for appropriate.			1
	(E) Comprehensiv	e care plan goals;		receive education during orientati	
		ssary information, including a		sending a copy of comprehensive	care
		nt's discharge summary, 83.21(c)(2) as applicable, and		plan goals, obtaining physician or	rder, and
		ntation, as applicable, to ensure		sending with resident upon a facil	lity
	1	e transition of care.		initiated transfer to the hospital.	
	by:	ENT is not met as evidenced		and the state of the mountain	

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 11 of 141

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' E	PLE CONSTRUCTION		SURVEY PLETED
		495139	B WING		09	/07/2018
LIFE CAR		ARKET STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL	ID PREFIX	STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844 PROVIDER'S PLAN OF CORRECTIVE ACTION SH	CTION	(X5) COMPLETION
PREFIX TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)		DATE
F 622	Based on staff intereview, and clinical determined that the that all the required to the hospital upon residents, Resident and 94. 1. The facility staff of Resident #26's commerce sent with the utransfer to the hospital on 2. The facility staff of Resident #40's commerce sent with the utransfer to the hospital on 3. The facility staff of the comprehensive with the resident up to the hospital on 0. 4. The facility staff of the comprehensive with the resident up to the hospital on 7. 5. The facility staff of the required documulimited to, the physician's note recomprehensive car	rview, facility document record review, it was facility staff failed to evidence documentation was provided a transfer for eight of 42 #26, 40, 42, 59, 58, 88, 97, failed to evidence that aprehensive care plan goals resident upon a facility initiated dital on 6/10/18 and 7/27/18.	F 62	Continued from page 11 Director of Nursing/Unit Mane evaluate facility initiated transhospital to ensure comprehensing goals and physician order was resident to the hospital and ensure physician made a note in regard transfer to the hospital 5 times x30days, 3 times a week x30days. 4. How will the facility monitor corrective plan to ensure the dispractice was corrected and note Director of nursing will present of audit accurate assessment for the Quality Assurance Performs and the Quality Assurance P	fers to the ive care plan sent with sure rds to facility a week ays, I time a pring the efficient reoccur? nt findings findings formance eview and The QAPI re Director, Director of vities,	,
	the comprehensive	failed to provide evidence that care plan goals were sent				

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

Event IO WE1111

Facility ID: VA0145

If continuation sheet Page 12 of 141

	TMENT OF HEALTH	HAND AN SERVICES			FORM	: 09/18/2018 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DAT	E SURVEY MPLETEO
		495139	B. WING		09/	07/2018
	PROVIDER OR SUPPLIER		31	REET ADDRESS, CITY, STATE, ZIP CO 5 EAST LEE HIGHWAY EW MARKET, VA 22844		18/1978
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 622	7. Resident #97 w the hospital on 5/2 There was no evid all required docum comprehensive ca plan goals were pr for each facility init 8. Resident #94 w the hospital on 7/2 evidence in the clid documentation inceplan and comprehe provided to the recinitiated transfer. The findings includ 1. The facility staff Resident #26's con were sent with the transfer to the hos Resident #26 was 3/14/18 and readm diagnoses that ince type two diabetes, swallowing), repeat communication de recent MDS (minimal a significant change) (assessment refered #26 was coded as cognitive function	7/21/18, for Resident #88. 7/21/18, for Resident #88. 7/21/18, 6/11/18, and 7/28/18. Rence in the clinical record that the entation including the replan or comprehensive care revided to the receiving hospital that transfer. 7/18 and 8/8/18. There was no inical record that all required fluding the comprehensive care ensive care plan goals were receiving hospital for each facility	F 622			

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 13 of 141

DEPARTMENT OF HEALT CENTERS FOR MEDICAL	TH AND HUMAI PRVICES RE & MEDICAID SERVICES		FRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	495139	B. WING	09/07/2018
NAME OF PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZI	P CODE
		315 FAST LEE HIGHWAY	

			1/2010		
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE				
LIFE CARE CENTER OF NEW MARKET		315 EAST LEE HIGHWAY			
	NEW MARKET, VA 22844				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
Review of Resident #26's clinical record revealed that she had been transferred to the hospital on 6/10/18 at 2:39 p.m. The following nursing note in part was documented: "Resident observed laying on her back on floor by CNA (certified nursing assistant). Resident stated that she was trying to put herself to bedNeuro checks WNL (within normal limits). B/P (blood pressure) elevated 186/108. NP (nurse practitioner) aware of fall and new order to given to send residents to ER (emergency room) to eval (evaluate) and treat. Daughter, (Name of Daughter) called. No answer. Message left to return call. Resident aware of new order given." The next note dated 6/10/18, documented that Resident #26's daughter was made aware of the transfer. Review of Resident #26's "Nursing Home to Hospital Transfer" form evidence that the following required information was sent with the resident upon transfer to the receiving provider: 1. Contact information of the practitioner responsible for the care of the patient 2. Resident representative information. 3. Advanced directives 4. All special instructions and precautions for ongoing care. There was no evidence that Resident #26's comprehensive care plan goals were sent to the receiving provider upon transfer to the hospital. Review of Resident #26's clinical record revealed that she was sent for the second time to the hospital on 7/27/18. The following note in part was documented: "Resident to be found on floor	F 63	22			

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 14 of 141

OCT 0 1 2018
VDH/OLC

	MENT OF HEALTH	HAND (IAN SERVICES E & MEDICAID SERVICES				FORM	09/18/2018 APPROVED . 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DAT	E SURVEY APLETED
		495139	B. WING _			09	/07/2018
	PROVIDER OR SUPPLIER RE CENTER OF NEV			STREET ADDRESS, CI 315 EAST LEE HIGH NEW MARKET, VA	WAY		11 31 31 31 31 31 31 31 31 31 31 31 31 3
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORE	R'S PLAN OF CORREC RECTIVE ACTION SHO RENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 622	on her back, the resever (sic) during (medical doctor) wassessed the resident be sent of (sic). Daughter was Emergency service continue to monitor Review of Resider Hospital Transfer following required resident upon transponsible for the 2. Resident repressions during the continued of the conti	2 pm, the resident noted to be esident had c/o (complaints) of movements of left leg, (sic) MD was notified, (sic) the MD dent and felt it was best if the out for evaluation of the left legs is notified of transfer, es has been contacted, Will or" Int #26's "Nursing Home to form evidence that the information was sent with the sfer to the receiving provider: Attion of the practitioner escare of the patient sentative information.	F 62	22			
	comprehensive careceiving provider On 9/7/18 at 12:12 conducted with LF LPN #3 was asked residents who are #3 stated that she resident's face she physical, copy of F summary), copy of the change or inci-	dence that Resident #26's are plan goals were sent to the upon transfer to the hospital. 2 p.m., an interview was PN (licensed practical nurse) #3. If what documents are sent with transferred to the hospital. LPN would send a copy of the eet, most updated history and POS (physician order of the nursing notes describing dent, applicable labs and opy of the MAR (Medication					

Administration Record) and TAR (Treatment Administration Record). LPN #3 stated that she also send a transfer notice and sends a copy of

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 15 of 141

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY APLETED
		495139	B. WING		09/	07/2018
	PROVIDER OR SUPPLIER		315	REET ADDRESS, CITY, STATE, ZIP C EAST LEE HIGHWAY W MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENT	FATEMENT OF DEFICIENCIES CY 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 622	nurses send a copcare plan goals, L. On 9/7/18 at 3:26 member) #1, the I the DON (Director of the above condition of the above condition of the above condition of the above condition of the resident, Resident Advanced Director instructions or precomprehensive Comprehensive Comprehe	pusiness office. When asked if by of the resident's care plan or PN #3 stated, "No." p.m., ASM (administrative staff Executive Director and ASM #2, of Nursing) were made aware terns. titled, "Transfers and ments in part, the following: sibilities of Nursing: Resident collowing sent with them at a seet, medication list, contact practitioner for care of the trepresentative information, we information, All special ecautions for ongoing care, care Plan Goals" ation was presented prior to exit.	F 622			
	being moderately	impaired in cognitive function possible 15 on the BIMS (Brief				

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 16 of 141

	RS FOR MEDICAR	E & MEDICAID SERVICES				MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495139	B. WING		00	/07/2018
	PROVIDER OR SUPPLIER		315	REET ADDRESS, CITY, STATE, ZIP BEAST LEE HIGHWAY W MARKET, VA 22844		10112010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 622	Review of Resider that he had been to 8/31/18. The follow documented: "8/3" c/o (complaint) he Percocet (1). reside manually, urine out heart rate regular, reactive. MD (medorders received for (milligrams) x 1. In half hours. BP still headache 8/10. Morders received for (sic) check BP. reside 8/30/18will continues second dose of cleange in headach MD) made aware new orders to seneval. (evaluation)	age 16 Int #40's clinical record revealed ransferred to the hospital on wing nursing notes were 1/18 at 4:33 AM: resident (sic) adache 9/10 after given dent's (sic) increased 220/105 atput WNL (within normal limits) no nausea noted, pupils dical doctor) made aware, new r clonidine (2) 0.1 mg echeck (sic) BO after one and increased to 230/110, c/o D made aware. new (sic) r clonidine 0.1 mg one time. will sident (sic) started on ceftin (3) nue to monitor"after (sic) onidine 0.1 mg there was no he or BP: 230/110. (Name of and rounded on resident, with d to ER (emergency room) for and treatment of acute he and hypertension (high blood	F 622			
	Hospital Transfer" following required resident upon tran 1. Contact informates responsible for the	nt #40's "Nursing Home to form evidence that the information was sent with the isfer to the receiving provider: ation of the practitioner e care of the patient				
	3. Advanced direc	sentative information. tives uctions and precautions for				
	comprehensive ca	dence that Resident #40's are plan goals were sent to the upon transfer to the hospital.				1

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 17 of 141

PRINTED 09/18/2018



PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495139	B. WING		09	/07/2018
	PROVIDER OR SUPPLIER	MARKET		STREET ADDRESS, CITY, STATE, ZIF 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 PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 622	On 9/7/18 at 12:12 conducted with LPI When asked if nurs resident's compreh goals with resident LPN #3 stated, "No On 9/7/18 at 3:26 pmember) #1, the Ethe DON (Director of the above conce was presented prior (1) Percocet - Opic relief of moderate to This information will institutes of Health https://dailymed.nlm?setid=0a4469475a. (2) Clonidine is use This information will institutes of Health https://www.ncbi.nlm.0009680/?reports (3) Ceftin is a ceph treat infections. The National https://www.ncbi.nlm.0009522/?reports (4) Pylenonephritis urinary tract infection the bladder and both of the kidneys	p.m., an interview was N (licensed practical nurse) #3. ses send a copy of the pensive care plan or care plan is transferred to the hospital, b." D.m., ASM (administrative staff executive Director and ASM #2, of Nursing) were made aware erns. No further information or to exit. Did analgesic indicated for the pension of the National moderately severe pain. The National moderate	F 6			

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 18 of 141

	MENT OF HEALT	TH AND I IAN SERVICES RE & MEDICAID SERVICES			FORM	9: 09/18/2018 MAPPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DA1	. 0938-0391 TE SURVEY MPLETED
		495139	B. WING		09	/07/2018
	PROVIDER OR SUPPLIE		3	TREET ADDRESS, CITY, STATE, ZIP 15 EAST LEE HIGHWAY IEW MARKET, VA 22844		70772010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 622	ogic-diseases/kid 3. The facility star the comprehension with the resident to the hospital on Resident # 42 wa 04/03/13 and a re diagnoses that in heart failure, gas atrial fibrillation, (Resident # 42's re set), a quarterly a (assessment refe Resident # 42 as interview for men 15, 15 - being c decisions. The nurse's "Producted 07/05/18 a "Resident with all confused and par irregular lab (labor (vital signs) 98.0 68 -blood pressu 90% on 2L (two linotified at 1700 (daughter-in-law, notified by NP (ne) Nurse Practitions on 7/1/18 without [sic] squad here to (Name of Hos)	c.nih.gov/health-information/urol Iney-infection-pyelonephritis. If failed to provide evidence that we care plan goals were sent upon a facility initiated transfer 07/05/18, for Resident # 42. Is admitted to the facility on eadmission of 07/08/18 with cluded but were not limited to troesophageal reflux disease (1), 2), and osteoarthritis (3). Inost recent MDS (minimum data assessment with an ARD erence date) of 07/11/18, coded scoring a 15 on the brief tal status (BIMS) of a score of 0 ognitively intact for making daily gress Notes" for Resident # 42 t 4:56 p.m., documented, tered mental status, alert but ranoid with visual hallucinations, oratory) work as of today. VS (temperature), 125/68 (125 over re), O2 SAT (oxygen saturation) iters). Resque [sic] Squad 5:00 p.m.). Resident's (Name of Daughter-in-law) urse practitioner), (Name of er). Resident did fall out of bed any apparent injuries. Resque at 1715 (5:15 p.m.), to transport bital)."	F 622			
		cility's transfer form entitled				

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 19 of 141

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DEPARTMENT OF HEALTH AND HUMAN	RVICES
CENTERS FOR MEDICARE & MEDICAID	

	PRINTED:: 09/18/2018
)	FORM APPROVED
	OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED		
		495139	B. WING_		09/	07/2018
	OF PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP C 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) I PREF TAG	IX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL B LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 6.	FORM" dated 07/evidence the resignals as part of the conducted with L. When asked if nuresident's compreguence with resident's compreguence with resident LPN #3 stated, "No no 09/06/18 at a (administrative st director, ASM #2 made aware of the No further inform References: (1) Stomach conducted the esophagus at was obtained from https://www.nlm.u. (2) A problem with heartbeat. This is the website: https://www.nlm.u. (3) The most compain, swelling, and It can occur in an hands, knees, his was obtained from https://medlineples.//medlineples.	705/18 for Resident # 42 failed to dent's comprehensive care plan he transfer paperwork. 2 p.m., an interview was PN (licensed practical nurse) #3. Irses send a copy of the chensive care plan or care plan has transferred to the hospital, No." 2 p.m. ASM aff member) #1, the executive the director of nursing, were refindings. 2 p.m. ASM aff member) #1, the executive the director of nursing, were refindings. 3 proximately 3:26 p.m. ASM aff member) #1, the executive the director of nursing, were refindings. 4 the director of nursing the provided prior to exit. 5 proximately 3:26 p.m. ASM aff member) #1, the executive the director of nursing the findings. 5 proximately 3:26 p.m. ASM aff member) #1, the executive the director of nursing the findings. 6 proximately 3:26 p.m. ASM aff member) #1, the executive the director of nursing the findings. 7 proximately 3:26 p.m. ASM aff member) #1, the executive the director of nursing the findings. 8 proximately 3:26 p.m. ASM aff member) #1, the executive the director of nursing the findings. 8 proximately 3:26 p.m. ASM aff member) #1, the executive the director of nursing the findings. 9 proximately 3:26 p.m. ASM aff member) #1, the executive the director of nursing the findings. 9 proximately 3:26 p.m. ASM aff member) #1, the executive the director of nursing the findings. 9 proximately 3:26 p.m. ASM aff member the findings that the executive the findings that	F 62			

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 20 of 141

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		TE SURVEY MPLETED
		495139	B. WING	(1)	05	0/07/2018
	PROVIDER OR SUPPLIE		31	REET ADDRESS, CITY, STATE, ZIP 5 EAST LEE HIGHWAY EW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 622	to the hospital on Resident #59 was 3/25/15, with a m 7/12/18, with diagnot limited to: head (weakness and p (1), high blood proceed to the most recent assessment, and assessment references as a scoring interview for men resident is cognit making.	page 20 upon a facility initiated transfer 7/10/18, for Resident #59. s admitted to the facility on lost recent readmission of gnoses that included but were lart failure, stroke, Bell's palsy earalysis of one side of the face) ressure, diabetes, and arthritis. MDS (minimum data set) lannual assessment, with an rence date of 7/20/18, coded the lang a "15" on the BIMS (brief latal status) score, indicating the lively intact for daily decision	F 622			
	documented] sta follow up on weig (shortness of bre The nurse practit 7/10/18 [no time Resident to [host R/t (related to) So Review of the cli	ted, "Patient seen today for the increase [and] SOB teath) increase." tioner's telephone order dated documented] stated, "Send pital's name] for eval (evaluation) OB (shortness of breath)."				
		9's comprehensive care plan or vere sent with him upon transfer			7	

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LPN #3 stated, "No."

to the hospital.

On 9/7/18 at 12:12 p.m., an interview was

When asked if a copy of the resident's

conducted with LPN (licensed practical nurse) #3.

comprehensive care plan or care plan goals are sent with residents transferred to the hospital,

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 21 of 141

DEPARTMENT OF	HEALTH	AND HUMAN	RVICES
CENTERS FOR MI	EDICARE.	& MEDICAID	SERVICES

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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
	495139	8. WING_		O:	9/07/2018
			315 EAST LEE HIGHWAY	TATE, ZIP CODE	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECT) CROSS-REFERENCE	IVE ACTION SHOULD BE ED TO THE APPROPRIATE	(X5) COMPLETION DATE
On 9/7/18 at 3:26 member) #1, the of the director of nurabove findings. The nursing notes transfer form, for requested but we surveyor's exit on No further information National Institutes.	p.m., ASM (administrative staff executive director, and ASM #2, rsing, were made aware of the s, as well as the resident date of service 7/10/18 were re not received prior to 9/7/18 at 5:15 p.m. ation was provided prior to exit.	F 62	22		
the required docu limited to, the phy physician's note recomprehensive casent with Resider hospital. Resident #58 was 3/14/18, with a mare 7/12/18, with diagonat limited to: atrithe speed and rhy blood pressure, distory of a hip fraction. The most recent assessment, a signal in the physical recomprehensive section.	mentation, including but not resician's order for transfer, the egarding transfer, and the are plan or care plan goals were at #58 upon transfer to the admitted to the facility on ost recent readmission of moses that included but were all fibrillation (an abnormality of other of a heart beat) (1), high inabetes, muscle weakness and acture in March 2018. MDS (minimum data set) grifficant change assessment,				
	ROVIDER OR SUPPLIER RECENTER OF NET SUMMARY S (EACH DEFICIEN REGULATORY OR ON 9/7/18 at 3:26 member) #1, the director of nur above findings. The nursing notes transfer form, for requested but we surveyor's exit on No further information National Institutes https://medlineplus. 5. The facility staff the required doculimited to, the phy physician's note recomprehensive or sent with Resider hospital. Resident #58 was 3/14/18, with a ma 3/14/18, with diagnot limited to: atrithe speed and rhy blood pressure, distory of a hip fraction of the most recent assessment, a significant assessment, a significant assessment, a significant recent	RE CENTER OF NEW MARKET SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were made aware of the above findings. The nursing notes, as well as the resident transfer form, for date of service 7/10/18 were requested but were not received prior to surveyor's exit on 9/7/18 at 5:15 p.m. No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/bellspalsy.html 5. The facility staff failed to evidence that all of the required documentation, including but not limited to, the physician's order for transfer, the physician's note regarding transfer, and the comprehensive care plan or care plan goals were sent with Resident #58 upon transfer to the	RE CENTER OF NEW MARKET SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 F 62 On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were made aware of the above findings. The nursing notes, as well as the resident transfer form, for date of service 7/10/18 were requested but were not received prior to surveyor's exit on 9/7/18 at 5:15 p.m. No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/bellspalsy.html 5. The facility staff failed to evidence that all of the required documentation, including but not limited to, the physician's order for transfer, the physician's note regarding transfer, and the comprehensive care plan or care plan goals were sent with Resident #58 upon transfer to the hospital. Resident #58 was admitted to the facility on 3/14/18, with a most recent readmission of 7/12/18, with diagnoses that included but were not limited to: atrial fibrillation (an abnormality of the speed and rhythm of a heart beat) (1), high blood pressure, diabetes, muscle weakness and history of a hip fracture in March 2018. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 8/20/18,	ROVIDER OR SUPPLIER RE CENTER OF NEW MARKET SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 21 Con 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were made aware of the above findings. The nursing notes, as well as the resident transfer form, for date of service 7/10/18 were requested but were not received prior to surveyor's exit on 9/7/18 at 5:15 p.m. No further information was obtained from the National Institutes of Health at https://medlineplus.gov/bellspalsy.html 5. The facility staff failed to evidence that all of the required documentation, including but not limited to, the physician's order for transfer, the physician's note regarding transfer, and the comprehensive care plan or care plan goals were sent with Resident #58 upon transfer to the hospital. Resident #58 was admitted to the facility on 3/14/18, with a most recent readmission of 7/12/18, with diagnoses that included but were not limited to; attrail fibrillation (an abnormality of the speed and rhythm of a heart beat) (1), high blood pressure, diabetes, muscle weakness and history of a hip fracture in March 2018. The most recent MDS (minimum data set) assessment, with an assessment, reference date of 8/20/18,	## A BUILDING A BUILDING BUILD

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

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 22 of 141

		TH AND MAN SERVICES RE & MEDICAID SERVICES			FORM	09/18/2018 APPROVED 0.0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	TE SURVEY MPLETED
		495139	B. WING _		09	/07/2018
NAME OF	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE		3
LIFE CA	RE CENTER OF NE	W MARKET		NEW MARKET, VA 22844		No.
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 622	(brief interview for the resident is modecision making.) The nursing note "Resident complarespirations labor wheezes noted be at 21 (liter) per ming was in and recome evaluated, alert, informed of situal [hospital's name]. Review of the cliration that all of the requestion but not limited to transfer, the physical that all comprehensive of the conducted with LLPN #3 was asked that should be comprehensive of the conducted with LLPN #3 was asked that should be comprehensive of the conducted with LLPN #3 was asked that should be comprehensive of the conducted with LLPN #3 was asked that should be comprehensive of the conducted with LLPN #3 was asked that should be comprehensive of the conducted with LLPN #3 was asked that should be comprehensive of the conducted with LLPN #3 was asked that should be comprehensive of the conducted with LLPN #3 was asked the conducted with LLPN #3 was asked that should be comprehensive of the conducted with LLPN #3 was asked that should be comprehensive of the conducted with LLPN #3 was asked that should be comprehensive of the conducted with LLPN #3 was asked the conducted with LLPN #	dated 7/12/18 at 4 p.m. stated, ains of feeling like he is dying, red, sat 89 [%] on room air, ilaterally, oxygen applied to [sic] nute. NP (nurse practitioner) mended [sic] be sent to be heart rate regular, son called and tion, pt (patient) to be sent to	F 62			

the change or incident, applicable labs and diagnostics and copy of the MAR (Medication Administration Record) and TAR (Treatment Administration Record). LPN #3 stated that she also send a transfer notice and sends a copy of that notice to the business office. When asked if nurses send a copy of the resident's care plan or

care plan goals, LPN #3 stated, "No."

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 23 of 141



DEPARTMENT			
CENTERS FOR	MEDICARE	& MEDICAID	SERVICES

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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0.3	E CONSTRUCTION		TE SURVEY MPLETED
		495139	B. WING		09	/07/2018
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 115 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 622	On 9/7/18 at 3:26 member) #1, the the director of nurabove findings. No further information National Institutes https://medlineplus. 6. The facility stafthe comprehensive with the resident to the hospital on Resident #88 was 5/7/16, with a most 7/27/18, with diagnot limited to: stroke, muscle we difficulty swallowing The most recent I assessment, a quassessment refer resident as rarely himself understanding of the nurse practition 7/21/18 [no time of Resident to ED (evaluation)/treater the nursing note documented in padiminished respirations.	p.m., ASM (administrative staff executive director, and ASM #2, rsing, were made aware of the ation was provided prior to exit. In was obtained from the of Health at its.gov/atrialfibrillation.html If failed to provide evidence that we care plan goals were sent upon a facility initiated transfer 7/21/18, for Resident #88. Is admitted to the facility on st recent readmission of moses that included but were oke, paralysis secondary to eakness, difficulty speaking, and, hypertension, and dementia. MDS (minimum data set) matterly assessment, with an ence date of 8/12/18, coded the never being able to make and as well as rarely-never ners. In oner's telephone order dated documented] stated, "Send emergency department) for eval	F 622			

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

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 24 of 141



	MAN SERVICES
CENTERS FOR MEDICARE & ME	AID SERVICES



PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		PLE CONSTRUCTION		E SURVEY MPLETED
		495139	B. WING		09/	07/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
F 622	rattling sounds in tinflammation of the (nurse practitioner) obtained for reside evaluation and treat Review of the clinic that Resident #88's comprehensive can him upon transfer of the comprehensive comprehensive findings. On 9/7/18 at 12:12 conducted with LP When asked if nurresident's comprehensive of the comprehensive can him upon transfer of the comprehensive can him upon transfer of the comprehensive can plan goals were prefor each facility initial control of the comprehensive can plan goals were prefor each facility initial control of the comprehensive can plan goals were prefored the comprehensive can be comprehensive the comprehensive the comprehensive can be comprehensive the comprehensive can be comprehensive the comprehensive the comprehensive can be comprehensive the comprehensive th	are small clicking, bubbling, or the lungs which could indicate elungs) (1) bilaterallyNP on notified and new order at to be sent to ED for atment." cal record failed to evidence is comprehensive care plan or the plan goals were sent with to the hospital. p.m., an interview was N (licensed practical nurse) #3. sees send a copy of the nensive care plan or care plan is transferred to the hospital, o." c.m., ASM (administrative staff executive director, and ASM #2, sing, were made aware of the tion was provided prior to exit. was obtained from the of Health us.gov/ency/article/007535.htm as transferred and admitted to 3/18, 6/11/18, and 7/28/18. ence in the clinical record that entation including the re plan or comprehensive care ovided to the receiving hospital	F 622			

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 25 of 141

-	PRINTED: 09/18/2018
)	FORM APPROVED
	OMB NO. 0938-0391

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY MPLETED
		495139	B. WING		09/	/07/2018
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1 +2	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 622	4/30/18 with the opulmonary embol congestive heart aftercare. The question with an ARD of 8/7/18 coded the intact in ability to the Anurse's note da (medical doctor) in patients. Resider (shortness of breadiminished right be and O2 (oxygen) (two liters) O2 via increased to 31. Obreath and complete (name of son) called and reside further evaluation. A physician's note "When I walked in roommate, (Residual tachypneic and disymptoms of miles somewhat short of 118, respiratory resaturation 93% of nurses at the end	liagnoses of but not limited to ism, atrial fibrillation, sepsis, failure, hypoxemia, and surgical larterly MDS (Minimum Data (Assessment Reference Date) ne resident as being cognitively make daily life decisions. Ited 5/23/18 documented, "MD in room this AM to assess in was diaphoretic and SOB eath). Lungs with rales and lase. Assessed again by nurse sats (saturation) were 78% on 21 in asal cannula, O2 was continues (sic) to be short of ains of dizziness and weakness. Ited and notified of condition and ad patient to hospital. Squad int sent to (name of hospital) for	F6	522		
	96.8Plan: She reason for acute diaphoresis with urologic causes,	espiratory rate 24, Temperature needs evaluation to clarify the tachypnea, tachycardia, and potential etiologies including PE (pulmonary embolism). R (emergency room) for urgent				

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 26 of 141

		AND JAN SERVICES					FORM	: 09/18/2018 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		(X3) DAT	. 0938-0391 E SURVEY IPLETED
		495139	B. WING				09/	07/2018
	PROVIDER OR SUPPLIER RE CENTER OF NEW			315	REET ADDRESS, CITY, STATE, ZIF EAST LEE HIGHWAY W MARKET, VA 22844	CODE	Ħ	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	x	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD IE APPROF) BE	(X5) COMPLETION DATE
F 622	Continued From pa	age 26	F6	22				
	Transfer Form date evidence Resident plan goals were pr	rsing Home to Hospital ed 5/23/18 failed to reveal any #97's comprehensive care ovided to the hospital.						
	note dated 6/11/18 drowsy, denied any	ical record revealed a nurse's that documented, "Patient felt y pain, and she stated, "I just er VS (vital signs) at the hift was						
	98.7-105-16-126/7 (temperature-pulse pressure-oxygen s statement that she VS was obtained a (temperature)-76/5 pressure)-26 (resp		-					
	based on her histo with pleural effusion	sed patient. He feels that ry that she may be presenting ins. Order obtained to send Emergency Department) for otified."						
	"Patient seen toda pressure) increase	dated 6/11/18 documented, y for dropping B/P (blood pleural effusions, etc. Pt to ER (emergency room) for ation)."						
		rsing Home to Hospital	1					

evidence of the comprehensive care plan goals

A review of the nurse's notes revealed one dated 7/28/18 that documented, "This nurse was notified by CNA (certified nursing assistant) that

being provided to the hospital.

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 27 of 141

PRINTED:	09/18/2018
FORM	APPROVED
OMB NO.	0938-0391

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1 IFF CARE CENTER OF NEW MARKET 315 EAST LEE HIGHWAY	(X5) COMPLETION DATE
LIFE CARE CENTER OF NEW MARKET	
NEW MARKET, VA 22844	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
Resident was clammy and not responding. Resident c/o (complained of) dizziness, hard to focus on anything, and nausea. Periods of hypotension (low blood pressure) this am. MD notified with new orders to send for evaluation. Son (name of son) notified but yet to be contacted. 911 activated." A review of the Nursing Home to Hospital Transfer Form dated 7/28/18 failed to reveal any evidence of the comprehensive care plan goals being provided to the hospital. On 9/7/18 at 12:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked what documents are sent with residents who are transferred to the hospital. LPN #3 stated that she would send a copy of the resident's face sheet, most updated history and physical, copy of POS (physician order summany), copy of the nursing notes describing the change or incident, applicable labs and diagnostics and copy of the MAR (Medication Administration Record). LPN #3 stated that she also send a transfer notice and sends a copy of that notice to the business office. When asked if nurses send a copy of the resident's care plan or care plan goals, LPN #3 stated, "No." On 9/7/18 at 3:26 PM in a meeting with ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) they were made aware of the findings. No further information was provided by the end of the survey.	

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Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 28 of 141

OCT 0 1 2018
VDH/OLC

AND JAN SERVICES & MEDICAID SERVICES			RINTED: 09/18/2018 FORM APPROVED MB NO. 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
495139	B. WING		09/07/2018
MARKET	31	5 EAST LEE HIGHWAY	K MI E
EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
ge 28 /18 and 8/8/18. There was no cal record that all required ding the comprehensive care is sive care plan goals were iving hospital for each facility dmitted to the facility on gnoses of but not limited to it, ischemic heart disease, and chronic kidney disease. We MDS (Minimum Data Set) sment Reference Date) of sident as being cognitively like daily life decisions. The sease of the same with nausea id not want to go to ER. Went to prior sched orthopedic) apt (appointment) laboratory test] drawn main at this timeBrother (continue) to assess. MD is aware, decided best course. "Resident was alert and gof shift this AM. Later came very lethargic and was staying awake. MD was at was assessed the started.	F 622		
	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495139 MARKET EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) DE 28 (18 and 8/8/18. There was notal record that all required ding the comprehensive care plan goals were iving hospital for each facility dimitted to the facility on gnoses of but not limited to ischemic heart disease, and chronic kidney disease. WMDS (Minimum Data Set) sment Reference Date) of sident as being cognitively like daily life decisions. Eal record revealed the es: 7/26/18 at 1:09 PM: esented this am with nausea id not want to go to ER. went to prior sched withopedic) apt (appointment) laboratory test] drawn main at this timeBrother (continue) to assess. MD is aware, decided best course "Resident was alert and go f shift this AM. Later came very lethargic and was staying awake. MD was the was assessed. Had started do Norco {2} this AM. and	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495139 MARKET EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) De 28 18 and 8/8/18. There was no cal record that all required ding the comprehensive care is vive care plan goals were iving hospital for each facility dmitted to the facility on gnoses of but not limited to process of but not limi	MARKET MEDITIFICATION NUMBER: 495139 MARKET MEMORIANTOP DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) MARKET MARKET MEMORIANTOP PREFIX TAG MARKET MARKET MEMORIANTOP MARKET MEMORIANTOP MARKET MEMORIANTOP MEMORIANTOP MEMORIANTOP MEACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) F 622 MIST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) F 622 F 622 MIST BE ATS LEE HIGHWAY MEW MARKET, VA 22844 MEMORIANTOP MEMORIANTOP MEMORIANTOP MARKET MEMORIANTOP MEMORIANTOP MEMORIANTOP MEMORIANTOP MARKET MEMORIANTOP MARKET MEMORIANTOP MARKET MEMORIANTOP

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

O2 (oxygen) sats were 86% on room air. 95% on

cannula....Addendum: Resident continues with

2l (two liters of oxygen) via nasal

Event ID:WE1L11

Facility ID. VA0145

If continuation sheet Page 29 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(2) (3)	IPLE CONSTRUCTION NG	CON	TE SURVEY MPLETED /07/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET				STREET ADDRESS, CITY, STATE, ZIP O 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		10772018
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 622	extreme lethargy for supplemental orders given to so Brother was notif admitted to (hosp A physician's note "Follow up on heafunction. (Have to being seen earlied history is being reand hospital perstypically has probfluid retention, etimologically has probfluid retention, etimologically femoral trochonoperatively, for 28Plan: 1. On after breakfast air renal and cardious emesis, I think how will have avaithis morning. I with this morning. I with the morning of the EFA review of the EFA rev	at this time with continued need O2. Reassessed by MD and ent to ER for further evaluation. ied. Addendum: Resident was oital) for acute kidney injury." de dated 7/26/18 documented, art failure and weight, renal oeen following him daily)now recause of vomitingRecent eiterated for the benefit of ER onnel. After hospitalizations he ollems afterward with increased ology not entirely clear. Most ation was late June because of hanter fracture treated ollowed by transfer here June set vomiting yesterday morning and todaysignificant underlying rescular issues2: With the eneeds labs more urgently than lable from blood specimen sent ill make arrangements for him to R" ursing Home to Hospital ated 7/27/18 failed to reveal any comprehensive care plan goals of the hospital. ated 8/8/18 at 1:30 PM esident with increasing tremors ated 8/8/18 at 1:30 PM esident with increasing tremors are the following process of the hospital. NP (nurse practitioner) notified of ident sent to (name of hospital) froom). Family notified. Squad	F 6	22		

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

Event ID; WE1L11

Facility ID: VA0145

If continuation sheet Page 30 of 141

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

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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

AND DEAN OF CORRECTION IDENTIFICATION NUMBER			G	COMPLETED		
		495139	B. WING		09/07/2018	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844			
(X4) iD PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
F 622	Transfer Form da evidence of the cobeing provided to On 9/7/18 at 12:12 conducted with LFLPN #3 was askeresidents who are #3 stated that sheresident's face shiphysical, copy of lournary), copy of the change or incidiagnostics and codiagnostics an	ursing Home to Hospital ted 8/8/18 failed to reveal any omprehensive care plan goals the hospital. 2 p.m., an interview was PN (licensed practical nurse) #3. d what documents are sent with transferred to the hospital. LPN would send a copy of the eet, most updated history and POS (physician order of the nursing notes describing ident, applicable labs and opy of the MAR (Medication cord) and TAR (Treatment cord). LPN #3 stated that she fer notice and sends a copy of business office. When asked if py of the resident's care plan or PN #3 stated, "No."	F 622			
	(Administrative SI Director) and ASM they were made a information was p survey. [1] Promethazine prevent and contrada occur after s medications to he Promethazine is a motion sickness.	aff Member - the Executive If #2 (the Director of Nursing) It ware of the findings. No further It would by the end of the If the Promethazine is also used to It is a				

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

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 31 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495139	B. WING		09/	07/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET			3	TREET ADDRESS, CITY, STATE, ZIP C 15 EAST LEE HIGHWAY IEW MARKET, VA 22844	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 622	tml {2} Norco - Hydroco combination is used moderately severe Information obtained https://www.ncbi.nlr	gov/druginfo/meds/a682284.h done and acetaminophen to relieve moderate to pain.	F 622			
	CFR(s): 483.15(c)(3) §483.15(c)(3) Notice Before a facility transition resident, the facility (i) Notify the resident representative(s) of the reasons for the language and mannal facility must send a representative of the Long-Term Care Or (ii) Record the reasons discharge in the respective of the reasons of the reasons of the language and mannal (iii) Include in the respective of the reasons	e before transfer. Isfers or discharges a must- Int and the resident's It the transfer or discharge and move in writing and in a Iter they understand. The Iter they understand. The Iter they understand in a Iter the transfer or Iter the items described in Iter they under the items described in Iter they under the items described in Iter they understand in a Iter they unders	F 623	F 623 1. How will the corrective accomplished for those rechave been affected by the practice? Business office staff sent Transfer/Discharge to the and long term care ombut for Resident #26 transfer 6/10/18 and 7/27/18. Resident hospital 7/5/18. Resident hospital 7/10/18. Resident hospital 7/12/18. Resident hospital 5/23/18, 6/11/18. Resident #94 transfer to and 8/8/18.	esidents found to e deficient notification of e responsible party dsman on 9/25/18 r to hospital sident #40 transfer dent #42 transfer ent #59 transfer to nt #58 transfer to nt #88 transfer to nt #88 transfer to nt #97 transfer to s, and 7/28/18.	

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

Event ID WE1L11

Facility ID VA0145

If continuation sheet Page 32 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. B		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MAME OF PE	ROVIDER OR SUPPLIER	490103		TREET ADDRESS, CITY, STATE, ZIP CODE	09/07/2018	
	E CENTER OF NEW MA	RKET	3	115 EAST LEE HIGHWAY NEW MARKET, VA 22844	M G	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 623	this section; (B) The health of ind be endangered, und this section; (C) The resident's he allow a more immed under paragraph (c)(D) An immediate trarequired by the residunder paragraph (c)(E) A resident has not days. §483.15(c)(5) Contenotice specified in paragraph (c)(D) The reason for training the folion of the contice specified in paragraph (c)(E) A resident has not days. §483.15(c)(5) Contenotice specified in paragraph (c)(E) A resident has not days. §483.15(c)(5) Contenotice specified in paragraph (c)(E) A statement of training the folion of the content of the content of the protection and a developmental disabilities, the mailitelephone number of the protection and a developmental disabilities, the mailitelephone number of the protection and a developmental disabilities.	er paragraph (c)(1)(i)(C) of lividuals in the facility would er paragraph (c)(1)(i)(D) of lividuals in the facility would er paragraph (c)(1)(i)(D) of liate transfer or discharge, (1)(i)(B) of this section; ansfer or discharge is lent's urgent medical needs, (1)(i)(A) of this section; or lot resided in the facility for 30 lents of the notice. The written laragraph (c)(3) of this section lowing: lens ansfer or discharge; le of transfer or discharge	F 623	2. How will the facility identification residents having the potential affected by the same practice? Any resident transferred to he facility has the potential to be this practice. •Director of Nursing, Assistant Nursing, Business office Man Executive Director to audit all discharges since September 1 ensure the resident and/or the representative were notified in transfers or discharges to include the resident and Director of Nursing, Assistant Nursing, Business office, and Director to audit all transfers/since September 1, 2018, to estate Long-Term Care Ombus notified in writing of transfers discharges to include the reas	spital from affected by Int Director of lager, and/or I transfers/ , 2018, to resident's In writing of lude the lige. Int Director of lor Executive discharges Insure the disman were liges Insure the	
<u> </u> 		ntal Disabilities Assistance		transfer or discharge.		

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

Event ID_WE1_11

Facility ID: VA0145

If continuation sheet Page 33 of 141

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED 09/18/2018 FORM APPROVED

CENTER	FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938	J-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	1	
		495139	B, WING		09/07/201	8
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY			
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPL	(5) LETION ATE
F 623	codified at 42 U.S. (vii) For nursing fa disorder or related email address and agency responsible advocacy of individestablished under for Mentally III Individestable on the information is effecting the transmust update the reaspracticable one becomes available §483.15(c)(8) Not In the case of facitive administrator of written notification to the State Survey State Long-Term of the facility, and the well as the plan for	Act of 2000 (Pub. L. 106-402, C. 15001 et seq.); and cility residents with a mental disabilities, the mailing and I telephone number of the le for the protection and duals with a mental disorder the Protection and Advocacy viduals Act. Inges to the notice. In the notice changes prior to fer or discharge, the facility ecipients of the notice as soon the the updated information	F 623	Continue from page 33 3. What measures will be put into por systematic changes made to ensurpractice will not reoccur? •By 10/8/18, Staff Development Coordinator will in-service Licenses Nurses on completing Notice of Re Transfer or Discharge and giving it business office. •By 10/8/18, Staff Development Coordinator will in-service Busines staff to assure Notice of Resident Tor Discharge to be sent to resident the resident's representative and St Long-Term Care Ombudsman. Any Licensed Nurses and Business staff that has not been in-serviced to	are the ad a sident to as office and/or ate	

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483.70(I).

This REQUIREMENT is not met as evidenced

Based on staff interview, facility document review, and clinical record review, it was

determined that facility staff failed to evidence

initiated transfer to the hospital for eight of 42

residents in the survey sample, Resident #26, #40, #42, #59, #58, #88, #97 and #94.

1. The facility staff failed to evidence written

written notification to the RP (responsible party) and the long term care ombudsman for a facility

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 34 of 141

RECEIVED OCT 0 1 2018 VDH/OLC

10/8/18 will not be allowed to provide care

Business office staff will receive education

Transfer or Discharge to be sent to resident

during orientation on Notice of Resident

and/or the resident's representative and

State Long-Term Care Ombudsman.

All newly hired Licensed Nurses and

until in-service completed.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

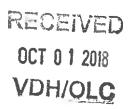
CENTER	S FUR MEDICARE 8	MEDICAID SERVICES			OWR MC). 0938-039 <u>1</u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		495139	B. WING		09/	07/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAR	E CENTER OF NEW MA	ARKET		315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623			F 62	3 Continue from page 34		
		sponsible party and long term r Resident #26's facility		Business office Manager will e	evaluate	
	initiated transfer to the 7/27/18.	he hospital on 6/10/18 and		facility initiated transfers to as	sure Notice	
				of Resident Transfer or Discha	rge was sent	
		ailed to evidence written sponsible party and long term		to resident and/or the resident'	s	
	care ombudsman for	r Resident #40's facility		representative and State Long-	Term Care	
	initiated transfer to the hospital on 8/31/18.			Ombudsman 5 times a week x	30days,	
	 The facility staff fa or the resident's rep 	ailed to provide Resident # 42 resentative and the		3 times a week x30days, 1 time	e a week	
	ombudsman written	notification of the facility he hospital on 07/05/18.		x30days.		
	·			4. How will the facility monitor	oring the	
	notification to the Re	ailed to provide written esident/Responsible		corrective plan to ensure the de	eficient	
		the ombudsman of the facility he hospital on 7/10/18, for		practice was corrected and not	reoccur?	
	Resident #59.			Director of nursing will presen	t findings	_
		ailed to provide written		of audit accurate assessment fi	ndings	:
	notification to the Re Representative and	esident/Responsible the ombudsman of the facility		to the Quality Assurance Perfo	rmance	
	-	he hospital on 7/12/18, for		Improvement committee for re	view and	
				recommendations for 90 days.	The QAPI	
	 The facility staff failed to provide written notification to the Resident/Responsible Representative and the ombudsman of the facility initiated transfer to the hospital on 7/21/18, for Resident #88. 			committee consist of Executiv	e Director,	1
				Director of Nursing, Assistant	Director of	
				Nursing, Social Services, Acti	vities,	
	7. Resident #97 wa	s transferred and admitted to		Dietary Manager, Pharmacy co	onsultant,	
	the hospital on 5/23/18, 6/11/18, and 7/28/18.			Medical Director.	-	
	1	nce in the clinical record Ombudsman and/or the		- '		
	Resident Represent of the facility initiate	tative was notified, in writing, d hospital transfers.				

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

Event ID WE1L11

Facility ID: VA0145

If continuation sheet Page 35 of 141



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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

AND DUAN OF CORDECTION INTERPRED		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495139	B. WING		09	/07/2018	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP 315 EAST LEE HIGHWAY NEW MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SI		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 623	the hospital, on 7 no evidence in the the Ombudsmand Representative we facility initiated hose the facility initiated hose the findings included in the findings included in the care ombudsman initiated transfer to 7/27/18. Resident #26 was 3/14/18 and read diagnoses that in type two diabetes swallowing), repercommunication does not be seen to make the finding in the BIMS (Bridge in the BIMS (Bridge) in t	was transferred and admitted to /27/18, and 8/8/18. There was e clinical record evidencing that d and/or the Resident as notified, in writing, of the espital transfers.	F 62	23			

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 36 of 141



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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495139	B. WING _		09/	07/2018
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		A P
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	Resident #26's de transfer. There we notification was pand the long term the reason for Resident that she was read at 7:12 p.m. with review of Resident that she was sen hospital on 7/27/documented: "Reapproximately 12 her back, the resident be sent (sic). Daughter we notificated the resident be sent (sic). Daughter we see the resident was provided to the resident be sent (sic). Daughter we notificated to the resident was provided to the resident be sent (sic). Daughter we notificated to the resident was provided to the resident was	ted 6/10/18, documented that aughter was made aware of the vas no evidence that written provided to the responsible party in care ombudsman documenting esident #26's transfer to the ent #26's clinical record revealed dmitted to the facility on 6/10/18 no new orders. The following note was esident to be found on floor at the pm, the resident noted to be on ident had c/o (complaints) of g movements of left leg, (sic) MD was notified, (sic) the MD esident and felt it was best if the out for evaluation of the left legs was notified of transfer, ces has been contacted, Will	F 62	3		
	was provided to to long term care or	idence that written notification the responsible party and the mbudsman documenting the ent #26's transfer to the hospital				
	conducted with C the social worker resident is sent of	9 a.m., an interview was DSM (other staff member) #12, regarding her role when a out to the hospital. OSM #12 id not have a role. OSM #12				

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 37 of 141

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

~	PRINTED: 09/18/2018
	FORM APPROVED
	OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		495139	B. WING		09	/07/2018	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET			= -	STREET ADDRESS, CITY, STATE, ZIF 315 EAST LEE HIGHWAY NEW MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 623	stated that she dombudsman for a #12 stated that swritten notification documenting the On 9/7/18 at 9:11 conducted with C Services. OSM # was only notified resident was not OSM #11 stated long term care of On 9/7/18 at 10: conducted with C #9 stated that so notifying the long regarding hospitation of the facility after #9 stated that this was notify their officito the facility after #9 stated that this was notify their officito the facility after #9 stated that this	d not notify the long term care a transfer to the hospital. OSM ocial services did not provide in to the responsible party reason for hospital transfer. a.m., an interview was oSM #11, the Director of Social 11 stated that the ombudsman of a hospital transfer if the expected back to the facility. That the receptionist notified the	F6	523			
	the facility, dated discharge notice Ombudsman offithen send them in planned and initial persons who are go home, do not get all the inform (appointments), equipment) conti	ail from the local Ombudsman to 5/31/18, documented, "The sare to be faxed to the State ce at (phone number). They will o me. If the discharge is a ated by the resident, such as there for therapy and going to need a discharge notice. The do ation regarding doctor appts DME (durable medical act information and when home ed. These are the resident					

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 38 of 141

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

PRINTED:	09/18/2018
FORM	APPROVED
OMB NO.	0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLETED	
		495139	B. WING		09/07/2018	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES.	OULD BE COMPLETION	
F 623	initiated. If the resinospital it is expect choose not to returback. If that is the needed. The charsent and expected also need the bed the facility is using the reasons if they not being discharg. On 9/7/18 at 12:12 conducted with LP When asked about a resident is being LPN #3 stated that resident, send the then notify the RP asked how she wo stated that she not asked if she notifie for hospital transfe wasn't entirely sure office provided that term care ombuds nurses did not provide a resident in part, the DON (Director of the above concerns that syste provide written not resident represent	ident is "transferred" to the sed they will return unless they nor the facility will not accept case a discharge notice is also need a note as to why return "when ready." They hold information. The notice is fine, but do not mark one of are sent to the hospital and ed." p.m., an interview was N (licensed practical nurse) #3. If the process staff follows when transferred to the hospital, she would first assess the appropriate documents, and (responsible party). When uld notify the RP, LPN #3 iffies the RP verbally. When is the RP in writing the reason or, LPN #3 stated that she is but thought that the business it notification to the RP and long man. LPN #3 stated that the vide written notification to the are ombudsman. D.m., ASM (administrative staff executive Director, and ASM #2, of Nursing) were made aware	F 623			

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 39 of 141

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

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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		TE SURVEY MPLETED
		495139	B. WING		09	/07/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET				TREET ADDRESS, CITY, STATE, ZIP COI 115 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 623	of Discharge/Trar be presented in a resident/resident/ understandA cotransfer/discharge of the Office of the Office of the Office of the Ombudsman for discharges." No further inform 2. The facility star notification to the care ombudsmar initiated transfer the care ombudsmar initiated transfer the transfer that in atrial fibrillation, resident #40 was 12/28/16 and readiagnoses that in atrial fibrillation, resident with date) of 7/8/18. It being moderately scoring 08 out of Interview for Merica Review of Reside that he had been 8/31/18. The following moderated: "8/31/18 at 4:33 is headache 9/10 a resident's (sic) in output WNL (with the control of the course of	page 39 Insfer form. This information will alanguage manner that the representative can opy of the notice of e will be sent to a representative e State Long Term Care all facility-initiated transfers or ation was presented prior to exit. If failed to evidence written responsible party and long term for Resident #40's facility to the hospital on 8/31/18. Is admitted to the facility on dmitted on 5/30/17 with cluded but were not limited to nuscle weakness, and acute esident #40's most recent MDS et) assessment was a quarterly an ARD (assessment reference Resident #40 was coded as impaired in cognitive function possible 15 on the BIMS (Brief etal Status) exam. In the Hall status of the hospital on owing nursing notes were AM: resident (sic) c/o (complaint) fiter given Percocet (1). creased 220/105 manually, urine hin normal limits)m heart rate ea noted, pupils reactive. MD	F 623			

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 40 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495139	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	co	TE SURVEY MPLETED
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET		STF	STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	W MARKET, VA 22844 PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHORE) CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	(medical doctor) received for clonic recheck (sic) BO increased to 230/made aware. new clonidine 0.1 mg or resident (sic) start continue to monitor clonidine 0.1 mg or the adache or BP: aware and rounded to send to ER (em (evaluation) and the adache and hyppressure)." There was no evid was provided to the long term care on reason for Resident #40 return with a diagnosis of (kidney infection). On 9/7/18 at 8:39 conducted with Orthe social worker resident is sent or stated that she diagnosis and the stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second worker resident is sent or stated that she diagnosis and the second work	nade aware, new orders dine (2) 0.1 mg (milligrams) x1. after one and half hours. BP still 110, c/o headache 8/10. MD (sic) orders received for one time. will (sic) check BP. ted on ceftin (3) 8/30/18will or" "after (sic) second dose of here was no change in 230/110. (Name of MD) made ed on resident, with new orders hergency room) for eval. reatment of acute refractory pertension (high blood dence that written notification he responsible party and the hbudsman documenting the nt #40's transfer to the hospital the clinical record revealed that rned to the facility on 9/1/18 if acute pylenonephritis (4)	F 623			

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

Event D:WE1L11

Facility ID: VA0145

If continuation sheet Page 41 of 141

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

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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495139	B. WING		09	/07/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET				STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 623	conducted with Of Services. OSM #11 was only notified or resident was not expensed on the conducted with Office on the conducted with Office office on the facility after #9 stated that this providing written or transfers. A copy of an emait of the facility, dated discharge notices of the send them to planned and initial persons who are go home, do not requipment) contains of the conducted with or transfers.	SM #11, the Director of Social 1 stated that the ombudsman of a hospital transfer if the expected back to the facility. That the receptionist notified the abudsman. 2 a.m., an interview was SM #9, the receptionist. OSM metime in June she had stopped term care ombudsman. I transfers. OSM #9 provided a rom the long term care d 5/31/18, telling the facility only e if the resident does not return a transfer to the hospital. OSM was also when she stopped notification to the RP for hospital of the face at (phone number). They will o me. If the discharge is a ted by the resident, such as there for therapy and going to need a discharge notice. The dottion regarding doctor appts of the formation and when home	F 62	· · · · · · · · · · · · · · · · · · ·		
	initiated. If the re hospital it is expe choose not to retu back. If that is the needed. The cha sent and expecte	ed. These are the resident sident is "transferred" to the cted they will return unless they urn or the facility will not accept e case a discharge notice is int also need a note as to why d return "when ready." They d hold information. The notice				

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 42 of 141

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

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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION UMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495139	B. WING			09	9/07/2018	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET				315 EAS	ADDRESS, CITY, STATE ST LEE HIGHWAY IARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 623		g is fine, but do not mark one of y are sent to the hospital and	F6	23		II.		
	conducted with LI When asked abo a resident is bein LPN #3 stated tha	2 p.m., an interview was PN (licensed practical nurse) #3. ut the process staff follows when g transferred to the hospital, at she would first assess the appropriate documents, and						
	then notify the RF asked how she w stated that she no asked if she notifi for hospital transf wasn't entirely su office provided th term care ombud	ould notify the RP, LPN #3 ould notify the RP, LPN #3 otifies the RP verbally. When les the RP in writing the reason er, LPN #3 stated that she re but thought that the business at notification to the RP and long sman. LPN #3 stated that the ovide written notification to the						
	member) #1, the	p.m., ASM (administrative staff Executive Director, and ASM #2, r of Nursing) were made aware terns.						
	relief of moderate This information of Institutes of Healt https://dailymed.rm?setid=0a44694 5a. (2) Clonidine is us This information of Institutes of Healt	alm.nih.gov/dailymed/druglnfo.cf 47-2cda-4a32-aa6a-53e0924582 sed to treat high blood pressure. was obtained from The National						
	T0009680/?repor						Ī	

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

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 43 of 141



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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 '	TIPLE CONSTRUCTION NG		E SURVEY MPLETED	
		495139	B. WING		09/	07/2018	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 623	treat infections. The from The National https://www.ncbi.nt T0009522/?report (4) Pylenonephritis urinary tract infection the bladder and both of the kidneys obtained from Nath https://www.niddk.ogic-diseases/kidr 3. The facility staff or the resident's reombudsman writte initiated transfer to 07/05/18. Resident # 42 was 04/03/13 and a readiagnoses that incheart failure, gastratrial fibrillation, (2) Resident # 42's m set), a quarterly as (assessment refer Resident # 42 as sinterview for mental fibrillation. The nurse's "Programment of the programment of the	his information was obtained Institutes of Health. Im.nih.gov/pubmedhealth/PMH edetails. So Kidney infection is a type of ion (UTI) that commonly begins moves upstream to one or so. This information was ional Institutes of Health. Inih.gov/health-information/urol ney-infection-pyelonephritis. If ailed to provide Resident # 42 appresentative and the en notification of the facility	F 62	23			

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 44 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495139	B. WING		09	/07/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET				STREET ADDRESS, CITY, STATE, ZIP CODE 815 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	90% on 2L (two lit notified at 1700 (5 daughter-in-law, (I notified by NP (nu Nurse Practitioner on 7/1/18 without [sic] squad here a to (Name of Hosp On 9/7/18 at 10:12 conducted with Os #9 stated that som notifying the long tregarding hospital copy of a letter fro ombudsman dated to notify their officito the facility after #9 stated that this	ers). Resque [sic] Squad :00 p.m.). Resident's Name of Daughter-in-law) rse practitioner), (Name of). Resident did fall out of bed any apparent injuries. Resque t 1715 (5:15 p.m.), to transport	F 623			
	the facility, dated discharge notices Ombudsman office then send them to planned and initial persons who are to go home, do not reget all the informal (appointments), Dequipment) containealth is schedule initiated. If the result hospital it is expection of the result	I from the local Ombudsman to 5/31/18, documented, "The are to be faxed to the State e at (phone number). They will me. If the discharge is a ted by the resident, such as here for therapy and going to seed a discharge notice. The dotton regarding doctor appts ME (durable medical et information and when home d. These are the resident sident is "transferred" to the sted they will return unless they are the facility will not accept a case a discharge notice is the also need a note as to why				

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

Event ID: WE1L11

Facility ID: VA0145

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495139	B. WING		09/0	07/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 623	Continued From p	page 45	F 623			
	also need the bed the facility is using	d return "when ready." They I hold information. The notice g is fine, but do not mark one of y are sent to the hospital and ged."				
	conducted with LI When asked about a resident is being LPN #3 stated that resident, send the then notify the RF asked how she with stated that she not asked if she notified for hospital transfewasn't entirely surpostice provided that term care ombuding.	2 p.m., an interview was PN (licensed practical nurse) #3. ut the process staff follows when g transferred to the hospital, at she would first assess the e appropriate documents, and P (responsible party). When ould notify the RP, LPN #3 offices the RP verbally. When less the RP in writing the reason er, LPN #3 stated that she re but thought that the business at notification to the RP and long sman. LPN #3 stated that the byide written notification to the eare ombudsman.		20		
	(administrative st	oproximately 3:26 p.m. ASM aff member) #1, the executive the director of nursing, were se findings.				
	No further inform	ation was provided prior to exit.				
	the esophagus ar was obtained fror https://www.nlm.r	ents to leak back, or reflux, into nd irritate it. This information in the website: nih.gov/medlineplus/gerd.html.				
		nformation was obtained from				

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 46 of 141

PRINTED: 09/18/2018 DEPARTMENT OF HEALTH AND MAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495139 B. WING 09/07/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY LIFE CARE CENTER OF NEW MARKET **NEW MARKET, VA 22844** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY)** F 623 Continued From page 46 F 623 https://www.nlm.nih.gov/medlineplus/atrialfibrillati on.html. (3) The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website: https://medlineplus.gov/osteoarthritis.html. 4. The facility staff failed to provide written notification to the Resident/Responsible Representative and the ombudsman of the facility initiated transfer to the hospital on 7/10/18, for Resident #59. Resident #59 was admitted to the facility on 3/25/15, with a most recent readmission of 7/12/18, with diagnoses that included but were not limited to: heart failure, stroke, Bell's palsy (weakness and paralysis of one side of the face) (1), high blood pressure, diabetes, and arthritis. The most recent MDS (minimum data set)

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making.

assessment, an annual assessment, with an assessment reference date of 7/20/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident is cognitively intact for daily decision

The physician's note dated 7/10/18 [no time documented] stated, "Patient seen today for follow up on weight increase [and] SOB

The nurse practitioner's telephone order dated 7/10/18 [no time documented] stated, "Send Resident to [hospital's name] for eval (evaluation)

(shortness of breath) increase."

Event ID: WE1L11

Facility ID: VA0145

RE (Population sheet Page 47 of 141

OCT 0 1 2018 VDH/OLC

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

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PRINTED: 09/18/2018 FORM APPROVED OMB NO: 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	124	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495139	B. WING		09	/07/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 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 PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(XS) COMPLETION DATE
F 623	A review of the clin that written notifical Resident/Respons ombudsman for Rehospital on 7/10/18 An interview was ca.m. with OSM (other of social standard of the nursing staff pregarding resident OSM #9, the recepting formation to the An interview was ca.m. with OSM #10 Stated the information to the June" but that the only to send disched At that time, OSM stopped providing a facility to the resident of the ombudsman "Up used to provide the only to send disched the only to the resident of the ombudsman "Up used the only to send the then notify the RP only the send the then notify the RP only to send the then notify the RP only the send the then notify the RP only to send the then notify the RP only	B (shortness of breath)." ical record failed to evidence atton was provided to the lible Representative and the esident #59's transfer to the B. conducted on 9/7/18 at 8:47 the staff member) #11, the ervices. OSM #11 stated that rovides the information transfers to the hospital to obtionist. OSM #9 then faxes the orbidoman. conducted on 9/7/18 at 9:39 conducted that they also written notification of transfer to ident and responsible me stated OSM #9 was ing the information to the intil about the first of June". P.m., an interview was N (licensed practical nurse) #3. It the process staff follows when transferred to the hospital, it she would first assess the appropriate documents, and (responsible party). When		23		
	stated that she no	ould notify the RP, LPN #3 tifies the RP verbally. When es the RP in writing the reason				

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 48 of 141

DEPARTMENT OF HEALTH AND 1AN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

PRINTED: 09/18/2018

 FORM APPROVEI MB NO. 0938-039
(X3) DATE SURVEY COMPLETED

STATE	MENT OF	DEFICIENCIES	
AND P	AN OF C	ORRECTION	

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING

495139

B. WING

09/07/2018

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 623	Continued From page 48 for hospital transfer, LPN #3 stated that she wasn't entirely sure but thought that the business office provided that notification to the RP and long term care ombudsman. LPN #3 stated that the nurses did not provide written notification to the RP or long term care ombudsman.	F 623				
	An interview was conducted on 9/7/18 at 10:12 a.m. with OSM #9, the receptionist. OSM #9 confirmed she was faxing information regarding transfers to a facility to the ombudsman until the beginning of June but that the ombudsman requested that she only be sent discharges and not transfers. OSM #9 stated she was not responsible for sending any notification to the resident or responsible party.					
	On 9/7/18 at 3:26 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were made aware of the above findings.		П			
	No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/bellspalsy.html					
	5. The facility staff failed to provide written notification to the Resident/Responsible Representative and the ombudsman of the facility initiated transfer to the hospital on 7/12/18, for Resident #58.					
	Resident #58 was admitted to the facility on 3/14/18, with a most recent readmission of 7/12/18, with diagnoses that included but were not limited to: atrial fibrillation (an abnormality of					

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 49 of 141

DEPARTMENT OF HEALTH AND HUMAN CRVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 09/18/2018
FORM APPROVED
OMB NO. 0938-0391

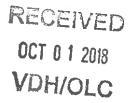
CENTE	13 I ON WILDIOA	IL & MILDIOAID GLI MIGLO			<u> </u>	7 7 7 7 7 7	. 0000 000 1
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY MPLETED
		495139	B. WING	i		09	/07/2018
	PROVIDER OR SUPPLIE			315	REET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY W MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 623	the speed and rhy blood pressure, dhistory of a hip fraction of a	ythm of a heart beat) (1), high liabetes, muscle weakness and acture in March 2018. MDS (minimum data set) gnificant change assessment, ent reference date of 8/20/18, at as scoring an "8" on the BIMS or mental status) score, indicating oderately impaired for daily dated 7/12/18 at 4 p.m. stated, ains of feeling like he is dying, red, sat 89 [%] on room air, ilaterally, oxygen applied to [sic] nute. NP (nurse practitioner) amended [sic] be sent to be theart rate regular, son called and tion, pt (patient) to be sent to via squad." Inical record failed to evidence eation was provided to the easible Representative and the ne Resident's transfer to the services. OSM #11 stated that provides the information at transfers to the hospital to eptionist. OSM #9 then faxes the		623			
	a.m. with OSM #	conducted on 9/7/18 at 9:39 10, the business office manager. the facility was faxing					

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 50 of 141



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

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PRINTED: 09/18/2018 FORM APPROVED OMB NO: 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		ATE SURVEY DMPLETED
		495139	B. WING		O:	9/07/2018
	OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		Y			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 623	information to the June" but that the only to send disch At that time, OSM stopped providing a facility to the responsible for facility that the notice with LI When asked about a resident is being LPN #3 stated that resident, send the then notify the RF asked how she with the stated that she not asked if she notified for hospital transfer wasn't entirely su office provided that the care ombud nurses did not proposed for long term of the director of null above findings. No further information in the state of the the director of null above findings.	ombudsman until about "early ombudsman asked the facility harges from the facility to her. If 10 stated that they also written notification of transfer to sident and responsible he stated OSM #9 was axing the information to the until about the first of June". 2 p.m., an interview was PN (licensed practical nurse) #3. In the process staff follows when go transferred to the hospital, at she would first assess the exappropriate documents, and Process the Process that the pould notify the RP, LPN #3 offices the RP verbally. When less the RP in writing the reason er, LPN #3 stated that she re but thought that the business at notification to the RP and long sman. LPN #3 stated that the exact ombudsman. In p.m., ASM (administrative staff executive director, and ASM #2, rasing, were made aware of the lation was provided prior to exit.		23		

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 51 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION		E SURVEY IPLETED
		495139	B. WING		09/	07/2018
	PROVIDER OR SUPPLIER RE CENTER OF NEV		STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844			
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 623	Continued From p	age 51	F 62	3		
	notification to the I Representative an	f failed to provide written Resident/Responsible d the ombudsman of the facility the hospital on 7/21/18, for				
45	5/7/16, with a mos 7/27/18, with diagr not limited to: stroke, muscle we	admitted to the facility on t recent readmission of noses that included but were ke, paralysis secondary to akness, difficulty speaking, g, hypertension, and dementia.				
	assessment, a qui assessment refere resident as rarely-	MDS (minimum data set) arterly assessment, with an ence date of 8/12/18, coded the never being able to make d as well as rarely - never ers.			12	
	7/21/18 [no time d	oner's telephone order dated ocumented] stated, "Send mergency department) for eval nent."				
	documented in pa diminished respira be in distress. Lur rhales [sic] (rales rattling sounds in inflammation of th (nurse practitioned obtained for reside	dated 7/21/18 at 12:31 p.m. rt, "Resident noted to have stions, clammy and appears to ng sounds diminished with are small clicking, bubbling, or the lungs which could indicate e lungs) (1) bilaterallyNP r) notified and new order ent to be sent to ED rtment) for evaluation and				
		nical record failed to evidence ation was provided to the				

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 52 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED		
		495139	B. WING		05	09/07/2018		
	OF PROVIDER OR SUPPLIER CARE CENTER OF NEW MARKET STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844							
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL I LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 623	Continued From (page 52	F 623					
		sible Representative and the e e Resident's transfer to the						
	a.m. with OSM (o director of social the nursing staff p regarding residen	conducted on 9/7/18 at 8:47 ther staff member) #11, the services. OSM #11 stated that provides the information at transfers to the hospital to eptionist. OSM #9 then faxes the ombudsman.						
	a.m. with OSM #1 OSM #10 stated to information to the June" but that the only to send disch At that time, OSM stopped providing a facility to the re- representative. So	conducted on 9/7/18 at 9:39 10, the business office manager. the facility was faxing combudsman until about "early combudsman asked the facility narges from the facility to her. If # 10 stated that they also written notification of transfer to sident and responsible the stated OSM #9 was xing the information to the until about the first of June".		\$7 \$7				
	conducted with LI When asked abo a resident is bein LPN #3 stated that resident, send the then notify the RF asked how she we stated that she notif for hospital transf wasn't entirely su office provided the	2 p.m., an interview was PN (licensed practical nurse) #3. ut the process staff follows when g transferred to the hospital, at she would first assess the e appropriate documents, and P (responsible party). When could notify the RP, LPN #3 offices the RP verbally. When lies the RP in writing the reason fer, LPN #3 stated that she re but thought that the business at notification to the RP and long sman. LPN #3 stated that the						

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 53 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		495139	B. WING		09	/07/2018
	PROVIDER OR SUPPLIE	STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844			701,2310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 623	nurses did not pre RP or long term of On 9/7/18 at 3:26 member) #1, the the director of nu above findings. No further inform 1) This informational Institute https://medlineplu 7. Resident #97 the hospital on 5/7 there was no evidencing that the Resident Repres of the facility initial Resident #97 wa 4/30/18 with the pulmonary emborongestive heart aftercare. The question of 8/7/18 coded to intact in ability to A nurse's note data (medical doctor) patients. Reside (shortness of bred diminished right and O2 (oxygen) (two liters) O2 via increased to 31. breath and comp	ovide written notification to the care ombudsman. 5 p.m., ASM (administrative staff executive director, and ASM #2, rsing, were made aware of the ation was provided prior to exit.	F 623			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 54 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		TE SURVEY MPLETED
		495139	B. WING	·	09	/07/2018
	CARE CENTER OF NEW MARKET STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844			511		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 623	of decision to ser called and reside further evaluation. There was no evithe Resident Rep. Resident #97's 5/writing. A review of the cl. note dated 6/11/1 drowsy, denied a don't feel right." I beginning of the s. 98.7-105-16-126/(temperature-puls. pressure-oxygen statement that sh. VS was obtained (temperature)-76 pressure)-26 (res. saturation on 5 lit. notified and asse based on her hist with pleural effus patient to the ED evaluation. Son the There was no evit Resident #97's 6/writing. A review of the notified by CNA (Resident was cla. Resident c/o (cor. series was cla.)	ind patient to hospital. Squad not sent to (name of hospital) for in." idence in the clinical record that presentative was notified of /23/18, hospital transfer in inical record revealed a nurse's 8 that documented, "Patient felt ny pain, and she stated, "I just Her VS (vital signs) at the shift was /74-96% se-respirations-blood saturation). After making the led id not feel well a new set of at 5:30pm and were 98.2 /50 (manually) (blood spirations)-98% 5L (oxygen ters). MD (medical doctor) ssed patient. He feels that tory that she may be presenting ions. Order obtained to send (Emergency Department) for	F 623			

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 55 of 141

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

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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING			E SURVEY MPLETED
		495139	B. WING			09/	07/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT 315 EAST LEE HIGHV NEW MARKET, VA	WAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOUL ENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 623	hypotension (low be notified with new of Son (name of son) contacted. 911 act. There was no evid Resident Represer Resident #97's 7/2 writing. On 9/7/18 at 8:39 at #12 (Other Staff M stated that she has residents being transtated that she does not does she proving the nursing staff prograding resident OSM #9, the receptinformation to the contact of the contact o	clood pressure) this am. MD reders to send for evaluation. notified but yet to be tivated." ence that the Ombudsman and netative were notified of 8/18, hospital transfer in a.m., in an interview with OSM ember) the social worker, she is no role in the process of insferred to the hospital. She is not notify the Ombudsman de a written letter to the family. conducted on 9/7/18 at 8:47 her staff member) #11, the ervices. OSM #11 stated that rovides the information transfers to the hospital to optionist. OSM #9 then faxes the ombudsman.	F6	23			
	OSM #10 stated the information to the of June" but that the conly to send dischart that time, OSM stopped providing a facility to the resistence of the combudsman "Up ut the combudsman".	o), the business office manager. The facility was faxing combudsman until about "early combudsman asked the facility carges from the facility to her. The facility was to her	Transport diposition of the property of the pr				

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 56 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO: 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION		E SURVEY APLETED
	Value V	495139	B. WING		09/	07/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET		100	STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD 8E	(X5) COMPLETION DATE
F 623	conducted with Lf When asked abord a resident is being LPN #3 stated that resident, send the then notify the RF asked how she we stated that she not asked if she notifit for hospital transf wasn't entirely surroffice provided that term care ombudanties did not proceed the term care of the term	PN (licensed practical nurse) #3. at the process staff follows when g transferred to the hospital, at she would first assess the appropriate documents, and responsible party). When ould notify the RP, LPN #3 offices the RP verbally. When es the RP in writing the reason er, LPN #3 stated that she re but thought that the business at notification to the RP and long sman. LPN #3 stated that the ovide written notification to the	F 623			
	the hospital, on 7/no evidence in the the Ombudsman Representative w facility initiated hose 6/28/18 with the corthopedic aftereshigh blood pressure admission/5-with an ARD (Ass 7/5/18 coded the	was transferred and admitted to /27/18, and 8/8/18. There was a clinical record evidencing that and/or the Resident as notified, in writing, of the espital transfers. Is admitted to the facility on liagnoses of but not limited to are, ischemic heart disease, are, and chronic kidney disease. day MDS (Minimum Data Set) ressment Reference Date) of resident as being cognitively make daily life decisions.				

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

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 57 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION NG		TE SURVEY MPLETED	
		495139	B. WING		09	/07/2018	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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 623	A review of the clifollowing nurses of shift this AM. It very lethargic and awake. MD (med resident was assepromethazine {1} lethargy was noted changesLungs O2 (oxygen) sats 2I (two liters of ox cannulaAddend extreme lethargy for supplemental orders given to see Brother was notified admitted to (hospotal transfer owiting. A nurse's note day documented, "Resident Representations 32. of changes. Resident Representations 32. There was no evidentations and evidentations and evidentations and evidentations are supplied to the clift of the control of the clift of the c	inical record revealed the notes: 7/27/18 at 9:54 AM: alert and oriented at beginning later morning resident became I was having a hard time staying lical doctor) was notified and essed. Had started and Norco {2} this AM. and ed to be related to medication with slight crackles bilaterally. were 86% on room air. 95% on tygen) via nasal dum: Resident continues with at this time with continued need O2. Reassessed by MD and ent to ER for further evaluation. ed. Addendum: Resident was ital) for acute kidney injury." Idence that the Ombudsman and entative were notified of this on 7/27/18 for Resident #94 in ted 8/8/18 at 1:30 PM sident with increasing tremors. Temp (temperature) this AM ow 102.1. Heart rate of 151. NP (nurse practitioner) notified dent sent to (name of hospital) from). Family notified. Squad	F 6	23			

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

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 58 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
	495139	B. WING		09	9/07/2018
		3	15 EAST LEE HIGHWAY		, , , , , , , , , , , , , , , , , , ,
CH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
ther Staff I that she had she provided was ith OSM (or of social resident she atton to the extreme was ith OSM #10 stated that the send dischard to the resident was ith OSM #110 stated the send dischard providing by to the resentative. Similarly to the resentative. Since the send that the send the send that the stated with Liasked about the send the se	a.m., in an interview with OSM Member) the social worker, she as no role in the process of ansferred to the hospital. She bes not notify the Ombudsman wide a written letter to the family. conducted on 9/7/18 at 8:47 ther staff member) #11, the services. OSM #11 stated that provides the information to transfers to the hospital to optionist. OSM #9 then faxes the ombudsman. conducted on 9/7/18 at 9:39 0, the business office manager. The facility was faxing ombudsman until about "early ombudsman asked the facility marges from the facility to her. If 10 stated that they also written notification of transfer to sident and responsible the stated OSM #9 was axing the information to the until about the first of June". 2 p.m., an interview was PN (licensed practical nurse) #3. If the process staff follows when go transferred to the hospital, at she would first assess the eappropriate documents, and of (responsible party). When ould notify the RP, LPN #3 otifies the RP verbally. When	F 623			
	SUMMARY SACH DEFICIENT GULATORY OF Used From provider Staff Methat she hands being treated that she does she provider was gift OSM (our of social straing staff pring resident to the erview was gift OSM #1 #10 stated that the send discrime, OSM #1 #10 stated that the send discrime, OSM gift providing the treated with LF asked about the country of the providing that the send discrime, OSM gift providing the treated with LF asked about the country of the providing that the country of the providing that th	TER OF NEW MARKET SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) BY THE STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) BY THE STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) BY THE STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) BY THE STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) BY THE STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) BY THE STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) BY THE OF NEW MARKET SUMMARY STATEMENT OF DEFICIENCIES STATEMENT OF NEW MARKET SUMMARY STATEMENT OF DEFICIENCIES STATEMENT OF DEFICIENCIES ACH DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES STATEMENT OF DEFICIENCIES SUMMARY STATEMENT	TER OF NEW MARKET SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) THE STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) THE STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) THE STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) THE STATEMENT OF DEFICIENCIES ACH DEFICIENCIES ACH DEFICIENCY MARKET SUMMARY STATEMENT OF DEFICIENCIES ACH DEFIC	A BUILDING A95139 ROR SUPPLIER TER OF NEW MARKET SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY MUST BE PRECEDED BY FULL GLANG WAS ARREST FOR A CHORECTIVE ACT CHOSS-REFERENCED TO DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) THE PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CHOSS-REFERENCED TO DEFICIENCY BY TAGE OF THE ACT CHOSS-REFER	A BUILDING 495139 B. WING STREET ADDRESS, CITY, STATE ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844 SUMMARY STATEMENT OF DEFICIENCIES AND HER PROPOSED BY PILL 3ULATORY OR LSC IDENTIFYING INFORMATION) WING THE STATEMENT OF DEFICIENCIES AND HER PROPOSES AFFERENCED TO THE APPROPRIATE BULATORY OR LSC IDENTIFYING INFORMATION) WING THE STATEMENT OF DEFICIENCIES AND HER PROPOSES AFFERENCED TO THE APPROPRIATE BULATORY OR LSC IDENTIFYING INFORMATION) F 623 WING THE PROPOSES AFFERENCED TO THE APPROPRIATE DEFICIENCY) F 623 F

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 59 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

OFIVIEN	STOR MEDIOTALE	WINEDION NO CENTROLE					
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE S COMPL	
		495139	B. WNG			09/0	7/2018
	NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET			318	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY 5 W MARKET, VA 22844		T .
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	office provided that term care ombuds nurses did not provided RP or long term care. On 9/7/18 at 3:26 (Administrative Str. Director) and ASM they were made at	e but thought that the business t notification to the RP and long man. LPN #3 stated that the vide written notification to the	F	623			
	prevent and control may occur after su medications to hel Promethazine is a motion sickness. I symptoms, but wil symptoms or spec Information obtain	-					
	combination is us moderately severe Information obtain https://www.ncbi.r T0010590/ Preparation for Sa	ned from hlm.nih.gov/pubmedhealth/PMH afe/Orderly Transfer/Dschrg	F	624	F624		10/15/18
SS=D		entation for transfer or			How will the corrective action be accomplished for those residents found to have been affected by the		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

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

Event ID WE1L11

Facility ID: VA0145

If continuation sheet Page 60 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

LIFE CARE CENTER OF NEW MARKET SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 624 Continued From page 60 A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident was oriented to provide evidence that they oriented Resident #40, #97, #94. 1. The facility staff failed to provide evidence that they oriented Resident #40, #97, #94. 1. The facility staff failed to provide evidence that they oriented Resident #40, #97, #94. 2. Resident #97 was transferred and admitted to the hospital on 5/23/18, 6/11/18, and 7/28/18. There was no evidence in the clinical record that the resident was prepared and oriented for the hospital transfer. 3. Resident #94 was transferred and admitted to the hospital transfer. 3. Resident #94 was transferred and admitted to the hospital transfer. 3. Resident #94 was transferred and admitted to the hospital transfer. 3. Resident #94 was transferred and admitted to the practice will not reoccur?		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	A. BUILDING _	CONSTRUCTION	(X3) DATE S COMPL	
CAJ DIAM NEW MARKET, VA 28844 CASH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG	de la	SOWINGOIT TO	495139	B. WING		ON OBE PRIATE O4 had eir facility other oe tal from ffected by /Unit sember 10, riented transfer o place as the cord. been intleded to live of the cord.	7/2018
F 624 Continued From page 60 A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to provide evidence that they oriented Resident #40, #97, #94. 1. The facility staff failed to provide evidence that they oriented Resident #40 to a facility initiated transfer on 8/31/18. 2. Resident #97 was transferred and admitted to the hospital or 5/23/18, 6/11/18, and 7/28/18. There was no evidence in the clinical record that the resident was prepared and oriented for the hospital transfer. 3. Resident #94 was transferred and admitted to practice will not recoccur?			MARKET	3	15 EAST LEE HIGHWAY		
A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to provide evidence that they oriented resident #40, #97, #94. 1. The facility staff failed to provide evidence that they oriented Resident #40 to a facility initiated transfer for three of 42 residents, Resident #40 to a facility initiated transfer to the hospital since September 10, 2018 to assure the resident was oriented and prepared for facility initiated transfer to the hospital. 2. Resident #97 was transferred and admitted to the hospital transfer. 3. Resident #94 was transferred and admitted to or systematic changes made to ensure the practice will not reoccur?	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
evidence in the clinical record that the resident was prepared and oriented for the hospital transfer. By 10/8/18, Staff Development Coordinator will in-service Licensed Nurses on resident being oriented and prepared for facility initiated transfer to	F 624	A facility must provo preparation and or safe and orderly to facility. This orients form and manner to understand. This REQUIREME by: Based on resident facility document rousely, it was deterned to provide evidence a facility initiated to residents, Resident. The facility staff they oriented Resistransfer on 8/31/18. Resident #97 with the hospital on 5/2. There was no evidence in the climate of the resident was phospital transfer. Resident #94 with the hospital on 7/2 evidence in the climate repared and	vide and document sufficient rientation to residents to ensure ansfer or discharge from the ation must be provided in a shat the resident can shat they oriented residents to ransfer for three of 42 at #40, #97, #94. If alled to provide evidence that dent #40 to a facility initiated as. If alled to provide evidence that dent #40 to a facility initiated as. If alled to provide evidence that dent #40 to a facility initiated to 23/18, 6/11/18, and 7/28/18. Incree in the clinical record that brepared and oriented for the constant of the shall sh	F 624	deficient practice? On 9/20/18 patient #40, 97, and 9 safely returned to facility after the initiated transfer to the hospital. 2. How will the facility identify o residents having the potential to be affected by the same practice? All residents transferred to hospit facility have the potential to be affected. Director of Nursing/Manager will review all residents transferred to hospital since Septe 2018 to assure the resident was on and prepared for facility initiated to the hospital. 3. What measures will be put into or systematic changes made to en practice will not reoccur? By 10/8/18, Staff Development Coordinator will in-service Licen Nurses on resident being oriented.	ther e al from fected by Unit ember 10, riented transfer place sure the	
The findings include: 1. The facility staff failed to provide evidence that they oriented Resident #40 to a facility initiated transfer on 8/31/18. Resident #40 was admitted to the facility on the facility of the facility on the facility of the facility on the facility on the facility on the facility of the facilit		The facility staff they oriented Resi transfer on 8/31/1.	f failed to provide evidence that ident #40 to a facility initiated 8.		documentation in the medical rec Any Licensed Nurse that has not serviced by 10/8/18 will not be al	ord. been in- lowed to	

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

Event ID, WE1L11

Facility ID: VA0145

If continuation sheet Page 61 of 141

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495139	B. WING		09/07/2018
	ROVIDER OR SUPPLIER	ARKET		STREET ADDRESS, CITY, STATE, ZIP CODE 115 EAST LEE HIGHWAY NEW MARKET, VA 22844	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 624	12/28/16 and readidiagnoses that inclatrial fibrillation, modidney failure. Res (minimum data set assessment with a date) of 7/8/18. Rebeing moderately is scoring 08 out of platerview for Menta Review of Resider that he had been to 8/31/18. The follow documented: "8/31 c/o (complaint) her Percocet (1). resid manually, urine out limits)m heart rate pupils reactive. MI new orders received (milligrams) x 1. rehalf hours. BP still headache 8/10. Morders received for (sic) check BP. residon (Sic) check BP. residon (Name of MD) maresident, with new (emergency room treatment of acute	mitted on 5/30/17 with uded but were not limited to uscle weakness, and acute ident #40's most recent MDS assessment was a quarterly in ARD (assessment reference esident #40 was coded as impaired in cognitive function ossible 15 on the BIMS (Brief al Status) exam. It #40's clinical record revealed ransferred to the hospital on ving nursing notes were 1/18 at 4:33 a.m.: resident (sic) adache 9/10 after given ent's (sic) increased 220/105 thut WNL (within normal regular, no nausea noted, D (medical doctor) made aware, ed for clonidine (2) 0.1 mg echeck (sic) BO after one and increased to 230/110, c/o D made aware, new (sic) in clonidine 0.1 mg one time, will sident (sic) started on ceftin (3)	F 624	Continued from page 61 completed. All newly hired Licent Nurses will receive education dur orientation on resident being orientation on resident being orientation on resident being orientation on resident being orientation in the medical recomplete of Nursing/Unit Manage evaluate resident was oriented and for facility initiated transfer to the and that sufficient documentation in the medical record 5 times a wix30days, 3 times a week x30days. 1 time a week x30days. 4. How will the facility monitoring corrective plan to ensure the defining practice was corrected and not resure the Quality Assurance Performs Improvement committee for revious recommendations for 90 days. The committee consist of Executive Indirector of Nursing, Assistant Director of Nursing, Assistant Director of Nursing, Social Services, Activity	ing nted and sfer to the ord. r will d prepared e hospital is present eek and ig the cient occur? indings ings nance ew and ne QAPI Director, irector of
		cumented evidence that coriented to the facility initiated 8.		Dietary Manager, Pharmacy con Medical Director.	· 1

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

Event ID: WE1L11

Facility IO: VA0145

If continuation sheet Page 62 of 141



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

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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION		E SURVEY IPLETED
		495139	B. WING		09/	07/2018
	PROVIDER OR SUPPLIE		315	EET ADDRESS, CITY, STATE, ZIP O EAST LEE HIGHWAY W MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 624	interview was con could not recall where the state of the was mutansfer why he was asked the proper that she would first appropriate docur (responsible party their transfer, was able to understan usually explains to transferred to the documented anywhole was not for 9/7/18 at 3:26 member) #1, the the DON (Directo of the above conditions of the above conditions of the was point of the formation was proposed to the state of the state of the state of the above conditions and the state of the above conditions and the state of the	oximately 1:50 p.m., an ducted with Resident #40. He hy he was recently hospitalized. ed that he thinks he was told he ation. Resident #40 could not ade aware at the time of as going to to the hospital. 2 p.m., an interview was PN (licensed practical nurse) #3. PN (licensed pr	F 624			
	relief of moderate This information values institutes of Healt	ioid analgesic indicated for the to moderately severe pain. was obtained from The National h ilm.nih.gov/dailymed/drugInfo.cf				

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 63 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		LE CONSTRUCTION	CO	TE SURVEY MPLETED
		495139	L		09	/07/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET			3	STREET ADDRESS, CITY, STATE, ZIP CODE B15 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 624	Continued From page 63 m?setid=0a446947-2cda-4a32-aa6a-53e0924582 5a. (2) Clonidine is used to treat high blood pressure. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH T0009680/?report=details. (3) Ceftin is a cephalosporin antibiotic used to treat infections. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH T0009522/?report=details. (4) Pylenonephritis- Kidney infection is a type of urinary tract infection (UTI) that commonly begins in the bladder and moves upstream to one or both of the kidneys. This information was obtained from National Institutes of Health. https://www.niddk.nih.gov/health-information/urologic-diseases/kidney-infection-pyelonephritis.		F 624			
	the hospital on 5/2 There was no evithe resident was phospital transfer. Resident #97 was 4/30/18 with the congestive heart aftercare. The quality with an ARD of 8/7/18 coded to intact in ability to resident was code assistance for transfer.	was transferred and admitted to 23/18, 6/11/18, and 7/28/18. dence in the clinical record that prepared and oriented for the sadmitted to the facility on diagnoses of but not limited to ism, atrial fibrillation, sepsis, failure, hypoxemia, and surgical parterly MDS (Minimum Data (Assessment Reference Date) the resident as being cognitively make daily life decisions. The ed as requiring extensive insfers and toileting; assistance dressing and hygiene; and was				

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Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 64 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495139	B. WING		ng	0/07/2018	
	PROVIDER OR SUPPLIER			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)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 624	independent for ear A nurse's note date (medical doctor) in patients. Resident (shortness of breat diminished right ba and O2 (oxygen) s (two liters) O2 via tincreased to 3l. co breath and compla (name of son) called of decision to send called and resident further evaluation. A review of the Nu Transfer Form date evidence of the resoriented for the ho A review of the clir note dated 6/11/18 drowsy, denied and don't feel right." Heginning of the statement that she VS was obtained a (temperature)-76/5 pressure)-26 (respective)-26 (respect	ed 5/23/18 documented, "MD room this a.m. to assess was diaphoretic and SOB th). Lungs with rales and use. Assessed again by nurse ats (saturation) were 78% on 21 masal cannula, O2 was portinues (sic) to be short of ins of dizziness and weakness. and notified of condition and a patient to hospital. Squad as sent to (name of hospital) for resing Home to Hospital and 5/23/18 failed to reveal any sident being prepared and spital transfer. Inical record revealed a nurse's that documented, "Patient felt by pain, and she stated, "I just er VS (vital signs) at the nift was					

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Event ID: WE1L11

Facility ID: VA0145

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495139	B. WING _		09	09/07/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 624	A review of the Nu Transfer Form day evidence of the re oriented for the ho A review of the nu 7/28/18 that docum notified by CNA (of Resident was clar Resident c/o (comfocus on anything hypotension (low notified with new of Son (name of son contacted. 911 ac A review of the Nu Transfer Form day	arsing Home to Hospital ted 6/11/18 failed to reveal any sident being prepared and ospital transfer. rse's notes revealed one dated mented, "This nurse was sertified nursing assistant) that may and not responding. Inplained of) dizziness, hard to and nausea. Periods of clood pressure) this am. MD orders to send for evaluation. In notified but yet to be citivated." arsing Home to Hospital ted 7/28/18 failed to reveal any sident being prepared and	F 62	4			
	On 9/7/18 at 12:13 conducted with LF When asked the plant being transferred that she would first appropriate docur (responsible party their transfer was to understand, LP explains to reside transferred to the documented anyw #3 stated that nor resident was notif	2 p.m., an interview was PN (licensed practical nurse) #3. process when a resident is to the hospital, LPN #3 stated at assess the resident, send the nents, and then notify the RP (). When asked if the reason for explained to the resident, if able N #3 stated that she usually not swhy they are being hospital. When asked if this is where in the clinical record, LPN mally does not chart that the					

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 66 of 141



	TMENT OF HEALT	H AND JAN SERVICES RE & MEDICAID SERVICES			FO	ED: 09/18/2018 RM APPROVED NO: 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495139	B. WING			09/07/2018		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 624	they were made a	page 66 M #2 (the Director of Nursing) aware of the findings. No further provided by the end of the	F 624					
	the hospital on 7/2 evidence in the cl	was transferred and admitted to 27/18 and 8/8/18. There was no inical record that the resident d oriented for the hospital						
	6/28/18 with the conthopedic aftercathigh blood pressurant The admission/5-with an ARD (Ass 7/5/18 coded the intact in ability to resident was code assistance for tra	s admitted to the facility on liagnoses of but not limited to are, ischemic heart disease, are, and chronic kidney disease. day MDS (Minimum Data Set) ressment Reference Date) of resident as being cognitively make daily life decisions. The ed as requiring extensive nsfers, dressing, and bathing; e for hygiene and toileting; and atting.		92				
	documented "R at beginning of sh resident became hard time staying	ted 7/27/18 at 9:54 a.m., esident was alert and oriented lift this a.m. Later morning very lethargic and was having a awake. MD (medical doctor) resident was assessed. Had				The second secon		

started promethazine {1} and Norco {2} this a.m.

medication changes...Lungs with slight crackles bilaterally. O2 (oxygen) sats were 86% on room air. 95% on 2l (two liters of oxygen) via nasal cannula....Addendum: Resident continues with

and lethargy was noted to be related to

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 67 of 141



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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE AND PLAN OF CORRECTION (DENTIFICATION NUMBER: A. BUILDING			STRUCTION		E SURVEY IPLETED		
		495139	B. WING			09/	07/2018
	PROVIDER OR SUPPLIE			315 EA	ADDRESS, CITY, STATE, ZIP CODE ST LEE HIGHWAY MARKET, VA 22844		1,2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 624	extreme lethargy for supplemental orders given to se further evaluation Addendum: Resi for acute kidney i A review of the N Transfer Form da evidence of the reoriented for the h A nurse's note da documented, "Re throughout today was 98. is {sic} n Respirations 32. of changes. Res ER (emergency rarrived at 1:30 PN A review of the N Transfer Form da evidence of the reoriented for the h On 9/7/18 at 12:1 conducted with L When asked the being transferred that she would fir appropriate docu (responsible part their transfer was to understand, Lifexplains to reside transferred to the documented any	at this time with continued need O2. Reassessed by MD and ent to ER (emergency room) for a Brother was notified. Ident was admitted to (hospital) injury." ursing Home to Hospital ated 7/27/18 failed to reveal any esident being prepared and ospital transfer. Ited 8/8/18 at 1:30 p.m. esident with increasing tremors. Temp (temperature) this a.m. now 102.1. Heart rate of 151. NP (nurse practitioner) notified ident sent to (name of hospital) room). Family notified. Squad M." ursing Home to Hospital ated 8/8/18 failed to reveal any esident being prepared and					

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 68 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE S					
		495139	B. WING		09/0	7/2018			
	ROVIDER OR SUPPLIER	AARKET	= = = \(\)	STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844					
(X4) ID PREFIX TAG	(EACH DEFICE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR 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 624	(Administrative Sta Director) and ASM they were made a	-	F 62	4					
	prevent and control may occur after su medications to hel Promethazine is a motion sickness. F symptoms, but wil symptoms or spee Information obtain	_							
F 625 SS=E	combination is use moderately severe Information obtain https://www.ncbi.r T0010590/ Notice of Bed Hole	ed from Ilm.nih.gov/pubmedhealth/PMH Ilm.nib.gov/pubmedhealth/PMH	F 62	5 F625 1. How will the corrective action	1	10/15/18			
	§483.15(d)(1) Not nursing facility trai the resident goes nursing facility mu	of bed-hold policy and return- ice before transfer. Before a nsfers a resident to a hospital or on therapeutic leave, the st provide written information to ident representative that		accomplished for those residents have been affected by the deficiency practice? Resident #26, 40, 65, 42, 59, 58 and 94 have safely returned to fafter facility initiated transfer to	ent = , 88, 97, acility				

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 69 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495139	B. WNG		09/07/2018
	ROVIDER OR SUPPLIER E CENTER OF NEW M.	ARKET	1	STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICENCY)	D BE COMPLETION
F 625	specifies- (i) The duration of the any, during which the return and resume facility; (ii) The reserve bed plan, under § 447.4 (iii) The nursing face bed-hold periods, we paragraph (e)(1) of resident to return; at (iv) The information of this section. §483.15(d)(2) Bed-the time of transfer hospitalization or the facility must provide resident represental specifies the durating described in paragraph this REQUIREMED by: Based on staff interview, and clinical determined that the written bed hold not hospital for nine of sample, Resident facility staff documentation that was provided to Resident facility staff documentative upo 7/27/18.	the state bed-hold policy, if the resident is permitted to residence in the nursing and payment policy in the state of of this chapter, if any; ility's policies regarding which must be consistent with this section, permitting a and a specified in paragraph (e)(1) whold notice upon transfer. At of a resident for the resident and the ative written notice which on of the bed-hold policy raph (d)(1) of this section. Note in the transfer to the service, facility staff failed to provide the tification for a transfer to the 42 residents in the survey face, 40, 65, 42, 59, 58, 88, 97 failed to evidence the acopy of the bed hold policy resident #26 and/or the resident in transfer to the hospital on	F 625	Continued from page 69 2. How will the facility identify of residents having the potential to be affected by the same practice? All residents transferred to the hot have the potential to be affected by practice. On 9/25/18, Director of reviewed all residents from facility currently residing at the hospital validated bed hold policy was ser resident upon discharge from facility to a systematic changes made to expractice will not reoccur? By 10/8/18, Staff Development Coordinator will in-service Licent Nurses on sending a copy of bed notice with resident upon a facility initiated transfer to the hospital. Any Licensed Nurse that has not serviced by 10/8/18 will not be a provide direct care until in-service completed. All newly hired Licent Nurses will receive education du orientation on sending a copy of notice with resident upon a facility initiated transfer to the hospital.	ospital oy this Nursing ty and nt with illity to o place nsure the ased hold ty been in- llowed to ce nsed ring bed hold

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

Event ID: WE1L11

Facility ID: VA0145

f continuation sheet Page 70 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY PLETED	
		495139	B. WING		09	/07/2018	
	ROVIDER OR SUPPLIER E CENTER OF NEW		STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844				
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 625	was provided to the resident representation 8/31/1 3. The facility state documentation the was provided to Frepresentative up 8/1/18. 4. The facility state documentation the was provided to Frepresentative up the hospital on 07 5. The facility state documentation the was provided to the resident representation of 7/21/1/18. Resident #97	the Resident #40 and/or the stative upon transfer to the late. If failed to evidence at a copy of the bed hold policy Resident #65 and/or the resident from transfer to the hospital on transfer to the hospital on transfer to the bed hold policy Resident # 42 and/or resident from a facility initiated transfer to 17/05/18. If failed to evidence at a copy of the bed hold policy he Resident #59 and/or the stative upon transfer to the late. If failed to evidence from the late is a copy of the bed hold policy he Resident #58 and/or the stative upon transfer to the late. If failed to evidence from the late is a copy of the bed hold policy he Resident #58 and/or the stative upon transfer to the late. If failed to evidence from the late is a copy of the bed hold policy he Resident #88 and/or the stative upon transfer to the late. If failed to evidence from the late is a copy of the bed hold policy he Resident #88 and/or the late is a copy of the bed hold policy he Resident #88 and/or the late is a copy of the late is a cop	F 625	Continued from page 70 Director of Nursing/Unit Meevaluate facility initiated trathospital have bed hold notice patient during transfer to howeek x30days, 3 times a well time a week x30days. 4. How will the facility more corrective plan to ensure the practice was corrected and a Director of nursing will presof audit accurate assessment to the Quality Assurance Pel Improvement committee for recommendations for 90 days committee consist of Execut Director of Nursing, Assistat Nursing, Social Services, A Dietary Manager, Pharmacy Medical Director.	ensfers to the see sent with spital 5 times a sek x30days, nitoring the edeficient not reoccur? sent findings triormance review and ys. The QAPI tive Director, ant Director of activities,		
	the hospital on 5/ There was no evi the resident and/	/23/18, 6/11/18, and 7/28/18. idence in the clinical record that or Resident Representative was written bed hold notification for					

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 71 of 141



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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

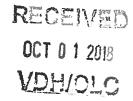
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/07/2018		
		495139	B. WING				
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 625	either transfer.	page 71 was transferred and admitted to	F 625				
	evidence in the c and/or Resident	727/18 and 8/8/18. There was no linical record that the resident Representative was provided hold notification for either				1.0	
	The findings incl	ude:					
	documentation the	ff failed to evidence nat a copy of the bed hold policy Resident #26 and/or the resident bon transfer to the hospital on					
	3/14/18 and read diagnoses that in type two diabetes swallowing), repe communication of recent MDS (min a significant chair (assessment reformable) #26 was coded a cognitive function	s admitted to the facility on a similar on 7/31/18 with acluded but were not limited to so, dysphagia (difficulty eated falls, and cognitive deficit. Resident #26's most himum data set) assessment was a seessment with an ARD erence date) of 8/30/18. Resident as being severely impaired in a scoring 01 out of possible 15 ef Interview for Mental Status)	Miles in the control of the control				
	that she was ser Further review o revealed that she	ent #26's clinical record revealed to the hospital on 7/27/18. f Resident #26's clinical record e was admitted back to the facility diagnosis of left hip repair post	4				

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

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 72 of 141



DEPARTMENT OF HEALTH AND I IAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	1	3	COMPLETED
		495139	B. WING		09/07/2018
	PROVIDER OR SUPPLIER RE CENTER OF NEW	MARKET		STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION
F 625	Continued From pa	ge 72	F 625	5	
	hold policy was pro	ence that a copy of the bed vided to the resident and/or tive upon transfer to the			
	conducted with OSI the social worker, re when a resident is to OSM #12 stated that a role. When asked sending bed hold n	.m., an interview was M (other staff member) #12, egarding social services role transferred to the hospital. at her department did not have I who was responsible for otifications to residents, OSM business office was			
	conducted with OS Services. OSM #11 the business office not enforcing their I	m., an interview was M #11, the Director of Social stated that she checked with and found that the facility was bed hold policy because the w and that the facility always to		•	
	a.m. with OSM #10 OSM #10 stated the information upon tr facility census has	onducted on 9/7/18 at 9:39, the business office manager. at they do not provide bed hold ansfer to a facility, as the been "way down for over a ys know they have a bed ng residents.			
	member) #1, the E	e.m., ASM (administrative staff eccutive Director, and ASM #2, of Nursing) were made aware rns.			
		tled, "Bed Hold/Reservation of uments in part, the following:			V

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

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 73 of 141



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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A, BUILOING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED - 09/07/2018	
		495139	B, WING			
	PROVIDER OR SUPPLIES		STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 625	to the patient upon the patient before the patient patient patient patient goes on the provide written not representative the state bed hold polypatient is permitted residence in the notification within the patient representation of the patient r	page 73 It will be provided and explained on admission and explained to each temporary absence. It transfers to the hospital or the parapeutic leave, the facility will estification to the patient or patient at specifies: -The duration of the licy, if any, during which the ed to return and resume pursing facility The reserve by in the state plan, if any - The reding bed-hold. In cases of ers, notice "at the time of that the family, surrogate, or ative are provided with written 24 hours of the transfer."	F 625			
	documentation the was provided to the resident represent hospital on 8/31/1 Resident #40 was 12/28/16 and read diagnoses that incatrial fibrillation, in kidney failure. Re (minimum data sea assessment with date) of 7/8/18. Feing moderately	s admitted to the facility on dmitted on 5/30/17 with cluded but were not limited to nuscle weakness, and acute sident #40's most recent MDS et) assessment was a quarterly an ARD (assessment reference Resident #40 was coded as impaired in cognitive function possible 15 on the BIMS (Brief				

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 74 of 141

	MENT OF HEALTH	AND AN SERVICES & MEDICAID SERVICES			0		FOR	D: 09/18/2018 M APPROVED D: 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DA	(X3) DATE SURVEY COMPLETED		
		495139	B. WING		X10= =		09	09/07/2018	
	PROVIDER OR SUPPLIER RE CENTER OF NEW			315 EA	ADDRESS, CITY ST LEE HIGHW MARKET, VA				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRE CTIVE ACTION SH NCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 625	that he had been to 8/31/18. Further re revealed that Resident 9/1/18 with a diapylenonephritis (4) There was no evident hold policy was prother esident representation 8/31/18. On 9/7/18 at 8:39 a conducted with OS the social worker, when a resident is OSM #12 stated tha role. When asket sending bed hold revealed to the sending bed hold revealed that the sending that the sending the sending that	at #40's clinical record revealed ransferred to the hospital on eview of the clinical record dent #40 returned to the facility agnosis of acute (kidney infection). ence that a copy of the bed ovided to Resident #40 and/or centative upon transfer to the	F 6	25					
	conducted with OS Services. OSM #1* the business office not enforcing their	a.m., an interview was SM #11, the Director of Social 1 stated that she checked with and found that the facility was bed hold policy because the ow and that the facility always e.	manufacture and provide the second control of the second control o						
	a.m. with OSM #10 OSM #10 stated the information upon to facility census has	conducted on 9/7/18 at 9:39 Of the business office manager, not they do not provide bed hold ransfer to a facility, as the been "way down for over a mays know they have a bed ling residents.	The same of the sa						

On 9/7/18 at 3:26 p.m., ASM (administrative staff

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 75 of 141

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

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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		COMPLETED	
		495139	B. WING _		00	/07/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844	1 00	70772010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 625	member) #1, the Ithe DON (Director of the above concoing of the above concoing the above concoing of the above	Executive Director, and ASM #2, rof Nursing) were made aware erns. oid analgesic indicated for the to moderately severe pain. was obtained from The National Indianal Institutes of Health. Indianal In	F 62				
	documentation the was provided to F representative up 8/1/18.	f failed to evidence at a copy of the bed hold policy lesident #65 and/or the resident on transfer to the hospital on admitted to the facility on					

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 76 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495139	B. WING		09	/07/2018
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZI 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 625	that included but infection, atrial fits and high blood precent MDS (min a quarterly asses (assessment reference Resident #65 was impaired in cognipossible 15 on the Mental Status) extended that she was sensident #65 was diagnoses of acutract infection. There was no evidence with a conducted with Composite on 8/1/18 on 9/7/18 at 8:39 conducted with Composite of the social worker when a resident in OSM #12 stated a role. When ask sending bed hold	mitted on 8/18/18 with diagnoses were not limited to urinary tract orillation, chronic kidney disease, ressure. Resident #65's most imum data set) assessment was sment with an ARD erence date) of 8/13/18. It is coded as being moderately tive function scoring 12 out of e BIMS (Brief Interview for fam. Bent #65's clinical record revealed to the hospital on 8/1/18. It is admitted to the hospital with the renal failure (1) and a urinary indence that a copy of the bed rovided to Resident #65 and/or esentative upon transfer to the	F 6	525		
	On 9/7/18 at 9:11 conducted with O Services. OSM # the business office	a.m., an interview was PSM #11, the Director of Social 11 stated that she checked with be and found that the facility was ir bed hold policy because the				

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

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 77 of 141



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

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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	2/0		ONSTRUCTION		MPLETED
		495139	B. WING			05	0/07/2018
	PROVIDER OR SUPPLIER			315 1	EET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY V MARKET, VA 22844	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 625	census has been I had a bed available. An interview was ca.m. with OSM #10 OSM #10 OSM #10 OSM #10 ostated the information upon the facility census has year", so they alway available for return On 9/7/18 at 3:26 pmember) #1, the Ethe DON (Director of the above concerns of the above con	ow and that the facility always e. conducted on 9/7/18 at 9:39 D, the business office manager. Let they do not provide bed hold transfer to a facility, as the been "way down for over a manager at they do not provide bed hold transfer to a facility, as the been "way down for over a manager at they down for over a manager at they down for over a manager at they are a bed at the standard at the st		25			

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

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 78 of 141

	TMENT OF HEALTH	HAND MAN SERVICES E & MEDICAID SERVICES		0		FOR	D: 09/18/2018 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DA	TE SURVEY
		495139	B. WING			00	9/07/2018
NAME OF F	PROVIDER OR SUPPLIER				ITY, STATE, ZIP COD		70172010
LIFE CAI	RE CENTER OF NEV	V MARKET		15 EAST LEE HIGH IEW MARKET, V			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRE RECTIVE ACTION SH RENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 625	(assessment refer Resident # 42 as s interview for menta	age 78 sessment with an ARD ence date) of 07/11/18, coded scoring a 15 on the brief al status (BIMS) of a score of 0 gnitively intact for making daily	F 625	·			
	dated 07/05/18 at a "Resident with alter confused and para irregular lab (labor (vital signs) 98.0 (to 68 -blood pressure 90% on 2L (two liter notified at 1700 (5: daughter-in-law, (Notified by NP (nur Nurse Practitioner) on 7/1/18 without a	ress Notes" for Resident # 42 4:56 p.m., documented, red mental status, alert but anoid with visual hallucinations, atory) work as of today. VS emperature), 125/68 (125 over e), O2 SAT (oxygen saturation) ers). Resque [sic] Squad and p.m.). Resident's lame of Daughter-in-law) rese practitioner), (Name of b. Resident did fall out of bed any apparent injuries. Resque 1715 (5:15 p.m.), to transport tal)."					
	conducted with OS the social worker, when a resident is OSM #12 stated th a role. When aske sending bed hold r	a.m., an interview was SM (other staff member) #12, regarding social services role transferred to the hospital, at her department did not have d who was responsible for notifications to residents, OSM business office was					
	a.m. with OSM #10	conducted on 9/7/18 at 9:39 O, the business office manager. nat they do not provide bed hold					See a

information upon transfer to a facility, as the facility census has been "way down for over a year", so they always know they have a bed

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 79 of 141

OCT 0 1 2018 VDH/OLC

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO: 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3		TE SURVEY MPLETED
		495139	B. WING		09	/07/2018
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 625	available for return On 09/06/18 at ap (administrative stadirector, ASM #2, made aware of the No further information on the esophagus ar was obtained from https://www.nlm.n	proximately 3:26 p.m. ASM aff member) #1, the executive the director of nursing, were e findings. ation was provided prior to exit. ents to leak back, or reflux, into a irritate it. This information in the website: aih.gov/medlineplus/gerd.html. In the speed or rhythm of the aformation was obtained from aih.gov/medlineplus/atrialfibrillating at reduced motion in your joints. A gioint, but usually it affects your as or spine. This information in the website: as.gov/osteoarthritis.html. If failed to evidence at a copy of the bed hold policy the Resident #59 and/or the stative upon transfer to the	F 625			

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 80 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION 3		E SURVEY PLETED
		495139	B. WING		09/0	07/2018
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 625	(1), high blood producted with Osh #12 stated that thresponsible.	aralysis of one side of the face) essure, diabetes, and arthritis. MDS (minimum data set) annual assessment, with an ence date of 7/20/18, coded the ga "15" on the BIMS (brief tal status) score, indicating the vely intact for daily decision ote dated 7/10/18 [no time ed, "Patient seen today for the increase [and] SOB	F 625			
		10, the business office manager,				

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 81 of 141

OCT 0 1 2018

VDH/OLC

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

-	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495139	B. WING		09/	/07/2018
	PROVIDER OR SUPPLIE		319	REET ADDRESS, CITY, STATE, ZII 5 EAST LEE HIGHWAY EW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 625	OSM #10 stated information upon facility census ha year", so they alwavailable for return on 9/7/18 at 3:26 member) #1, the the director of nuabove findings. No further inform 1) This informational Institutes https://medlineplu. 6. The facility stated ocumentation the was provided to the resident represent hospital on 7/12/18. With a material and the speed and rhe blood pressure, of history of a hip fractional institutes and the speed and rhe blood pressure, of history of a hip fractional institutes and the speed and rhe blood pressure, of history of a hip fractional institutes and recent assessment, a si with an assessment, a si with an assessment coded the resided (brief interview for the speed and rhe placed in the	that they do not provide bed hold transfer to a facility, as the s been "way down for over a rays know they have a bed rning residents." I. p.m., ASM (administrative staff executive director, and ASM #2, rsing, were made aware of the ation was provided prior to exit. In was obtained from the sof Health at us.gov/bellspalsy.html If failed to evidence at a copy of the bed hold policy he Resident #58 and/or the ative upon transfer to the sea admitted to the facility on ost recent readmission of phoses that included but were all fibrillation (an abnormality of ythm of a heart beat) (1), high liabetes, muscle weakness and acture in March 2018. MDS (minimum data set) gnificant change assessment, ent reference date of 8/20/18, and as scoring an "8" on the BIMS or mental status) score, indicating oderately impaired for daily	F 625			

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 82 of 141

	TMENT OF HEALT	TH AND MAN SERVICES RE & MEDICAID SERVICES			FORM	0. 09/18/2018 MAPPROVED 0. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495139	B. WING		09	/07/2018
	PROVIDER OR SUPPLIE		315	REET ADDRESS, CITY, STATE, ZIP CODE EAST LEE HIGHWAY W MARKET, VA 22844	1 00	70172010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT! (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 625	Continued From	page 82	F 625			Series 1
	"Resident complates respirations labor wheezes noted be at 21 (liter) per minus in and recomevaluated, alert, h	dated 7/12/18 at 4 p.m. stated, ains of feeling like he is dying, red, sat 89 [%] on room air, ilaterally, oxygen applied to [sic] nute. NP (nurse practitioner) mended [sic] be sent to be neart rate regular, son called and tion, pt (patient) to be sent to via squad."				
	that written notific hold policy was p the Responsible I	inical record failed to evidence eation regarding the facility's bed rovided to Resident #58 and or Representative upon the r to the hospital on 7/12/18.				
	conducted with O the social worker when a resident i OSM #12 stated a role. When ask sending bed hold	a.m., an interview was as a.m., an interview was as as a constant of the staff member) #12, and a constant of the stransferred to the hospital. That her department did not have a constant of the stransferred to the hospital of the stransferred to the stransf				
	a.m. with OSM #* OSM #10 stated to information upon facility census ha	conducted on 9/7/18 at 9:39 10, the business office manager. that they do not provide bed hold transfer to a facility, as the s been "way down for over a vays know they have a bed rning residents.				
	member) #1, the	p.m., ASM (administrative staff executive director, and ASM #2, rsing, were made aware of the				il iii

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 83 of 141

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

	PRINTED: 09/18/2018
)	FORM APPROVED
	OMB NO. 0938-0391

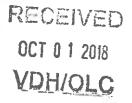
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD	TIPLE CONSTRUCTION		TE SURVEY MPLETED		
		495139	B. WING		09	/07/2018		
	PROVIDER OR SUPPLIE		4	STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 625	Continued From p	page 83	F6	25				
	No further informa	ation was provided prior to exit.						
	National Institutes	on was obtained from the s of Health at us.gov/atrialfibrillation.html						
	documentation th was provided to t	if failed to evidence at a copy of the bed hold policy he Resident #88 and/or the Itative upon transfer to the 18.						
	5/7/16, with a mo 7/27/18, with diag not limited to: stro stroke, muscle w	s admitted to the facility on st recent readmission of moses that included but were oke, paralysis secondary to eakness, difficulty speaking, ng, hypertension, and dementia.						
	assessment, a quassessment referencesident as rarely	MDS (minimum data set) parterly assessment, with an rence date of 8/12/18, coded the rence being able to make od as well as rarely- never thers.				The state of the s		
	7/21/18 [no time	ioner's telephone order dated documented] stated, "Send emergency department) for eval ment."						
	documented in particular diminished respirate be in distress. Lurhales [sic] (rales	dated 7/21/18 at 12:31 p.m. art, "Resident noted to have rations, clammy and appears to ung sounds diminished with are small clicking, bubbling, or the lungs which could indicate						

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 84 of 141



STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CON	STRUCTION			(X3) DAT	0938-0391 E SURVEY PLETED
		495139	B. WING		D.W.			09/	07/2018
	PROVIDER OR SUPPLIER			315 EAS	ADDRESS, CI ST LEE HIGH MARKET, VA	1 H W I S	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORE	R'S PLAN OF CO RECTIVE ACTION RENCED TO THE DEFICIENCY	N SHOUL E APPROI	D BE	(X5) COMPLETION DATE
F 625	(nurse practitioner obtained for reside evaluation and treat A review of the clin that written notificated hold policy was proor the Responsible resident's transfer On 9/7/18 at 8:39 a conducted with OS the social worker, when a resident is OSM #12 stated tha role. When asket sending bed hold resident of the second of the social worker, when a resident is OSM #12 stated tha role. When asket sending bed hold resident in the second of	e lungs) (1) bilaterallyNP) notified and new order ent to be sent to ED for	Fé	F 625					
	An interview was c a.m. with OSM #10 OSM #10 stated th information upon to facility census has year", so they alwa available for return On 9/7/18 at 3:26 p member) #1, the e	onducted on 9/7/18 at 9:39), the business office manager. Leat they do not provide bed hold ransfer to a facility, as the been "way down for over a sys know they have a bed ing residents. D.m., ASM (administrative staff xecutive director, and ASM #2, sing, were made aware of the							
	No further informa	tion was provided prior to exit.							
	1) This information	was obtained from the							

National Institutes of Health at

https://medlineplus.gov/ency/article/007535.htm

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 85 of 141

	TMENT OF HEALTH	AND HUMAN RVICES			RINTED: 09/18/2018 FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495139	B. WING		09/07/2018
NAME OF I	PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE	1 00/01/2010
LIFE CA	RE CENTER OF NEW	MARKET		W 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 625	Continued From pa	age 85	F 625		
	the hospital on 5/23. There was no evide the resident and/or provided with a write either transfer. Resident #97 was a 4/30/18 with the dia pulmonary embolis congestive heart fa aftercare. The quaset) with an ARD (x of 8/7/18 coded the intact in ability to m resident was coded assistance for transfer.	as transferred and admitted to 3/18, 6/11/18, and 7/28/18. ence in the clinical record that Resident Representative was ten bed hold notification for admitted to the facility on agnoses of but not limited to m, atrial fibrillation, sepsis, illure, hypoxemia, and surgical arterly MDS (Minimum Data Assessment Reference Date) e resident as being cognitively take daily life decisions. The d as requiring extensive sfers and toileting; assistance tressing and hygiene; and was ting.			
	(medical doctor) in patients. Resident (shortness of breat diminished right ba and O2 (oxygen) so (two liters) O2 via rincreased to 3l. cobreath and compla (name of son) called of decision to send called and resident further evaluation."				
		rsing Home to Hospital ed 5/23/18 failed to reveal any			1 to 1

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 86 of 141

		HAND MAN SERVICES E & MEDICAID SERVICES			FORM	: 09/18/2018 1APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		TE SURVEY MPLETED
		495139	B. WING	II E E E	09.	/07/2018
188	PROVIDER OR SUPPLIER RE CENTER OF NEV		318	REET ADDRESS, CITY, STATE, ZIP CO 5 EAST LEE HIGHWAY EW MARKET, VA 22844		_vr =œ _v/8 4/=
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 625	evidence of a bed There was no evid Resident Represe written bed hold no hospital on 5/23/13 A review of the clin note dated 6/11/18 drowsy, denied and don't feel right." In beginning of the signal systement that she VS was obtained a (temperature)-76/19 pressure)-26 (respectively)-26 (respectively	hold notice being provided. lence that the Resident or ntative was provided with a otice for the transfer to the B. nical record revealed a nurse's B that documented, "Patient felt by pain, and she stated, "I just ler VS (vital signs) at the hift was	F 625			
l I	Transfer Form dat evidence of a bed There was no evid Resident Represe	resing Home to Hospital and 6/11/18 failed to reveal any hold notice being provided. If the Resident or entative was provided with a otice for the transfer to the 8.				
	7/28/18 that documentified by CNA (conceptions) Resident was clar	rse's notes revealed one dated mented, "This nurse was ertified nursing assistant) that nmy and not responding. aplained of) dizziness, hard to				

focus on anything, and nausea. Periods of

Event ID:WE1L11

Facility ID VA0145

If continuation sheet Page 87 of 141



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

-	City.	
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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

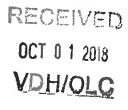
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG	COMPLETED		
		495139	B. WING _		09	9/07/2018	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844			70172010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
F 625	notified with new Son (name of sor contacted. 911 at A review of the N Transfer Form date vidence of a bed There was no evidence of a bed There was no evidence of a bed There was no evident Repressive written bed hold in hospital on 7/28/10 on 9/7/18 at 8:47 #11, the director that Admissions in 19:11 a.m., she follow were not enfolged bed available." On 9/7/18 at 9:39 #10, the business "We have not bed census being wat take everybody bed Chaministrative S Director) and AS they were made information was survey. 9. Resident #94 the hospital on 7 evidence in the contact of the survey of the Normalian survey.	blood pressure) this am. MD orders to send for evaluation. In notified but yet to be ctivated." ursing Home to Hospital ated 7/28/18 failed to reveal any dishold notice being provided. It dence that the Resident or entative was provided with a notice for the transfer to the It. If a.m., in an interview with OSM of social services, she stated provides a written bed hold. At slowed up with "For the bed hold, arcing it because census has that we have been able to have to a.m., in an interview with OSM of soffice manager, she stated, en doing bed holds due to y down for over a year. We just		25			

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 88 of 141



CENTE	RS FOR MEDICAR	RE & MEDICAID SERVICES			OMB NO	0.0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		TE SURVEY MPLETED
		495139	B. WING		09	/07/2018
NAME OF	PROVIDER OR SUPPLIE	R	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAI	RE CENTER OF NE	W MARKET		15 EAST LEE HIGHWAY IEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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)	LD BE	(XS) COMPLETION DATE
F 625	Continued From point with a written bed transfer.	page 88 hold notification for either	F 625			
	6/28/18 with the conthopedic aftercathigh blood pressurate admission/5-with an ARD (Ass 7/5/18 coded the	s admitted to the facility on liagnoses of but not limited to are, ischemic heart disease, are, and chronic kidney disease. day MDS (Minimum Data Set) essment Reference Date) of resident as being cognitively make daily life decisions.				
	following nurses r "Resident was a shift this AM. Lat very lethargic and awake. MD (med resident was asse promethazine {1} lethargy was note changesLungs O2 (oxygen) sats room air. 95% or nasal cannulaA with extreme leth need for supplem and orders given for further evalual Addendum: Resi for acute kidney in	inical record revealed the notes: 7/27/18 at 9:54 a.m., alert and oriented at beginning of er morning resident became I was having a hard time staying lical doctor was notified and essed. Had started and Norco {2} this AM. and ed to be related to medication with slight crackles bilaterally. (saturations) were 86% on a 2I (two liters of oxygen) via addendum: Resident continues argy at this time with continued lental O2. Reassessed by MD to sent to ER [emergency room] tion. Brother was notified. dent was admitted to (hospital) njury."				

There was no evidence that the Resident or Resident Representative was provided with a written bed hold notice for the transfer to the

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 89 of 141

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		HAND HUMAN	
CENTERS EC	AR MEDICAR	E & MEDICAID	SERVICES



PRINTED: 09/18/2018 FORM APPROVED OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	NG		(X3) DATE SURVEY COMPLETED		
		495139	B. WING		09	/07/2018	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844			00/01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 625	hospital on 7/27/18 A nurse's note date documented, "Res throughout today. was 98. is {sic} no Respirations 32. Nof changes. Resid ER (emergency rodarrived at 1:30 PM. A review of the Nur Transfer Form date evidence of a bed There was no evid. Resident Represer written bed hold not hospital on 8/18/18 On 9/7/18 at 8:47 at #11, the director of that Admissions programmer of the process of the p	and 8/8/18 at 1:30 PM ident with increasing tremors Temp (temperature) this AM w 102.1. Heart rate of 151. IP (nurse practitioner) notified ent sent to (name of hospital) om). Family notified. Squad " " " " " " " " " " " " " " " " " " "	F 63	25			

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 90 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY
		495139	B. WING		09/	07/2018
	ROVIDER OR SUPPLIER E CENTER OF NEW M	ARKET	3	TREET ADDRESS, CITY, STATE, ZIP CODE 15 EAST LEE HIGHWAY IEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 625	Continued From pe	ge 90	F 625		4	
	prevent and contro may occur after sur medications to help Promethazine is als motion sickness. P symptoms, but will symptoms or speed Information obtaine https://medlineplus tml	ed from gov/druginfo/meds/a682284,h odone and acetaminophen d to relieve moderate to				
	Information obtaine https://www.ncbi.nl T0010590/ Accuracy of Assess CFR(s): 483.20(g) §483.20(g) Accuracy The assessment material resident's status. This REQUIREMED by: Based on staff interand clinical record facility staff failed to (minimum data set) residents in the sur	d from m.nih.gov/pubmedhealth/PMH sments cy of Assessments. ust accurately reflect the NT is not met as evidenced erview, facility document review review, it was determined the maintain accurate MDS assessments for one of 42 evey sample, Resident #55.		F 641 1. How will the corrective action accomplished for those residents have been affected by the deficier practice? On 9/19/18, MDS Coordinator co following assessments for residen MDS Assessment Sections B0700 C0100 and C0500 for annual assedated 10/19/17;	found to at rrected the t #55:), B0800,	10/15/18
	B0700, B0800 and	led to accurately code Section failed to complete the sfor Resident #55's annual		MDS Assessment Sections C010 C0500 for Significant Change As dated 1/15/18;		

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 91 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO 0938-0391

	OMB NO. 0938-0391
(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY

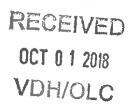
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		POENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495139	B. WING			09/0	7/2018
	NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET			31	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page 91 MDS assessment, with an assessment reference date of 10/19/17, and failed to complete the interview for the cognitive status for Resident #55's significant change MDS assessment with an assessment reference date of 1/15/18. The facility staff also failed to accurately code Section B0600 Speech Clarity and failed to complete the interviews for the quarterly MDS assessment,		F		Continued from page 91 MDS Assessment Sections B0600, C and C0500 for Quarterly Assessment 4/17/18; MDS Assessment Sections B0600, C and C0500 for Quarterly Assessment	dated 0100	
3	and the quarterly N	nt reference date of 4/17/18 MDS assessment, with an name of 7/18/18.			7/18/18. 2. How will the facility identify othe residents having the potential to be affected by the same practice?	r	
	The facility staff fai B0700, B0800 and cognitive interview MDS assessment, date of 10/19/17, a interview for the co #55's significant ch an assessment ref Resident #55 was January 2004 with were not limited to condition in which	findings include: facility staff failed to accurately code Section 00, B0800 and failed to complete the nitive interviews for Resident #55's annual 6 assessment, with an assessment reference of 10/19/17, and failed to complete the view for the cognitive status for Resident is significant change MDS assessment with ssessment reference date of 1/15/18. Ident #55 was admitted to the facility in uary 2004 with diagnoses that included but in not limited to: Down's Syndrome (A genetic dition in which a person has 47 chromosomes			Any resident with cognitive communication deficits have the pote to be affected by this practice. On 9/19/18, MDS Coordinator and Social Services Director reviewed most recent MDS assessment of all current residents with cognitive communication deficits to ensure accurate coding of Sections B0600,	ential	
	instead of the usual 46. The extra chromosome causes problems with the way the body and brain develop. Down syndrome is one of the most common causes of birth defects.) (1), dementia, and diabetes. The MDS assessment, an annual assessment, with an ARD (assessment reference date) of 10/19/17, in Section B 0700 - Ability to express ideas and wants - coded the resident as understood. In Section B 0800 - Understanding				B0700, B0800, C0100 and C0500. Any resident assessment found to be inaccurately coded, assessment was corrected. 3. What measures will be put into pl or systematic changes made to ensurpractice will not reoccur.		

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 92 of 141



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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495139	B. WING		09/07/2018	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET			3	TREET ADDRESS, CITY, STATE, ZIP CODE 15 EAST LEE HIGHWAY IEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLET	
F 641	verbal content, ho device) - the resid In Section C- Cog brief interview for The form docume that the resident is interview was not was coded as undurated. The significant change in the significant c	wever able (with hearing aid or ent was coded as understands. Initive Patterns, for should a mental status be conducted? Inted a "No." The "No" indicated a rarely/never understood. The completed, though the resident lerstands and being ange MDS assessment, with an oded the resident in Section B lity with unclear speech, stood, and sometimes as. In Section C- Cognitive uestion should a brief interview be conducted? The form of the "No" indicated that the never understood. The interview of, though the resident was sees understanding others and	F 641	Continued from page 92 By 9/20/18, Staff Development Coordinator will provide writter to current MDS Coordinators, A Director of Nursing, Social Services As follow RAI Manual reference to completing MDS Assessment to accurate coding. On 9/19/18 MDS Coordinator, A Director of Nursing, Social Services of Nursing, Social Services Director participated in company promoted webinar that included of Section B and Section C of RAI Manual effective October 2018. Director of Nursing/MDS Coor Social Services Director will re Assessment Sections B0600, B0 B0800, C0100 and C0500 of re determined to have cognitive	n education Assistant vices ssistant to bool when beensure Assistant vices by l updates 1, dinator and view MDS 0700,	
	4/17/18, coded the Speech Clarity as resident was code as sometimes und being understood Patterns, for the company of the code	S assessment with an ARD of a resident in Section B0600 having clear speech. The ad in Section B0700 and B0800 derstanding and sometimes. In Section C- Cognitive question should a brief interview one conducted? The form		communication deficits to ensure coding prior to transmission on week x90 days. 4. How will the facility monito corrective plan to ensure the de practice was corrected and not a Director of nursing will present	ring the ficient reoccur?	

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 93 of 141

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO	<i>).</i> 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495139	B. WING		09	/07/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LIFE CAR	E CENTER OF NEW M	ARKET		315 EAST LEE HIGHWAY NEW MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 641	documented a "No. resident is rarely/ne was not completed, coded as sometimes sometimes underst The quarterly asses 7/18/18, coded the Speech Clarity as he resident was coded as sometimes understood. I Patterns, for the quarterns, for the q	"The "No" indicated that the ever understood. The interview though the resident was as understanding others and cood. Sement with an ARD of resident in Section B0600 aving clear speech. The lin Section B0700 and B0800 erstanding and sometimes in Section C- Cognitive estion should a brief interview experience conducted? The form "The "No" indicated that the ever understood). The completed, though the resident estimes understanding others derstood. The care plan dated, 2/20/15 and documented in part, and the simpaired experience in part, "Use be answered 'yes' or 'no' with lead nod, blinking, eye, etc.) if the care plan dated, 2/20/18 and documented in part, "Company of the care plan dated, 2/20/18 and documented in part, "Company of the care plan dated, 2/20/18 and documented in part, "Company of the care plan dated, 2/20/18 and documented in part,"	F 64	Continue from page 93 of audit accurate assessment fit to the Quality Assurance Perform Improvement committee for refrecommendations for 90 days. committee consist of Executive Director of Nursing, Assistant Nursing, Social Services, Activated Dietary Manager, Pharmacy of Medical Director.	ormance eview and The QAPI e Director, Director of vities,		

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

Syndrome and Alzheimer's disease." The

Event ID WE1L11

Facility ID: VA0145

If continuation sheet Page 94 of 141

	TMENT OF HEALT	TH AND MAN SERVICES RE & MEDICAID SERVICES			FORM	: 09/18/2018 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		495139	B. WING	2 X = 1	09.	/07/2018
	PROVIDER OR SUPPLIE		315	REET ADDRESS, CITY, STATE, ZIP CODE S EAST LEE HIGHWAY SW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	OULD BE	(X5) COMPLETION DATE
F 641	Continued From page 94 "Approaches" documented in part, "Use questions that can be answered 'yes' or 'no' with non-verbal signs (head nod, blinking, eye, etc.) if needed." An interview was conducted on 9/7/18 at 8:19 a.m. with LPN (licensed practical nurse) #5, the MDS nurse. When asked who completes Section B of the MDS assessments, LPN #5 stated the MDS nurses do that section. When asked who completes Section C of the MDS assessments, LPN #5 stated the social workers do that section. An interview was conducted with other staff member (OSM) #12, the social services assistant, on 9/7/18 at 8:24 a.m. When asked who completes Section C - Cognitive Patterns, OSM #12 stated that she did that section. Section C of the following MDS assessments were reviewed with OSM #12: Significant change assessment with an ARD of 1/15/18, the quarterly assessment with an ARD of 4/17/18 and the quarterly assessment with an ARD of 7/18/18. When asked why she did not complete the interview for cognitive status, OSM #12 stated the resident is non-verbal and can't complete the interview. When asked if he was rarely/never understood, OSM #12 stated no, he does say "Yeah and No." Section B of the above assessments were reviewed where the resident was coded as sometimes understood on all three		F 641			
	be completed, On to look into that. An interview was 9/7/18 at 8:53 a.m. Resident #55's M.	hen asked if the interview should SM #12 stated she would have conducted with LPN #5 on m. LPN #5 was asked to review MDS assessments from April and #5 was then asked if the resident				

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 95 of 141



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

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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495139	B. WING		05	9/07/2018	
LIFE CARE CENTER OF NEW MARKET (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 641 Continued From page 95 has clear speech. LPN #5 stated that no he doesn't have clear speech. When asked if this			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844				
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
F 641	has clear speech. doesn't have clear section was coded not coded correctly the facility utilizes a ssessments, LPN assessment instru An interview was of director of social soci	LPN #5 stated that no he speech. When asked if this correctly, LPN #5 stated it was when asked what reference for completing the MDS I #5 stated, "The RAI (resident ment) Manual." conducted with OSM #11, the ervices, on 9/7/18 at 8:57 a.m. nent with an ARD of 10/19/17 OSM #11. When asked if the tive status should have been ent stated, "Yes, it was coded	F 641				

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 96 of 141



	TMENT OF HEALT	H AND I AN SERVICES RE & MEDICAID SERVICES			FOR	D: 09/18/2018 M APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495139	B. WING	21 1,2		2/07/2010
NAME OF	PROVIDER OR SUPPLIE	R	ST	REET ADDRESS, CITY		9/07/2018
LIFE CA	RE CENTER OF NE	W MARKET		5 EAST LEE HIGHW EW MARKET, VA		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTED CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From	220.06	F C44			
1 041		-	F 641			
		ability to speak should not be				
		nitive impairment. Coding				
		e 0, clear speech if the resident				
		inct, intelligible words. Code 1,				
		the resident usually utters				
	slurred or mumble	ed words. Code 2, no speech if				
	there is absence					
	B0700 - Makes S	elf Understood - Code 0 -				
	understood if the	resident expresses requests				
	and ideas clearly.	Code 1 - usually understood if				
	the resident has d	difficulty communicating some				
		thought but is able if prompted				
	or given time. He	or she may have delayed				
	responses or may	require some prompting to				
	make self-unders	tood. Code 2 - sometimes				
	understood if the	resident has limited ability, but is				
		oncrete requests regarding at				
		(food, drink, sleep toilet). Code				
		understood if, at best, the				
		tanding is limited to staff	_			
	interpretation of h					
		sounds or body language				
		ce of pain or need to toilet). B				
		Inderstand Others - Code 0 if	}			
		ly c Code 1, usually understands	į			1
		sses some part of intent of the				1
		prehends most of it. The				1
		e periodic difficulties integrating				1
		enerally demonstrates				1
		responding in words or actions.				i
		nes understands if the resident				1
		quent difficulties integrating				1
	•	responds adequately only to				1
		questions or instructions.				1
		ase or simplify the message				î
		ares, the resident's				1
		s enhanced. Code 3 -				1
		erstands if the resident				
		y limited ability to understand	1 1			i

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 97 of 141



DEPARTMENT OF HEALTH AND HUMAI RVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495139	B. WING		09	/07/2018	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET		STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 641	determining whet comprehends me non verbal responsounds but does Section C - Cognithe cognitive interested the resident. Codnot be attempted rarely/never under or in writing or an available. Code 1 attempted because ometimes under an interpreter is resonetimes under an interpreter is resonet for men were coded 0 becanswer or gave and of the BIMS items score does not make an interpreter in the provided in th	Or, if staff have difficulty her or not the resident essages, based on verbal and inses. Or, the resident can hear not understand messages. itive Patterns - Record whether riview should be attempted with e 0, no if the interview should because the resident erstood, cannot respond verbally interpreter is needed but not yes if the interview should be see the resident is at least estood verbally or in writing and if needed, one is availableCode inplete interview if the resident enticipated in the BIMS (brief tal status); if four or more items cause the resident chose not to a nonsensical response or if any is is coded with a dash. A zero rean the BIMS was incomplete. It is a resident had to choose not to ompletely unrelated, nonsensical ror more items." The aff member (ASM) #1, the rand ASM #2, the director of the aware of the above findings p.m. ation was provided prior to exit.	F 6	41			

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		495139	B. WING		09	07/2018
	ROVIDER OR SUPPLIER E CENTER OF NEW		3	TREET ADDRESS, CITY, STATE, ZIP CODE 15 EAST LEE HIGHWAY IEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 645	Continued From p	page 98	F 645			
F 645	traction and the second		F 645	F 645		10/15/18
SS=D	CFR(s): 483,20(k)(1)-(3)		1. How will the corrective action	be	
		mission Screening for		accomplished for those residents		
	individuals with a with intellectual di	mental disorder and individuals		found to have been affected by the		
	Will kilokodda di	Sability.		deficient practice?		
		ursing facility must not admit, on		Our policy at Life Care Centers	of America	
		, 1989, any new residents with: r as defined in paragraph (k)(3)		is to ensure a Preadmission Screen		
	(i) of this section,	unless the State mental health		Resident Review (PASRR) is co	•	II.
		ermined, based on an sical and mental evaluation		that individuals are not inapprop	•	
	performed by a pe	erson or entity other than the			•	
		th authority, prior to admission, of the physical and mental		placed in nursing homes for long		
	condition of the in	dividual, the individual requires		Federal requirements state PASF	•	
	the level of service	es provided by a nursing facility;		1) all applicants to a Medicaid-co		
		al requires such level of		nursing facility be evaluated for		
	services, whether specialized service	the individual requires		mental illness (SMI) and/or intel		
	-	æs, or ability, as defined in paragraph		disability; 2) be offered the most		
		ction, unless the State		appropriate and least restrictive s	etting for	
		lity or developmental disability ermined prior to admission-		their needs (in the community, a	nursing	
	(A) That, because	of the physical and mental		facility, or acute care settings); a	nd	
		dividual, the individual requires es provided by a nursing facility;		3) receive the services they need	in those	
	and			settings.		
	(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.			When concern was identified		
				Social Services and Admissions	Director	
	£492 20(k)/2) T	postions For surposes of this		collaborated to obtain Level 1 PA	ASRR	
	9483.20(K)(2) Ext section-	ceptions. For purposes of this		screening tool.	-	
		on screening program under		On 9/21/18, Level 1 PASRR was		
	paragraph(k)(1) o	f this section need not provide		completed on resident #48, #88,		

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

Event ID WE1L11

Facility ID: VA0145

If continuation sheet Page 99 of 141

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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	<u>S FOR MEDICARE</u>	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED		
		495139	B. WING		09/07/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
LISE CAR	E CENTER OF NEW 8	AADVET	3	15 EAST LEE HIGHWAY	
LIFE OAK	L CENTER OF NEW !	MARKET	_ N	IEW MARKET, VA 22844	
(X4) ID PREFIX TAG	(EACH DEFICIS	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION.
F 645	Continued From p	age 99	F 645	Continued from page 99	
		in the case of the readmission		2. How will the facility identify of	her
		of an individual who, after		residents having the potential to be	l.
	being admitted to transferred for care	the nursing facility, was		1	
		choose not to apply the		affected by the same practice?	
		ening program under		All residents have the potential to b	
	paragraph (k)(1) o to a nursing facility	f this section to the admission		affected if they are admitted to faci	lity
		ed to the facility directly from a		without having Level 1 PASRR.	
	[-	iving acute inpatient care at the		On 9/7/18, Admission Directors we	ere
	hospital, (B) Who requires (nursing facility services for the		made aware to verify each potentia	1
		the individual received care in		admission had Level 1 PASRR on	1
	the hospital, and	in a shunisian has codified		to admission to facility.	
		ing physician has certified, to the facility that the individual		512 Az	dical
	is likely to require	less than 30 days of nursing		On 9/20/18, all current resident me	l l
	facility services.			records were reviewed by Social S	1
	§483.20(k)(3) Defi	inition. For purposes of this		Director, Health Information Mana	gement,
	section-			and Unit Manager. Any resident for	und to
		considered to have a mental vidual has a serious mental		not have a Level 1 PASRR present	in their
	disorder defined in			medical record will have a screening	ng
	1 ' '	considered to have an		completed by qualified associate b	efore
		ity if the individual has an ity as defined in §483.102(b)(3)		9/28/18.	
	l	a related condition as		3. What measures will be put into	nlace
		1010 of this chapter. ENT is not met as evidenced		•	1
	by:	ENT is not met as evidenced		or systematic changes made to ens	me me
	Based on staff in	terview, facility document review		practice will not reoccur?	
	i	I review, it was determined that		Staff Development Coordinator pr	ovided
	, -	iled to ensure a level one nission Screening and Resident		written education and policy to	
	Review) was com	pleted for three of 42 residents		Admission Directors, Social Service	ces
	in the survey sam	ple, Residents # 48, 88, and 40.	ı	Director and Social Services Assi	etant

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

1. The facility staff failed to ensure Resident

Event ID: WE1L11

Facility ID: VA0145

on 9/24/18.

If continuation sheet Page 100 of 141



PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A BUILDING		
		495139	B. WING		09/07/2018	
	NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET		STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 645	#48's level one PASARR was completed to		F 645	Continued from page 100 Admission Directors will verify Le	evel 1	
		was evaluated and receiving the most integrated setting resident's needs.		PASRR is present and complete praccepting any new admission to fa	i	
	level one PASARR	ailed to ensure Resident #88's (preadmission screening and s completed to ensure the		Social Services Director will valid presence of Level 1 PASRR on all		
	services in the most			admissions 5 times a week x4 wee 3 times a week x4 weeks, 1 time a		
	fevel one PASARR resident was evalual services in the most	ne facility staff failed to ensure Resident #40's one PASARR was completed to ensure the lent was evaluated and receiving care and ices in the most integrated setting opriate for the resident's needs.		 x 4 weeks. 4. How will the facility monitorin corrective plan to ensure the defici practice was corrected and not reo 	ent	
	The findings include	: :		Social Services Director will prese findings of audit accurate assessme	1	
	8/20/07, with a mos	is admitted to the facility on t recent readmission of oses that included but were		findings to the Quality Assurance		
	not limited to: chron	ic obstructive pulmonary order that makes it hard to		Performance Improvement commi review and recommendations for 9		
	anxiety, and bipolar	strokes, high blood pressure, disorder (a serious mental s people who have it go		The QAPI committee consist of Ex Director, Director of Nursing, Ass	ı	
	through unusual movery happy, "up," ar	ood changes. They go from nd active to very sad and		Director of Nursing, Social Service	es,	
	hopeless, "down," a again) (2).	and inactive, and then back		Activities, Dietary Manager, Phariconsultant, Medical Director.	nacy	
	assessment, a sign assessment, with a of 7/05/18, coded th	DS (minimum data set) ificant change in status n assessment reference date ne resident as scoring a "9" on rview for mental status) score,				

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

Event ID WE1L11

Facility ID: VA0145

If continuation sheet Page 101 of 141



PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE		ATE SURVEY
AND PLAN OF	CORRECTION	DENTIFICATION NOMBER.	A. BUILDING		
		495139	B. WING		09/07/2018
	ROVIDER OR SUPPLIER E CENTER OF NEW N	IARKET	3	TREET ADDRESS, CITY, STATE, ZIP CODE 15 EAST LEE HIGHWAY IEW MARKET, VA 22844	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 645	the DON (Director of the above concerns the above concerns the above concerns the above concerns the above common but serior severe symptoms and handle daily a eating, or working depression, the sy least two weeks. If the above concerns the	xecutive Director, and ASM #2, of Nursing) were made aware	F 645		
F 657 SS=D	(2) Anxiety Disorded dread, and uneasing Anxiety disorder is characterized as for Feelings may caus racing heart, shaking anxiety and worry information was of Institutes of Health https://www.ncbi.nt. T0024920/. Care Plan Timing CFR(s): 483.21(b) Compage \$483.21(b) Compage \$483.21(b)(2) A comp	Im.nih.gov/pubmedhealth/PMH and Revision (2)(i)-(iii) rehensive Care Plans omprehensive care plan must in 7 days after completion of	F 657	F 657 1. How will the corrective action be accomplished for those residents found to he been affected by the deficient practice? On 9/7/18, MDS Coordinator reviewed and revised the comprehensive care plan for resident #55. A patient centered care plan for Seizure Activity was implemented that	

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

Event ID: WE1L11

Feolity ID: VA0145

If continuation sheet Page 107 of 141



PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

				E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495139	B. WING		09/0	7/2018	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET		STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844			III OZFEE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 657	includes but is not (A) The attending p (B) A registered nu resident. (C) A nurse aide w resident. (D) A member of for (E) To the extent puthe resident and the resident and the resident and the resident resident in not practicable for resident's care plan (F) Other appropria disciplines as dete or as requested by (iii)Reviewed and ream after each as comprehensive an assessments. This REQUIREME by: Based on staff interior and clinical record facility staff failed to comprehensive care in the survey samp. The facility staff failed to resident #55's comost recent MDS's recent most recent	limited to- physician. It is with responsibility for the ith responsibility for the od and nutrition services staff. racticable, the participation of re resident's representative(s). Is the included in a resident's representative is determined the development of the representative is determined the development of the remined by the resident's needs the resident. revised by the interdisciplinary resessment, including both the did quarterly review INT is not met as evidenced review, facility document review review, it was determined the re plan for one of 42 residents ple, Resident #55. illed to review and revise mprehensive care plan after the was completed, to address the gnosis of and medication	F 657		y other to be affected by of seizures has his practice. On viewed all cures for essing Seizure in use. Any rrent eizure Activity their care plan by Director of into place or sure the practice t Coordinator/ Director of will educate on e plans for ion for seizures		
	The findings includence Resident #55 was	de: admitted to the facility in		Any Licensed Nurse that has n in-serviced by 10/8/18 will not provide direct care until in-serviced.	be allowed to		

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 108 of 141



PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	
		495139	B. WING		09/0	07/2018
	CENTER OF NEW M.	ARKET	3:	TREET ADDRESS, CITY, STATE, ZIP CODE 15 EAST LEE HIGHWAY EW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 657	were not limited to: condition in which a instead of the usual causes problems will develop. Down syr common causes of and diabetes. The most recent Mill assessment, a qual ARD (assessment and coded the resident difficulties and no left the resident was compaired to make difficulties and no left the resident was compaired to make difficulties and no left the resident was compaired to make difficulties of dail Diagnoses, the resident #55 was assistance of one of his activities of dail Diagnoses, the resident escitation of the following the following the following the was bleeding coming from the following. He was bleeding coming from the following the following. No response the following the f	ge 108 diagnoses that included but Down's Syndrome (A genetic a person has 47 chromosomes I 46. The extra chromosome with the way the body and brain adrome is one of the most birth defects.) (1), dementia, DS (minimum data set) rterly assessment, with an reference date) of 7/18/18, as having short-term memory rong term memory difficulties. coded as being severely laily cognitive decisions. coded as requiring extensive or more staff members for all of y living. In Section I - Active ident was coded as having a ated, 9/5/17 at 5:20 a.m. t, "At 5:00 a.m. while receiving ment), I entered the resident's ith red face, grunting is extremities with decorticate moted to have some light om his mouth. Breathing tx d. Resident's normal skin tone and he began to take deep re crossed and not focusing on onse to verbal stimuli from I outer lips, but resident mouth so I could check for the . After a few minutes his eyes ormal and resident closed his ith normal respirations. Before	F 657	Continued from page 108 All newly hired nurses will receiv on implementing and revising car orientation. All new admissions/readmissions telephone orders will be reviewed rounds (daily clinical meeting) by Nursing/Unit Manager/MDS Coodetermine if resident has diagnost and/or receives medications for seensure a patient centered care pla implemented to reflect Seizure Amedication for seizures with appressions and the work of	and lin grand lin so f seizures leizures to lin has been lin ctivity and/or loaches la week x30 ling the linel	

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 109 of 141



PRINTED: 09/18/2018 DEPARTMENT OF HEALTH AND H AN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495139 B. WING 09/07/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY LIFE CARE CENTER OF NEW MARKET **NEW MARKET, VA 22844** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CAOSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 657 Continued From page 109 F 657 moving his arms about normally." The nurse's note dated, 9/5/17 at 6:19 pm. documented, "7a-7p (7:00 a.m. to 7:00 p.m.) nursing note: Resident was observed with seizure like activity this morning lasting approximately 5-7 minutes. Resident was unresponsive, with no pupillary reflex, with abdominal breath at 32 breaths per minute. Resident was placed on side to prevent any further complications. Post seizure VS (vital signs) 120/55 (blood pressure) 93 (heart rate), 22 (respirations) O2 (Oxygen) sat (saturation) on RA (room Air). Resident was transported via ambulance to (initials of hospital)

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

seizure disorder."

ER (emergency room) for evaluation. Residents brother stated resident should have been taking Keppra 500 mg BID after previous discharge from (initials of hospital). Oder for Keppra 500 mg BID obtained, faxed to Pharmacy and is pending in delivery. Residents brother stated that resident

maintained a 'decent blood glucose.' Resident arrived back from (initials of hospital) at 5:15 p.m. with a blood glucose of 327, no insulin given. All meds (medications) from 7 am until 4 p.m. have not been given due to resident being OOF (out of facility). Resident is currently in bed resting with eves closed, with respiration being even and

Review of the active care plan dated, 2/20/15, reprinted, and revised on 7/30/18, failed to evidence documentation related to seizures. The care plan documented in part, "At risk for fall related injury - disease process - Hx (history) of

On 9/7/18, at approximately 9:15 a.m., an interview was conducted with RN (registered

has not eaten anything all day and has

unlabored. Call bell is within reach."

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 110 of 141



DEPARTMENT OF HEALTH AND HUMAN	RVICES
CENTERS FOR MEDICARE & MEDICAID SE	RVICES



PRINTED: 09/18/2018 FORM APPROVED OMB NO: 0938-0391

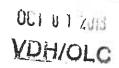
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	3/3	CONSTRUCTION		E SURVEY APLETED
		495139	B. WING		09	/07/2018
	PROVIDER OR SUPPLIE		315	EET ADDRESS, CITY, STATE, ZII EAST LEE HIGHWAY W MARKET, VA 22844		
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F 657	nurse) #3, a.m. Ricare plan to addrediagnosed as have anti-seizure medibelieve so." RN # notes from Septe documented above see if it addresse stated, "There is there should be on have to keep the An interview was practical nurse) # #3 was asked if a of seizures, would the diagnosis and "Yes, once they have to keep the have to keep the An interview was practical nurse) # #3 was asked if a of seizures, would the diagnosis and "Yes, once they have their care plan shasked the purpos stated, "It lays out and the steps to and the steps to and the steps to give that patient, we know their go. The facility policy Instrument & Cai. "The information Care Area Asses develop an indivi. Plan that include goals while resid discharge that as	IN #3 was asked if there be a less seizures for a resident ving seizures, who is on cation. RN #3 stated, "Yes, I sawas asked to review nurse's imber 2017 for Resident #55 as we and the current care plan to sethe resident's seizures. RN #3 at one here." When asked if one, RN #3 stated, "Yes, you resident safe during a seizure." conducted with LPN (licensed as on 9/7/18 at 12:13 p.m. LPN as resident with a new diagnosis decare required. LPN #3 stated, have a care plan addressing decare required. LPN #3 stated, have a diagnosis of seizures, hould be updated for it." When see of the care plan, LPN #3 at their plan of care, their goals	F 657			

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 111 of 141



DEPARTMENT OF HEALTH AND IN AN SERVICES



PRINTED: 09/18/2018

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		LE CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
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	PROVIDER OR SUPPLIER RE CENTER OF NEV			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
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F 657		if member (ASM) #1, the	F 657	7		
	nursing, were mad on 9/7/18 at 3:26 p					7.
	(1) This informatio	tion was provided prior to exit. n was obtained from the				
F 658 SS=G	· ·	s.gov/ency/article/000997.htm. Meet Professional Standards (3)(i)	F 658	3		
	The services provi	nprehensive Care Plans ided or arranged by the facility, comprehensive care plan,				320
	(i) Meet professior This REQUIREME by:	nal standards of quality. ENT is not met as evidenced				
	document review a was determined the resident was free	nterview, staff interview, facility and clinical record review, it he facility staff failed to ensure a of a significant medication error lents in the survey sample,		Past noncompliance: no plan of correction required.		
	review of hospital #55, and failed tra anti-seizure medic readmission to the	illed to ensure a complete discharge orders for Resident nscribe an order for an eation upon Resident #55's a facility on 8/31/17. The administered the anti-seizure				

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

medication from 9/1 through 9/5/17 and on 9/5/17, Resident #55 had a seizure, resulting in harm and transfer to a local emergency room.

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 112 of 141

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PRINTED. 09/18/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495139	B. WING _		09	/07/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET		STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 658	The findings included Resident #55 was January 2004 with were not limited to condition in which instead of the use causes problems develop. Down's common causes and diabetes. The most recent assessment, a quantum ARD (assessment, a quantum ARD (assessment) and the resident was impaired to make Resident #55 was assistance of one his activities of difficulties and not activities of difficulties and not assistance of one his activities of difficulties and not assistance of one his activities of difficulties and not assistance of one his activities of difficulties and not assistance of one his activities of difficulties of difficulties of difficulties of the MDS assessmedication error, ARD of 10/19/17 both short and lobeing severely in decisions. Residents assistance of one his activities of difficulties and lobeing severely in decisions. Residents assistance of one his activities of difficulties and lobeing severely in decisions. Residents assistance activity Resident was severely in the facility Repeat documented in prongue with lacer (Keppra*) omittee in seizure activity. Resident was severely as a severely in the facility Resident was severely in the fa	s admitted to the facility in h diagnoses that included but o: Down's Syndrome (A genetic n a person has 47 chromosomes all 46. The extra chromosome with the way the body and brain syndrome is one of the most of birth defects.) (1), dementia, MDS (minimum data set) uarterly assessment, with an interference date) of 7/18/18, int as having short term memory of long term memory difficulties. It is coded as being severely endaily cognitive decisions. It is coded as requiring extensive the or more staff members for all of	F 65	3		

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 113 of 141

	MENT OF HEALT	TH AND I AN SERVICES RE & MEDICAID SERVICES			FORM	09/18/2018 1 APPROVED 0. 0938-0391
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		495139	B. WING		09	/07/2018
	PROVIDER OR SUPPLIE		31!	REET ADDRESS, CITY, STATE, ZIP CODI 5 EAST LEE HIGHWAY EW MARKET, VA 22844		344 39
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F 658	Continued From to facility on 9/5/1		F 658			
	in the treatment of cannot cure epile seizures as long a pharmacokinetics studied in healthy pediatric patients and subjects with Keppra (Levetirad completely absor	to treat certain types of seizures of epilepsy. This medication psy and will only work to control as you continue to use it.(2) The sof levetiracetam have been adult subjects, adults and with epilepsy, elderly subjects renal and hepatic impairment. Cetam) is rapidly and almost bed after oral administration. Cetam) plasma half-life in adults				
	documented in parto Unit Manager ((Resident #55) has 9/5/17 and was treated to precautionary metrom the same date.	9/8/17 to the state agency art the following: "It was reported on 9/5/17 that above resident ad a seizure on the morning of ansferred to the hospital as a easure and resident returned ay, Resident had been the hospital on 9/1/17.				
	hospital on 9/1/17 orders, there wer the Nurse or Phy- medicine. This re seizure medication this resident return the facility receive	discharge orders from the 7 to this resident's previous e not any new orders noted by sician or staff for a seizure esident also was not on any on prior to his hospital stay. After med to the facility [on 9/1/17], ed by fax, the After Discharge was reviewed by Physician and		9		

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forwarded to nursing unit with no new orders.
Upon review of both documents it was noted that the After Discharge Summary, did contain a seizure medication, which this resident was not on prior to hospital stay. Nursing staff will be educated that all documents coming in for

Event ID: WE1L11

Facility ID; VA0145

If continuation sheet Page 114 of 141

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PRINTED: 09/18/2018 FORM APPROVED OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	visits need to be appropriate follow. The physician or evidence documented for the property of the physician or evidence documented in posturing to the preathing tx (treat room to find him respirations, and posturing. He was bleeding coming (treatment) stopper turned to his fabreaths. Eyes we anything. No respirations, and posturing to prevented to their eyes and began I left the room, the moving his arms. The nurse's noted documented, "7an nursing note: Relike activity this reminutes. Reside pupillary reflex, weaths per minute to prevent any for evidence of the prevent any for the prevent any for evidence of the prevent any for the prevent any for evidence of the prevent and t	page 114 e hospital or outside physician reviewed for any changes and w taken as needed." ders dated 8/31/17 failed to entation of a physician order for a dated, 9/5/17 documented, (milligrams) po (by mouth) take BID (twice a day) for seizures." dated, 9/5/17 at 5:20 a.m. art, "At 5:00 a.m. while receiving atment), I entered the resident's with red face, grunting his extremities with decorticate as noted to have some light from his mouth. Breathing tx bed. Resident's normal skin tone are and he began to take deep ere crossed and not focusing on ponse to verbal stimuli from ed outer lips, but resident so mouth so I could check for the ag. After a few minutes his eyes normal and resident closed his with normal respirations. Before the resident was smiling and about normally." e dated, 9/5/17 at 6:19 p.m., a-7p (7:00 a.m. to 7:00 p.m.) sident was observed with seizure norning lasting approximately 5-7 ent was unresponsive, with no with abdominal breath at 32 ate. Resident was placed on side on the resident complications. Post seizure 120/55 (blood pressure) 93 (heart	F	558				

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 115 of 141

	TMENT OF HEALT	TH AND HOAN SERVICES RE & MEDICAID SERVICES	30 20 10 10 10 10 10 10 10 10 10 10 10 10 10		FORM): 09/18/2018 APPROVED): 0938-0391
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F 658	(saturation) on Ratransported via an ER (emergency reprother stated research to the stated	tions) O2 (Oxygen) sat A (room Air). Resident was mbulance to (initials of hospital) room) for evaluation. Residents sident should have been taking BID after previous discharge from al). Order for Keppra 500 mg ted to Pharmacy and is pending tents brother stated that resident ything all day and has cent blood glucose.' Resident in (initials of hospital) at 5:15 p.m. tose of 327, no insulin given. All has) from 7 am until 4 p.m. have tue to resident being OOF (out of the tis currently in bed resting with the respiration being even and the pell is within reach."	F 65	8		

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

An interview was conducted with Resident #55's family member on 9/6/18 at 4:00 p.m. the family member explained to this surveyor that when Resident #55 returned from the hospital on 8/31/17, from being treated for a UTI (urinary tract infection), the facility staff didn't have an order for the Keppra. The family member explained that during his stay at the hospital Resident #55 was observed to have a grand mal seizure while in the emergency room. He was

Event ID: WE1L11

Facility ID: VA0145

RECIficantinuation sheet Page 116 of 141

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

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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

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	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, 3 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 658	started on Keppr Upon his return to asked a nurse, to Each time the nurse, to Each time the nurse didn't have an or #55 returned from longer employed and told him that here all the time. On 9/6/18 at 6:08 member (ASM) #4 ASM #2, the direct aware of the condition of the condition of the condition of the process staff when a resident LPN #4 stated, "order from the history order from the history order from the history of the medication. The ach page. After the pharmacy orders. One nurse and initiate the fix after that is print verify every order updated sheets. (medication admitistion admitistion admitistion admitistion admitistion and medication admitistion a	a in the hospital for seizures. to the facility, the family member vice, about the order for Keppra. The told him he (Resident #55) der for Keppra. After Resident in the ER on 9/5/17, a nurse (no at the facility) pulled him aside the order (for Keppra) was The property of the property of the executive director, and ctor of nursing, were made		558		

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

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 117 of 141



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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

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F 658	the MARs with the LPN #4 was asked Resident #55 retu LPN #4 stated shithe second or thin asked if she reme Keppra, LPN #4 sof family member a medication for slook at the chart. our orders; there I looked at the disresident had received and I looked went on vacation had a new order *(Lorazepam is in a benzodiazepines the brain to allow An interview was staff member (AS 9/6/18 at 6:51 p.r. had difficulty with residents transfer facility goes by the get the medication facility receives a stated he has spondocurred and the ASM #4 stated, The Resident #55) and was reviewed by physician as ASN Somehow, anoth	e orders." ed what she recalled from when urned to the facility on 9/1/17. e took care of Resident #55 on ad day he was back. When embered the family asking about stated, "No, I remember (name of saying (Resident #55) received seizures. That triggered me to I looked at hospital records and was no orders for Keppra. Then scharge packet, I noted that the elived Ativan*. He asked me did at the exact same spot. I then I came back and found out he				

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 118 of 141



DEPARTMENT OF HEALTH	AND HUMAI RVICES
CENTERS FOR MEDICARE	& MEDICAID SERVICES



PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

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	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, 2 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
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F 658	physician and it we #4 stated, now the from what they of call us. ASM #4 stated, we were record. The second order for the Kepfultimately responsible. An interview was nurse) #3, the intime of the incide asked her knowless tated, "I know the had come in. A phave the page we he was supposed find the order for the orders." When the facility, RN #	vas kept somewhere else. ASM he process is if there is a change riginally sent, the hospital has to stated that upon his return from at through the entire paper and AVS was there and had the pra. When asked who is sible, ASM #4 stated, "We are." conducted with RN (registered terim director of nursing at the ent, on 9/7/18 at 9:15 a.m. When edge of the incident, RN #3 hat there was an order set that biece was out of it. We didn't with the Keppra. The family told us do be on Keppra. We couldn't it. We were missing a page of an asked if the order was found in 3 stated, "Yes, (ASM #4 [medical trough the record, page by page	F6	558		
	member (OSM) development; on was asked abou September 2017 hospital for an ac process hasn't re information in the hospital. I print i directly. That's th asked about the stated, the hospi that the facility h print the informa provider. The AV	s conducted with other staff #17, the director of business 9/7/18 at 9:23 a.m., OSM #17 the process in place during for reciving information from the dmission. OSM #17 stated, "My eally changed. I will review the ecomputer program from the tout and hand it to the physician he end of my involvement." When process in place now, OSM #17 ital has an upgraded system and as access to the system. I still tion and hand it to the medical (S (after visit summary) is what ds. It used to be called discharge	7			

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 119 of 141



		HAND I IAN SERVICES E & MEDICAID SERVICES		50		FORM	0: 09/18/2018 MAPPROVED 0: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
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					EAST LEE HIGHWAY		
LIFE CAI	RE CENTER OF NEW	V MARKET			W MARKET, VA 22844		
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F 658	orders. It's essent the H&P (history a orders. Then I har The papers go straphysician or nurse When asked her k with Resident #55 stated that the firs 2:00 p.m. I took th set came over the second document summary). The hiprovide a discharg the doctors go by hours before the sasked why the document stated, "Sometime that the patient is being	tially the medication list. I print and physical) and that set of a dit to (ASM #4) or (ASM #5). The aight into the hands of the practitioner." Inowledge of what happened last September, OSM #17 to set of orders came in around the em down to the unit. A second fax around 4:00 p.m. It was a but an AVS (after visit pospital has up to 72 hours to be summary but the AVS is what for the orders, and it was two the econd one arrived here." When the at 4:00 p.m., OSM #17 to sit doesn't the AVS is the one walking in the door with. The are unpredictable they are for the admission steps is the was in September, last year.		558			
	executive director, asked about his ke Resident #55 on 9 had come into the reviewed the orde the nurse. It wasn seizure that (ASM	conducted with ASM #1, the on 9/7/18 at 9:55 a.m. When nowledge of the incident with 1/5/17, ASM #1 stated the order facility. The doctor (ASM #5) rs and then gave the orders to it until he went out with the #4) the medical director, went al record, page by page, and					Name of the second seco

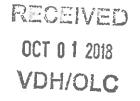
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found the order in the hospital paperwork." When asked who is ultimately responsible, ASM #1 stated, "We are." ASM #1 stated there is now a double check system by two nurses that was put

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 120 of 141



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

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

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F 658	in place after this made at this time new process that the incident. The facility policy Procedure" dated "Admission order each admission or physician, nurse assistant; obtains staff from the physician, staff from the physician of the faxed to the physician of the "Qualing of	page 120 happened." A request was for any documentation of the the facility put into place after ""Physician Order Processing for 11/19/16, documented in part, res are written prior to or upon or readmission. Or written by the practitioner or physician's ed via telephone by the nursing ysician, or transcribed from the force of the admitting orders will harmacy as soon as possible. Idedication and Treatment forceds will be created and placed a medication/treatment books." for a.m., ASM #1 presented a lity Assurance and Performance an" dated, 9/5/17, which reservation: Resident did not have resion orders from hospital." The ented, "Resident was assessed. For and responsible party was be possible missing medications. Int to ER for evaluation. Resident of facility." All residents admitted had been assisting admission wiewed for any missing orders or ors. Nursing will be educated completed prior to resident for the compare to orders received for any changes made prior al. Two nurses will review all new resing administration will review 5 I nurses not receiving in service work until education is completed. In added to orientation packet.	F	658			

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 121 of 141

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

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		495139	B. WNG		09/	07/2018
	ROVIDER OR SUPPLIER E CENTER OF NEW MA	ARKET	mail :	STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844	ii¥ Xveriii X _X ≡ ii	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(XS) COMPLETION DATE
F 658	audit 5 days a week improvement) for re Interviews were connurses. The nurses facility before the injust started working ago. All of the nurse double check system orders and following. No further information FAST NON-COMPL. (1) This information following website: https://medlineplus. (2) This information following website: https://www.ncbi.nlr. T0010898/?report=(3) This information following website: https://medlineplus.tml. (4) This information website:	rsing) to report finding of daily to PI (performance view and recommendations." Iducted with six current interviewed had been in the cident and two nurses had at the facility a few months as could correctly state the month for admission/readmission aphysician orders. IANCE was obtained from the gov/ency/article/000997.htm. was obtained from the m.nih.gov/pubmedhealth/PMH	F 658			
	m?setid=d1329893 35 Activities Meet Intel CFR(s): 483.24(c)(§483.24(c) Activitie	-a8bc-4f31-a31b-76690d1110 rest/Needs Each Resident	F 679	F 679 1. How will the corrective action accomplished for those residents	found to	10/15/18
			1	have been affected by deficient	oractice?	1

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 122 of 141



PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY LETED
		495139	B. WNG_		09/	07/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
LIFE CAR	E CENTER OF NEW I	MARKET		315 EAST LEE HIGHWAY		
LII L OAK	COUNTER OF HEN	MARKE!		NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICI	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 679	Continued From p	age 122	F6	79 Continued from page 122	100	
		e assessment and care plan es of each resident, an ongoing		Our facility policy states w	e must provide,	
	program to suppor	t residents in their choice of		based on comprehensive as	sessment and	
		ility-sponsored group and sand independent activities,		care plan and the preferenc	es of each	
		the interests of and support the and psychosocial well-being of		patient, an ongoing prograr	n to support	
	each resident, end	couraging both independence		patients in their choice of a	ctivities, both	
	and interaction in This REQUIREME	the community. ENT is not met as evidenced		facility sponsored group an	d individual	
	by:	ation, staff interview, facility		activities and independent	activities,	
	document review	and clinical record review, it		designed to meet the intere	sts of and	
		nat the facility staff failed to e activity program for one of 42		support the physical, menta	ıl, and	
		rvey sample, Resident # 75.		psychosocial well-being of	f each patient,	
	· ·	iled to provide evidence staff		encouraging both independ	ence and	
	offered and engage program of activiti	jed Resident #42 in an ongoing es.		interaction in the communi	ty. When	
	The findings inclu			Activity Director was notif	ied on 9/6/18 of	90
				concern for resident #75 sh	e immediately	
		s admitted to the facility on gnoses that included but were		assessed resident room and	placed a music	
	not limited to aner	mia (1), hypertension (2), (3), and dementia (4).		player with resident prefer	ence of radio	
	diabetes menitus	(3), and dementia (4).		station. Comprehensive car	re plan goals and	
		ost recent MDS (minimum data n assessment with an ARD		approaches for activities w	ere reviewed	
	(assessment refe	rence date) of 08/01/18, coded		and revised for resident #7	5 to indicate	
		scoring a three (3) on the brief al status (BIMS) of a score of 0		one-to one activities.		
		eing severely impaired of ing daily decisions. Resident #		2. How will the facility id	entify other	
	75 was coded as	requiring extensive assistance		residents having the potent	•	
		per for activities of daily living. ences for Customary Routine		affected by the same pract		
	and Activities" co	ded Resident # 75 as "Very				-

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

Event ID | WE1L11

Facility ID: VA0145

If continuation sheet Page 123 of 141



PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495139	B. WING		09/	07/2018
	ROVIDER OR SUPPLIER E CENTER OF NEW N	MARKET	3	STREET ADDRESS, CITY, STATE, ZIP CODE 115 EAST LEE HIGHWAY NEW MARKET, VA 22844		a var
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
F 679	Continued From pa	age 123	F 679	Continued from page 123		
36		g family or a close friend		All residents other than independen	t	
		ion about your care" and ant for going outside to get		residents are at risk to be potentially		
8	fresh air when the					
	On 00/05/48 at any	rendenataly 4,42 mm. Paridant		affected by this practice. Activities		
		proximately 1:43 p.m., Resident I lying in bed, with the bed		Director and Assistant Activities Di	rector	
	positioned was low	to floor. Observation of		will identify all residents other than		
	Resident # 75's roomusic playing or a	om failed to evidence a radio, television.		independent residents from 9/1/18,	review	
		their comprehensive care plan goals	and			
		proximately 3:00 p.m., Resident I lying in bed, with the bed		approaches to ensure activity prefer		
	positioned was low	to floor. Observation of the			CHCCS	
	Resident # 75's roomusic playing or a	om failed to evidence a radio,		are being met and available.		
	music playing or a	television.		3. What measures will be put into p		
		proximately 11:00 a.m.,		or systematic changes made to ensu	re the	
		observed lying in bed, with the slow to floor. Observation of		practice will not reoccur?		
	the Resident # 75's	s room failed to evidence a		On 9/25/18, Activities Director will	l	
	radio, music playin	g or a television.		provide written education to Assista	ant	
		proximately 3:30 p.m., Resident		Activities Director on policy we mu		
		l lying in bed, with the bed			เรเ	
		to floor. Observation of the om failed to evidence a radio.		provide, based on comprehensive		
	music playing or a	television.		assessment and care plan and the		
	The "Activities Eva	luation" for Resident # 75		preferences of each patient, an ongo	oing	
	dated 08/01/18 wa	s reviewed. Under "Activity		program to support patients in their	choice	
		nd Preferences" it documented to "Family/Friends Visits,		of activities, both facility sponsored	l group	
	Music and Radio."	· · · · · · · · · · · · · · · · · · ·		and individual activities and indepe	•	
	The comments and	o core plan for Desident # 25	6	-		
		e care plan for Resident # 75 plems: 08/02/2018. Resident		activities, designed to meet the inte		
	may need assistan	ice and encouragement to		and support the physical, mental, ar	nd	
	attend activities. F	Resident at this time is unable	K	psychosocial well-being of each pa	tient.	

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

Event ID WE1L11

Facility ID: VA0145

If continuation sheet Page 124 of 141



DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/18/2018 FORM APPROVED

CENTERS FOR MEDICARE &	MEDICAID SERVICES			OMB NO.	0938-0391
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		CONSTRUCTION	(X3) DATE S COMPL	
	495139	B. WING		09/0	7/2018
NAME OF PROVIDER OR SUPPLIER	ARKET	3	TREET ADDRESS, CITY, STATE, ZIP CODE 15 EAST LEE HIGHWAY IEW MARKET, VA 22844	1, 00,0	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY 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)	LD BE	(XS) COMPLETION DATE
attend activities of cit documented, "Encresident to attend at Invite/encourage the attend activities with participation. Monit initiated activities. For can choose events attendance at activities, attendance at activities of the process activities for resident input from the nursi resident needs one asked if they take the one-to-one activities wait for the referral OSM #18 was asked receiving any one-to-one activities. OSM #18 is not on the list for asked to provide even been offered to attendance at activities. OSM #18 is not on the list for asked to provide even offered to attendance at activities. OSM #18 is not on the list for asked to provide even offered to attendance at activities. OSM #16, activities of the residents, OSM interview, part of the and based on the activities.	er family member. ent needs to be reminded to hoice." Under "Approaches" courage, assist and remind ctivities of interest. e resident's family members to a resident in order to support or for family visits and self Post calendar in room so she to attend. Thank resident for	F 679	Continued from page 124 encouraging both independence interaction in the community. E will include guidelines of initiat one-to-one activities for Low-fu Bed-bound Residents. Activities Director will review a comprehensive care plan and ac preferences to validate needs of are being met through activities consist of 10 residents a week x with 50% of sample to include I function, Bed-bound Residents. On 9/25/18, Executive Director provide written education to Ac Director and Assistant Activitie on documentation necessary to residents were offered and enga ongoing activities program. Activities Director will review I Daily Activity Attendance Reco a week x4 weeks, 3 times a wee weekly x4 weeks to ensure documents supports residents were offered	ducation ing nction, activity tivity resident Audit will 90 days Low- will tivities s Director support ged in an Resident ord 5 times k x4 weeks umentation	

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

prefer self-directed activities. If the resident is

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 125 of 141



engaged in an ongoing activities program.

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495139	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION		PLETED
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		07/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 679	unable to answer the information from the dementia we try to one-to-one activities or a asked to describe the one-to-one activities into the room and play wants, it could be or going outside or any requested." When activities are provided stated, "Two to three was asked to review MDS with an ARD (of 08/01/18, and the When asked about activities, OSM # 16 one-to-one list and When asked to provide the provided asked to accompany of the provided with a sked to accompany of the provided has asked about the provided has asked about Resident # 75 date. "The evaluation is company of the provided with OSi when asked about Resident # 75 date." The evaluation is company of the provided has asked about three days." After the evaluation of the Resident # 75 date. "The evaluation of the Resident of the provided has a sked about the provided has a sked about the provided has a sked about Resident # 75 date." The evaluation is company of the provided has a sked about the provided has a sked to p	the questions, we get the se family. If they have get them involved in so or get them to come to combination of both." When the process for providing so, OSM # 16 stated, "We go rovide whatever the resident conversation, prayer, singing, sything the family has asked how often one-to-one and to residents, OSM # 16 to the times a week." OSM # 16 to the times a week." OSM # 16 to the care plan dated 08/02/2018. Providing Resident # 75 to stated, she should be on the getting one-to-one activities." A stated, she should be on the getting one-to-one activities." A stated, she should be on the getting one-to-one activities. The stated of the stated of the stated of the stated, "I'm going to t	F 679	Continued from page 125 4. How will the facility mo corrective plan to ensure the practice was corrected and a Activities Director will presof audits accurate assessment to the Quality Assurance Pel Improvement committee for recommendations for 90 day committee consist of Execu Director of Nursing, Assista Nursing, Social Services, A Dietary Manager, Pharmacy Medical Director.	e deficient not reoccur? tent findings nt findings reformance review and ys. The QAPI tive Director, ant Director of ctivities,	

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 126 of 141



DEPARTMENT OF HEAL	TH AND HUMA	RVICES
CENTERS FOR MEDICA	RE & MEDICAL	D SERVICES

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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
		495139	B. WING			09	/07/2018
,	ROVIDER OR SUPPLIE			315	REET ADDRESS, CITY, STATE, ZIP CODI EAST LEE HIGHWAY W MARKET, VA 22844		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	provided and eve ask the resident in The facility's "Active Manual, Suggested documented, "Ex Room-bound Active Music, Correspor Reality Orientation On 09/06/18 at any (administrative sted director, ASM #2, made aware of the No further inform References: (1) Low iron. This the website: https://www.nlm.r (2) High blood probationed from the https://www.nlm.r (3) A chronic diseregulate the amoinformation was continued to the amoinformation was continued to the second of the second o	under "Preferences" should be n if an item is not checked I will if they would like to try it." Ivity & Recreation Services ed Activity Program, Chapter 3" amples of Bed-bound / vities: Arts and Crafts, Bedside idence, Games/Exercises, in and Religious Activities." Opproximately 3:26 p.m. ASM aff member) #1, the executive the director of nursing, were se findings. ation was provided prior to exit. Information was obtained from hih.gov/medlineplus/anemia.html		679			

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY PLETED
		495139	B. WING		ng	/07/2018
6.	ROVIDER OR SUPPLIER	MARKET	3	TREET ADDRESS, CITY, STATE, ZIP CODE 15 EAST LEE HIGHWAY IEW MARKET, VA 22844	1 03	10712010
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
F 679	Continued From p	page 127 s.gov/ency/article/000739.htm.	F 679	100		A I H
F 695 SS≃D	Respiratory/Trach CFR(s): 483.25(i) § 483.25(i) Respir	eostomy Care and Suctioning	F 695	F 695 1. How will the corrective acti accomplished for those resider		10/15/18
	The facility must e needs respiratory care and tracheal	e and tracheal suctioning. ensure that a resident who care, including tracheostomy suctioning, is provided such		have been affected by the defice practice?	cient	
	practice, the compare plan, the res and 483.65 of this			On 9/6/18, Unit Manager apprresident #60 to clean and propestore CPAP mask and tubing.		
	by: Based on observ	ENT is not met as evidenced attention ation, resident interview, staff document review, and clinical		Resident #60 declined Unit Materials to perform task. Unit Manager	provided	
	record review it w staff failed to prov with professional	as determined, that the facility ride respiratory care consistent standards of practice for one of		education for resident #60 incl increased risk of respiratory in related to resident declining to	fection	
	#60.	e survey sample, Residents		CPAP mask in storage bag wh	ile not in	
	CPAP (continuous	ailed to store Resident #60's s positive airway pressure) r to prevent infection.		use. Unit Manager reviewed as revised comprehensive care pl	an to	
	The findings inclu			reflect resident preferences and approaches. Resident #60 is	d	
	4/13/2018 with dia	s admitted to the facility on agnosis that included but were		independent with care of her C and she wishes to leave CPAP		
	(Obstructive sleep	structive sleep apnea o apnea [OSA] is a problem in ning pauses during sleep. This		to air dry on her nightstand; sh	ne does	
	occurs because o	ing pauses ouring sleep. This if narrowed or blocked airways) uctive pulmonary disease		not want to place her mask in a provided storage bag. Most re		
	(COPD- is a gene	eral term for chronic, g disease that is usually a		resident assessment dated 7/21 reflected BIMS 15.	./18	

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

Event ID WE1L11

Facility ID: VA0145

If continuation sheet Page 128 of 141

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	S FUR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495139	B. WNG		09/07/2018
NAME OF P	ROMDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAR	E CENTER OF NEW MA	ARKET	1	315 EAST LEE HIGHWAY NEW MARKET, VA 22844	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 695	combination of emp bronchitis) (2) and continuous is a condition in white enough blood to me failure does not meator is about to stop wheart is not able to put can affect one or in The minimum data assessment, with an (ARD) of 7/21/18, continuous in the BIMS (brit	hysema and chronic congestive heart failure (CHF ch the heart can't pump set the body's needs. Heart an that your heart has stopped working. It means that your pump blood the way it should. both sides of the heart.) (3) set (MDS), a quarterly assessment reference date oded the resident as scoring a sef interview for mental status) se was capable of making	F 695	Continued from page 128 2. How will the facility identify residents having the potential to affected by the same practice? All residents using a CPAP/BiP the potential to be affected by the On 9/6/18, Unit Managers evaluates with CPAP/BiPAP and other masks were stored properly time. On 9/19/18, Unit Manage	be AP have is practice. ated all I all y at that
	The physician order "CPAP/BiPAP* setti millimeters of mercu while sleeping every order on 9/6/2018 d storage bag q (ever CPAP mask in stora *Positive airway pre to pump air under p lungs. This helps ke sleep. The forced a (continuous positive episodes of airway breathing in people and other breathing On 09/05/18 at 12:	r dated 8/17/2018 documented ngs 5-20 (mmHg or ary) with 3L (liters) oxygen y shift". A second physician documented "Change CPAP y) week (Sunday). Place age bag when not in use". essure (PAP) "uses a machine aressure into the airway of the ep the windpipe open during ir delivered by CPAP airway pressure) prevents collapse that block the with obstructive sleep apnea		Director of Nursing evaluated al residents with CPAP/BiPAP ord ensure proper storage of mask. CPAP/BiPAP mask found to be improperly was wiped down, air then stored properly at bedside. 3. What measures will be put in or systematic changes made to e practice will not reoccur? By 10/8/18, Staff Development Coordinator/Director of Nursing Manager will educate on proper	lers to Any stored dried, to place ensure the
	#60's CPAP mask v	vas observed on the resident's ed. On 09/06/18, at 9:00 a.m. on was made, again the CPAP		air dry, and storage of BiPAP/C	-

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mask was observed on the resident's nightstand

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 129 of 141

PRINTED: 09/18/2018 FORM APPROVED OMB NO: 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE : COMPL	
		495139	B. WING		09/0	07/2018
	ROVIDER OR SUPPLIER E CENTER OF NEW		3.	TREET ADDRESS, CITY, STATE, ZIP CODE 15 EAST LEE HIGHWAY EW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 695	09/06/18 at 3:27 #5 who noted the nightstand uncov conducted with R how a CPAP mas #5 responded "In a CPAP mask shoresponded "For c dirty." When ask mask is being sto mask is not in a b Review of Reside	d observation was made on p.m. with Registered Nurse (RN) CPAP mask was on the ered. An interview was N #5 at that time. When asked the is stored when not in use, RN plastic bags". When asked why buld be covered, RN #5 teanliness to keep from getting ed how Resident #60's CPAP ored, RN #5 stated, "The CPAP	F 695	Continued from page 129 Any Licensed Nurse that has a in-serviced by 10/8/18 will not to provide direct care until incompleted. All newly hired not receive education on proper of dry, and storage of BiPAP/CP and tubing on orientation. Direct of Nursing/Unit Manager/Staff Development Coordinator will proper storage of BiPAP/CPA tubing 5 times a week x30 day	t be allowed service is urses will leaning, air AP mask ector of l evaluate P mask and	
	2018 and Septen documented the documented the According to the administration por mask should be proved should be allowed be bagged/ store. In Fundamentals Patricia A. Potter Inc.; Page 648. E. Causes of Health under Respirator respiratory theraps.			week x30 days, 1 time a week 4. How will the facility monicorrective plan to ensure the depractice was corrected and not Director of nursing will present of audit accurate assessment to QAPI committee for review a recommendations for 90 days committee consist of Executive Director of Nursing, Assistant Nursing, Social Services, Act Dietary Manager, Pharmacy of	toring the leficient treoccur? Int findings the md The QAPI The Director, t Director of ivities,	
	L	:27 p.m., the ASM		Medical Director.	onsuitalit,	

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 130 of 141

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

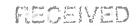
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		495139	B. WING_		09	/07/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 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 760 SS=G	No further informa 1. This information website: https://medlineplus 2. This information website: https://www.nlm.ni 3. This information website: https://med. 4. This information website: https://med. this information website: https://medlineplus Residents are Free CFR(s): 483.45(f)(The facility must e §483.45(f)(2) Resimedication errors. This REQUIREME by: Based on family indocument review a was determined the one of 42 resident.	ASM#2 the director of nursing ove concerns. tion was provided prior to exit. was obtained from the s.gov/ency/article/000811.htm. was obtained from the th.gov/medlineplus/copd.html. was obtained from the edlineplus.gov/heartfailure.html was obtained from the s.gov/ency/article/001916.htm e of Significant Med Errors 2)	F 69		f	
	from the hospital of failed to administe medication for sei Resident #55 had	5's readmission to the facility, on 8/31/17, the facility staff r a newly prescribed zures from 9/1 through 9/5/17, a seizure on 9/5/17, resulting in r to a local emergency room.	At the state of th			

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 131 of 141



DEPARTMENT OF HEALTH AND H	AN SERVICES
CENTERS FOR MEDICARE & MEDICA	AID SERVICES

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PRINTED. 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	1	S		PLETED
		495139	B. WING	Weighten V	09/0	7/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 760	The findings included Resident #55 was January 2004 with were not limited to condition in which instead of the usure causes problems develop. Down sy common causes of and diabetes. The most recent is assessment, a quantum ARD (assessment, a quantum ARD (assessment) and infliculties and note that the resident was make daily cognitic coded as requiring more staff members living. The MDS assessment is a member of 10/19/17, both short and long as severely impaired extensive assistant members for all of the Facility Report of the resident was sent of the resident was		F 760			

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 132 of 141



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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION		TE SURVEY MPLETED
		495139	B. WING		09	0/07/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP 315 EAST LEE HIGHWAY NEW MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIEN		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 760	to facility on 9/5/1 *Keppra- is used in the treatment of cannot cure epile seizures as long pharmacokinetics studied in healthy pediatric patients and subjects with Keppra (Levetiral completely absorkeppra (Levetiral is 7 ± 1 hour. (4) The letter dated documented in puto Unit Manager (Resident #55) health 19/5/17 and was the precautionary means from the same direadmitted from the same direadmitted from the Nurse or Phymedicine. This resizure medications are returned to nurse of the After Discharseizure medication prior to hospital on prior to pri	-				

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 133 of 141

DEPARTMENT OF HEALTH AND H	AN SERVICES
CENTERS FOR MEDICARE & MEDICARE	CAID SERVICES

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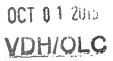
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ELE CONSTRUCTION		ATE SURVEY OMPLETED
	1-181-11	495139	B. WING		0	9/07/2018
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COD 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		Wal III
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC 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 760	visits need to be a appropriate follow The physician ord evidence docume Keppra. A telephone order "Keppra 500 mg (page 133 e hospital or outside physician reviewed for any changes and a taken as needed." Hers dated 8/31/17 failed to entation of a physician order for dated, 9/5/17 documented, (milligrams) po (by mouth) take BID (twice a day) for seizures."	F 760			
	documented in particle breathing tx (treat room to find him was respirations, and posturing. He was bleeding coming to (treatment) stopper returned to his fact breaths. Eyes we anything. No respiration of the company	dated, 9/5/17 at 5:20 a.m. art, "At 5:00 a.m. while receiving tment), I entered the resident's with red face, grunting his extremities with decorticate is noted to have some light from his mouth. Breathing tx ed. Resident's normal skin tone be and he began to take deep ere crossed and not focusing on conse to verbal stimuli from douter lips, but resident mouth so I could check for the g. After a few minutes his eyes formal and resident closed his with normal respirations. Before a resident was smiling and about normally."				
	documented, "7a- nursing note: Res like activity this m minutes. Resider pupillary reflex, w breaths per minut to prevent any fur	dated, 9/5/17 at 6:19 p.m., -7p (7:00 a.m. to 7:00 p.m.) -ident was observed with seizure orning lasting approximately 5-7 -it was unresponsive, with no -ith abdominal breath at 32 -ie. Resident was placed on side -ther complications. Post seizure -20/55 (blood pressure) 93 (heart				

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

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 134 of 141



DEPARTMENT	OF HEALTH	I AND HUMA	 ERVICES
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CENTERS FOR	₹MEDICARE	- & MEDICAID	SERVICES

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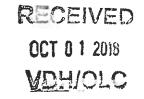
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	LE CONSTRUCTION		TE SURVEY MPLETED
		495139	B. WING		09	/07/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844	<u>-</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 760	(saturation) on RA transported via am ER (emergency robrother stated resic Keppra 500 mg Bll (initials of hospital) BID obtained, faxe in delivery. Reside has not eaten anyt maintained a 'decearrived back from with a blood glucos meds (medications not been given due facility). Resident eyes closed, with runlabored. Call be The comprehensive revised on 8/31/17 documentation of ton the care plan. The "Discharge State of the Care plan. The "Discharge State of the Care plan. The "Discharge State of the Care plan. An interview was of family member on member explained Resident #55 returns 8/31/17, from bein tract infection), the order for the Kepp explained that during Resident #55 was	cons) O2 (Oxygen) sat (room Air). Resident was bulance to (initials of hospital) com) for evaluation. Residents dent should have been taking D after previous discharge from . Order for Keppra 500 mg d to Pharmacy and is pending ints brother stated that resident hing all day and has ent blood glucose.' Resident (initials of hospital) at 5:15 p.m. se of 327, no insulin given. All is from 7 am until 4 p.m. have et to resident being OOF (out of is currently in bed resting with espiration being even and	F 760			

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

Event ID WE1L11

Facility ID: VA0145

If continuation sheet Page 135 of 141



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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		E SURVEY MPLETED
		495139	B. WING		09	/07/2018
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP C 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		DEMOCIÁNIE
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 760	Upon his return to asked a nurse, to Each time the nudidn't have an ord #55 returned from longer employed and told him that here all the time. On 9/6/18 at 6:08 member (ASM) # ASM #2, the direct aware of the conditional expension of the condition of the conditional expension of the condition of the conditional expension of the condition of the conditional expension of the condition of the	a in the hospital for seizures. In the facility, the family member vice, about the order for Keppra. It is told him he (Resident #55) der for Keppra. After Resident in the ER on 9/5/17, a nurse (no at the facility) pulled him aside the order (for Keppra) was It p.m. administrative staff in the executive director, and octor of nursing, were made	F 76			

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

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 136 of 141

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DEPARTMENT OF HEALTH AND HUMA	RVICES
CENTERS FOR MEDICARE & MEDICAID	SERVICES

PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION 3		E SURVEY MPLETED
		495139	B. WING _		09/	07/2018
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, Z 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 760	the MARs with the LPN #4 was asked Resident #55 retu LPN #4 stated shithe second or thin asked if she reme Keppra, LPN #4 of family member a medication for slook at the chart. Our orders; there I looked at the distresident had receiving and I looked went on vacation had a new order the brain to allow An interview was staff member (AS 9/6/18 at 6:51 p.r. had difficulty with residents transfer facility goes by the get the medication facility receives a stated he has spontaged occurred and the ASM #4 stated, The Resident #55) and was reviewed by	d what she recalled from when urned to the facility on 9/1/17. e took care of Resident #55 on d day he was back. When embered the family asking about stated, "No, I remember (name) saying (Resident #55) received seizures. That triggered me to I looked at hospital records and was no orders for Keppra. Then scharge packet, I noted that the sived Ativan*. He asked me d at the exact same spot. I then I came back and found out he for Keppra. I wan] is used to relieve anxiety. A class of medications called a lt works by slowing activity in for relaxation. (3) conducted with administrative SM) #4, the medical director; on an, ASM #4 stated the facility has obtaining the correct orders for a red to the facility. He stated the e AVS (after visit summary) to ans in the facility. Sometimes the second and third AVS. He oken to the hospital after this y are only sending one AVS. The hospital sent the AVS (for d the Keppra was not on it. It (ASM #5), the covering				
	Somehow, anoth	If #4 stated he was out of town. er AVS [for Resident #55] came it was not signed by the				

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 137 of 141

DEPARTMENT OF HEALTH AND H 'AN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY

AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING _		COMPLETED
		495139	B. WING		09/07/2018
	PROVIDER OR SUPPLIER		31	REET ADDRESS, CITY, STATE, ZIP COI 5 EAST LEE HIGHWAY EW MARKET, VA 22844	
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 760	#4 stated, now the from what they oricall us. ASM #4 st vacation, we went record. The secon order for the Kepp ultimately respons An interview was onurse) #3, the intetime of the inciden asked her knowled stated, "I know the had come in. A pin have the page with he was supposed find the order for it the orders." When the facility, RN #3	as kept somewhere else. ASM process is if there is a change ginally sent, the hospital has to ated that upon his return from through the entire paper d AVS was there and had the ra. When asked who is ible, ASM #4 stated, "We are." conducted with RN (registered rim director of nursing at the t, on 9/7/18 at 9:15 a.m. When alge of the incident, RN #3 at there was an order set that ece was out of it. We didn't in the Keppra. The family told us to be on Keppra. We couldn't asked if the order was found in stated, "Yes, (ASM #4 [medical bugh the record, page by page	F 760		
	member (OSM) #* development; on 9 was asked about t September 2017, hospital for an adr process hasn't rea information in the hospital. I print it t directly. That's the asked about the p stated, the hospita that the facility has print the information	conducted with other staff 17, the director of business 17/18 at 9:23 a.m., OSM #17 he process in place during for reciving information from the nission. OSM #17 stated, "My lly changed. I will review the computer program from the but and hand it to the physician end of my involvement." When rocess in place now, OSM #17 Il has an upgraded system and access to the system. I still on and hand it to the medical (after visit summary) is what			

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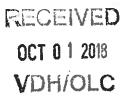
the hospital sends. It used to be called discharge

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 138 of 141

PRINTED: 09/18/2018



PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		riple construction NG		TE SURVEY MPLETED
		495139	B. WING		0!	9/07/2018
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP C 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	orders. It's esser the H&P (history a orders. Then I ha The papers go stiphysician or nurse. When asked her with Resident #55 stated that the firs 2:00 p.m. I took the second documen summary). The reprovide a discharthe doctors go by hours before the asked why the domatch the docum stated, "Sometim that the patient is Discharge summelate. The process same today as it We still print the sto the physician of the	ntially the medication list. I print and physical) and that set of and it to (ASM #4) or (ASM #5). raight into the hands of the expractitioner." knowledge of what happened is last September, OSM #17 is set of orders came in around them down to the unit. A second is fax around 4:00 p.m. It was a to but an AVS (after visit hospital has up to 72 hours to ge summary but the AVS is what for the orders, and it was two second one arrived here." When becoments at 2:00 p.m. didn't tents at 4:00 p.m., OSM #17 is it doesn't the AVS is the one walking in the door with. Aries are unpredictable they are for the admission steps is the was in September, last year. It is an educated with ASM #1, the result of the incident with 9/5/17, ASM #1 stated the order is facility. The doctor (ASM #5) is and then gave the orders to	F 70			
	seizure that (ASN through the clinic found the order in asked who is ultin stated, "We are."	n't until he went out with the M #4) the medical director, went al record, page by page, and in the hospital paperwork." When mately responsible, ASM #1 ASM #1 stated there is now a stem by two nurses that was put				

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

Event ID:WE1L11

Facility ID: VA0145

If continuation sheet Page 139 of 141

OCT 0 1 2018 VDH/OLC

	TMENT OF HEALT RS FOR MEDICAR	TH AND I AN SERVICES RE & MEDICAID SERVICES			PRINTED: 09/18/20 FORM APPROVE OMB NO. 0938-039	ΞD
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495139	B. WING		09/07/2018	
	PROVIDER OR SUPPLIE		31	REET ADDRESS, CITY, STATE, ZIP CODE 5 EAST LEE HIGHWAY EW MARKET, VA 22844	101 a	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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 APPRI DEFICIENCY)	JLD BE COMPLETIO	N
F 760	made at this time new process that the incident. The facility policy Procedure" dated "Admission order each admission or physician, nurse assistant; obtains staff from the phytransfer orders. A be faxed to the plan initial set of M Administration rein the appropriate On 9/7/18 at 11:5 copy of the "Qual Improvement Plandocumented "Obekeppra on admis" Actions" documented documented "Actions" documented do	happened." A request was, for any documentation of the the facility put into place after "Physician Order Processing I, 11/19/16, documented in part, are written prior to or upon or readmission. Or written by the practitioner or physician's and via telephone by the nursing resician, or transcribed from the acopy of the admitting orders will narmacy as soon as possible. edication and Treatment cords will be created and placed a medication/treatment books. " 1 a.m., ASM #1 presented a ity Assurance and Performance on dated, 9/5/17, which servation: Resident did not have sion orders from hospital." The ented, "Resident was assessed. Itor) and responsible party was	F 760			

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notified of seizure possible missing medications. Resident was sent to ER for evaluation. Resident was sent back to facility." All residents admitted since (ASM #5) had been assisting admission orders will be reviewed for any missing orders or transcription errors. Nursing will be educated when orders are completed prior to resident arriving they must compare to orders received when resident arrives for any changes made prior to leaving hospital. Two nurses will review all new admissions. Nursing administration will review 5 days a week. All nurses not receiving in service training will not work until education is completed. Education will be added to orientation packet.

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 140 of 141

OCT 0 1 2018

VDH/OLC

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PRINTED: 09/18/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED 09/07/2018	
		495139				
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET				STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 760	DON (director of raudit 5 days a wee improvement) for Interviews were conurses. The nurse facility before the just started working. All of the nurse orders and following. No further information of the in	nursing) to report finding of daily ek to PI (performance review and recommendations." onducted with six current es interviewed had been in the incident and two nurses had ag at the facility a few months ses could correctly state the em for admission/readmission and physician orders. Ation was provided prior to exit. PLIANCE On was obtained from the entering solution seed the service of the provided prior to exit. T	F 76	50		

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

Event ID: WE1L11

Facility ID: VA0145

If continuation sheet Page 141 of 141