	-	ID HUMAN SERVICES			FORM APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		495139	B. WING		C 01/06/2022
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAR	E CENTER OF NEW MA	RKET		15 EAST LEE HIGHWAY IEW 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
E 000	Initial Comments		E 000		
F 000	Survey was conducte facility was in substar	nergency Preparedness ed 1/4/22 through 1/6/22. The ntial compliance with 42 CFR ment for Long-Term Care	F 000		
	survey was conducte complaint (VA000540 investigated during th required for complian	dicare/Medicaid standard d 1/4/22 through 1/6/22. One 10- unsubstantiated) was e survey. Corrections are ce with 42 CFR Part 483 are requirements. The Life eport will follow.			
F 554 SS=D	87 at the time of the s consisted of 30 curre closed record reviews Resident Self-Admin	8 certified bed facility was survey. The survey sample nt resident reviews and 5 s. Meds-Clinically Approp	F 554		2/18/22
	defined by §483.21(b this practice is clinica	erdisciplinary team, as)(2)(ii), has determined that			
	interview, clinical reco document review, the 1 of 35 residents in th self administration of Resident #31 was ob	n, resident interview, staff ord review and facility a facility staff failed to assess a survey sample for safe medications, Resident #31. served with prescribed ed and unsupervised by staff		1. Self Assessment of Medication Administration will be completed for resident #31. Assessment will be reviewed by IDT to evaluate if resident can safely self administer medication an follow facility policy and procedure. Car plan for resident #31 will be reviewed a revised as indicated.	e
LABORATORY I	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	 :E	TITLE	(X6) DATE
	cally Signed				01/18/2022

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

			0.00			IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			E SURVEY IPLETED
			A. BUILDING	<u> </u>		С
		495139	B. WING			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		1/06/2022
				315 EAST LEE HIGHWAY		
LIFE CAR	E CENTER OF NEW MA	RKET	NEW MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 554	Continued From pag	e 1	F 55	54		
	The findings include:			2. Resident's that have	a BIM score of 15	
				independent, and wish		
		lmitted to the facility with		medication will have a	Self Assessment of	
	diagnoses that include but were not limited to Parkinson's disease (1), dysphagia (2) and atrial			Medication Administrat		
		(1), dysphagia (2) and atrial		resident that meets crit		
	fibrillation (3).			administer, their care p to reflect assessment.	bian will be updated	
	Resident #31's most	recent MDS (minimum data				
		uarterly assessment with an		3. Staff Development C	Coordinator will	
		ference date) of 11/12/2021		provide education of th		
		as scoring a 15 on the BIMS		policies to all licensed		
		ental status) assessment,		Administration of Medi		
	decisions.	intact for making daily		Dose Preparation and		
	decisions.			Administration", and "S Medications". Any licer		
	Resident #31 was ob	oserved on 1/4/2022 at		not completed education		
		.m. Resident #31 was out of		not be allowed to work	-	
		ized wheelchair. The		completed. All newly h	ired nurses will	
		front of Resident #31 with a		receive education durin		
	-	aining two visible medication		the following facility po		
		d medication cup containing		Administration of Medi		
		time an interview was dent #31. Resident #31		Dose Preparation and Administration", and "S		
	stated that the nurse	had left the medications for er eating. Resident #31		Medications".	Solage of	
	stated that she had r	-		Staff Development Coo	ordinator will review	
		advised her to wait at least		Residents Right to self		
	•	ng any protein to take her		medications in next Re		
	medication for Parkir			Meeting.		
		e medications on the bed				
	side table with the ap	opiesauce.		Unit Manager or Desig		
	The eMAR (electroni	c medication administration		administration of medic quarterly care meeting	-	
		22-1/31/2022 for Resident		residents that may wis		
		dications most recently		medications in the futu		
		dent #31 at 1:00 p.m. on				
	1/4/2022.			Director of Nursing or I		
	,			Medication self admini		
	i ne comprehensive	care plan for Resident #31		and accurate and audit	care plan reflects	

Facility ID: VA0145

If continuation sheet Page 2 of 26

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		495139	B. WING		C 01/06/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAR	E CENTER OF NEW MAP	RKET		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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC
F 554	Continued From page	2	F 554		
	failed to evidence doo self-administration of			self administration for all residen identified. Audit will be complete x 12 weeks.	
	evidence an assessm medications or a phys medications to be saf bedside for her to tak On 1/5/2022 at appro- interview was conduct nurse) #2. RN #2 state an order in place to g bolus with applesauce not supposed to be le- bedside. RN #2 state that Resident #31 wis 30 minutes after prote stated that they should medication for Parkin after she had finished them in the room. RN completed self-admin assessments on resid demonstrate taking th independently and no residents with inhaler leaving the facility wit	Tely left at Resident #31's e unsupervised. ximately 1:20 p.m., an ted with RN (registered ted that Resident #31 had ive her medications as a e but the medications were eff unattended at the ed that they were not aware shed to take the medications eins until 1/4/2022. RN #2 Id have brought the son's back to Resident #31 I eating rather than leave N #2 stated that they istration of medication dents who could heir medications ormally did these on s or anyone who was h a medication. RN #2 ot have an assessment		4. Director of Nursing or Designer present findings of audit to the C Assurance Performance Improve (QAPI) committee for review and recommendations x3 months. Q Committee will consist of Execut Director, Director of Nursing, Sta Development Coordinator, Socia Services, MDS Coordinator, Pha Consultant, and Medical Director	uality ement I API ive iff I armacy
		r the facility policies on ation, medication storage			

Facility ID: VA0145

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 03/10/2022 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495139	B. WING			_		C 06/2022
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
LIFE CAR	E CENTER OF NEW MAR	₹KET			315 EAST LEE HIGHWAY NEW MARKET, VA 228	44		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 554	documented in part, " leave medications or The facility policy, "Se Medications" dated 11 "2. Facility, in conju Interdisciplinary Care determine, with respe Self-Administration of clinically appropriate, functionality and heal should document the medications in the res Facility should docum medications in the res Facility should docum medications in the res The facility policy, "St of Medications, Biolog Needles" dated 12/1/("Facility should not medications or biolog Physician/Prescriber Interdisciplinary Care administration" On 1/5/2022 at appro (administrative staff m director, and ASM #2 made aware of the ab No further information References: 1. Parkinson's disea A type of movement of was obtained from the	Facility staff should not chemical unattended" elf Administration of 1/28/16 documented in part, unction with the Team, should assess and ect to each resident, whether i medications is safe and based on the resident's th condition11. Facility Self-Administration of sident's care plan. 12. hent the self-storage of sident's care plan." torage and Expiration Dating gicals, Syringes and 07 documented in part, administer/provide bedside icals without a order and approval by the Team and Facility ximately 4:30 p.m., ASM hember) #1, the executive , the director of nursing were bove concern. h was provided prior to exit.	F	554				

Facility ID: VA0145

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		495139	B. WING				06/2022
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
LIFE CAR	E CENTER OF NEW MAR	RKET			815 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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 554 F 622 SS=D	obtained from the well https://www.nlm.nih.g sorders.html. 3. atrial fibrillation A problem with the sp heartbeat. This inform the website: <https: www.nlm.nih.<br="">ion.html>. Transfer and Discharg CFR(s): 483.15(c)(1)(§483.15(c) Transfer at §483.15(c)(1) Facility (i) The facility must per remain in the facility, discharge the resident (A) The transfer or dis resident's welfare and cannot be met in the facility (B) The transfer or dis because the resident's sufficiently so the resident's</https:>	r. This information was bsite: lov/medlineplus/swallowingdi beed or rhythm of the mation was obtained from gov/medlineplus/atrialfibrillat ge Requirements (i)(ii)(2)(i)-(iii) and discharge- requirements- ermit each resident to and not transfer or it from the facility unless- scharge is necessary for the d the resident's needs facility; scharge is appropriate 's health has improved ident no longer needs the		622			2/18/22
	endangered due to th status of the resident; (D) The health of indir otherwise be endange (E) The resident has appropriate notice, to under Medicare or Me Nonpayment applies	viduals in the facility is le clinical or behavioral ; viduals in the facility would					

Facility ID: VA0145

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/10/2022 APPROVED 0. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495139	B. WING _				(01/	C 06/2022
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, 2	ZIP CODE		
				31	15 EAST LEE HIGHWAY			
	E CENTER OF NEW MAR	(KE I		Ν	EW MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
F 622	Continued From page		F	522				
	payment or after the t Medicare or Medicaid resident refuses to par resident who become admission to a facility resident only allowabl or (F) The facility ceases (ii) The facility may no resident while the app § 431.230 of this chap exercises his or her ri- discharge notice from 431.220(a)(3) of this of discharge or transfer or safety of the reside facility. The facility m that failure to transfer §483.15(c)(2) Docume When the facility trans- resident under any of in paragraphs (c)(1)(i) section, the facility m or discharge is docum- medical record and ap communicated to the institution or provider. (i) Documentation in t must include: (A) The basis for the t (i) of this section. (B) In the case of para section, the specific re-	hird party, including , denies the claim and the y for his or her stay. For a s eligible for Medicaid after , the facility may charge a e charges under Medicaid; a to operate. the transfer or discharge the weal is pending, pursuant to obter, when a resident ght to appeal a transfer or the facility pursuant to § chapter, unless the failure to would endanger the health nt or other individuals in the ust document the danger or discharge would pose. entation. sfers or discharges a the circumstances specified (A) through (F) of this ust ensure that the transfer mented in the resident's opropriate information is receiving health care the resident's medical record ransfer per paragraph (c)(1) agraph (c)(1)(i)(A) of this esident need(s) that cannot		222				
	needs, and the servic facility to meet the needs	its to meet the resident e available at the receiving ed(s). n required by paragraph (c)						

Facility ID: VA0145

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 03/10/202 RM APPROVE IO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	(X3) DATE SURV COMPLETED		
		495139	B. WING		C 01/06/2022		
NAME OF PI	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	E CENTER OF NEW MA	RKET		15 EAST LEE HIGHWAY			
				EW MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 622	discharge is necessa (A) or (B) of this secti (B) A physician when necessary under para this section. (iii) Information provide must include a minim (A) Contact information (A) Contact information (B) Resident represe contact information (C) Advance Directive (D) All special instruct ongoing care, as app (E) Comprehensive of (F) All other necessa copy of the resident's consistent with §483. any other documenta a safe and effective t This REQUIREMENT by: Based on staff interv and facility document failed to evidence that and comprehensive of provided to the receiver	hust be made by- ysician when transfer or ry under paragraph (c) (1) ion; and transfer or discharge is agraph (c)(1)(i)(C) or (D) of ded to the receiving provider num of the following: on of the practitioner are of the resident. Intative information including e information totons or precautions for ropriate. are plan goals; ary information, including a e discharge summary, 21(c)(2) as applicable, and tion, as applicable, to ensure ransition of care. T is not met as evidenced riew, clinical record review a review, the facility staff at the physician wrote a note, care plan goals were ving facility upon a hospital esidents in the survey	F 622	 Resident #39 safely returned on 11/10/2021. Director of Nursing or Design audit all facility initiated transfers/discharges from 1/6/20 current to ensure the following of been met: *Provider has a documented pro- 	ee will 022 to criteria has		
	6/21/19, hospitalized on 11/10/21. Resider but not limited to high	mitted to the facility on on 11/7/21 and readmitted nt #39 had the diagnoses of blood pressure, congestive oke. The most recent MDS		note present in the resident med record that reflects needs for transfer/discharge. *Evidence present in the medica that facility staff sent comprehensive care plan for res	al record		

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		MEDICAID SERVICES					NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495139	B. WING _			c	C 01/06/2022	
NAME OF PF	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
	E CENTER OF NEW MAI	DVET		31	15 EAST LEE HIGHWAY			
	E CENTER OF NEW MA	ARE I		N	EW MARKET, VA 22844			
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR I	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 622	Continued From page	<u>ə</u> 7	F	522				
		was 5-day readmission		522	receiving facility.			
		1/17/21. The resident was			3. Staff Development Coordinator will			
		ely cognitively impaired in			provide education to Universal Health			
		fe decisions. The resident			Providers to reflect evidence of provide	er		
	•	ng extensive assistance for			progress note following facility initiated	l		
		of daily living except for			transfer/discharge.			
	eating, which require	d limited assistance.			Staff Development Coordinator will			
	A review of the clinica	al record revealed the			provide education to all licensed nurse	s		
	following nurse's note				that resident medical record must cont			
	5				evidence that comprehensive care pla	n		
		resident continues with			was sent to receiving facility following			
		y this shift. resident had			facility initiated transfer/discharge. Any			
		alert but not oriented to			licensed nurse that has not received th	ne		
	person, place, time a	nd situation. resident hknow". resident's pupils			education before 2/15/22 will not be allowed to work until education is			
	reactive bilaterally, ur				complete. All newly hired licensed nurs	sed		
		ng fingers. resident states			will receive education in new hire	Jou		
	• • •	s of) pain. bil (bilateral) lung			orientation.			
		piratory distress noted.						
		sugar): 201, Temp elevated			Director of Nursing or Designee will au			
	at 101.6, room was v				all facility initiated transfers/discharges			
		temp (temperature) of tylenol (1) per md (medical			ensure medical record reflects evidence of the the following criteria:	e		
	-	ested per facility protocol			*Provider has a documented progress			
		resident's temp decreased			note present in the resident medical			
		alert and oriented to person,			record that reflects needs for			
		e questions appropriately,			transfer/discharge.			
		s. resident is resting quietly			*Evidence present in the medical reco	rd		
	-	ed with no pain or discomfort			that facility staff sent	-		
	noted."				comprehensive care plan for resident to receiving facility.	0		
	11/7/21 at 12:39 PM:	"Daughter (name)			<u> </u>			
	-	bout her dads confusion.			Audit will be conducted 5x per week x4			
		call provider who ordered UA			weeks, weekly x4 weeks, then x1 for 1			
		ith culture and sensitivity),			month.			
	CBC (3 - complete bl	ooa count), CMP (4 -						

Facility ID: VA0145

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/10/2022 M APPROVED D. 0938-0391	
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495139	B. WING				C /06/2022	
NAME OF PF	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	E CARE CENTER OF NEW MARKET			3	15 EAST LEE HIGHWAY			
				N	IEW MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 622	Continued From page	2 8	F	622				
	and 1 gram of Rocepi (intramuscularly for or informed about new of time." 11/7/21 at 2:56 PM: ' tested during shift and (nurse practitioner) av and resident aware of 11/7/21 at 7:01 PM: ' and is unable to arous eating or drinking d/t house done and looks administered @ (at) 1 buttocks. Per Daught ER (emergency room evaluation." 11/7/21 at 8:38 PM: ' in facility visiting resid send resident out to E resident to be sent ou (doctor) (name) award 11/8/21 at 12:47 AM: of hospital) for urosep The above notes did f documentation was p	hin (5) IM x 1 ne dose). Daughter (name) orders. No concerns at this 'Resident was covid and flu d was negative. MD/NP ware, RP (responsible party) f results." 'Resident is very lethargic se at this time. Resident not not being awake. UA in s positive. IM Rocephin 1750 (5:50 PM) in right er requests, sending out to i) (name of hospital) for 'RP-Daughter, (name), was dent when it was decided to ER. RP aware are requested at @ 1930. On Call Dr e of resident being sent out." "resident admitted to (name osis." not evidence what rovided to the receiving no note located in the clinical		022	present findings of audit to the Quality Assurance Performance Improvemen (QAPI) committee for review and recommendations x3 months. QAPI Committee will consist of Executive Director, Director of Nursing, Staff Development Coordinator, Social Services, MDS Coordinator, Pharma Consultant, and Medical Director.	t		
		person, primary care						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495139	B. WING				C 06/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAR	E CENTER OF NEW MAR	RKET	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 622	allergies, precautions etc. However, it did r comprehensive care i the hospital. In addition, there was wrote a note regardin On 1/6/22 at 10:00 Al conducted with LPN # Nurse). She stated th when residents are tr the checklist is kept in stated that upon a tra medication list, care p form, and pertinent la and that the physician #5 was asked for a co On 1/6/22 at 10:17 Al with LPN #5, she pro- of this checklist revea care plan goals were asked if a copy of a c the clinical record for hospital transfer of 11 not. When asked if th she stated that he ha A review of the facility Discharges" documer permit each resident not transfer or discha facility unless-(A) The necessary for the res resident's needs cam facilityDocumentati	 alerts, devices, treatments, not document that the plan goals were provided to a no evidence the physician g this hospitalization. M, an interview was #5 (Licensed Practical nat a check list is completed ansferred and that a copy of a the clinical record. She nsfer, the facesheet, olan, nurses notes, transfer bs are sent to the hospital a should write a note. LPN opy of this checklist. M, in a follow up interview vided the checklist. A review ided that comprehensive listed. However, when ompleted checklist was in Resident #39 regarding the /7/21, she stated that it was he physician wrote a note, d not. y policy, "Transfers and nted, "The facility must to remain in the facility, and rge the resident from the a transfer or discharge is ident's welfare and the not be met in the 	F	622			

Facility ID: VA0145

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION 495139 B. WING 01/06/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 01/06/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY NEW MARKET, VA 22844 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			ID HUMAN SERVICES				FORM	M APPROVED 0. 0938-0391
Mate OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE UFE CARE CENTER OF NEW MARKET STREET ADDRESS, CITY, STATE, 2P CODE 00100/ TYD STREET ADDRESS, CITY, STATE, 2P CODE 001000/ TYD STREET ADDRESS, CITY, STATE, 2P CODE 0010000 STREET ADDRESS, CITY, STATE, 2P CODE 00100000 STREET ADDRESS, CITY, STATE, 2P CODE 0010000000 STREET ADDRESS, CITY, STATE, 2P CODE 0010000000000000000000000000000000000	STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	SURVEY
NMLE OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY STRE 2P CODE LIFE CARE CENTER OF NEW MARKET STREET ADDRESS. CITY STRE 2P CODE OWID PREFIX TG SUMMARY STREMENT OF DEFICIENCIES (EACH DEPICIENCY WOR LES CEREDED BY FULL RECOLLATORY OR LSC DENTIFYING INFORMATION) PD F 622 Continued From page 10 (I)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(0) of this section, the case of paragraph (c)(1)(0) of this section. (B) In the case of paragraph (c)(1)(0) of this section. (B) In the case of paragraph (c)(1)(0) of this section. (B) In the case of paragraph (c)(1)(0) of this section. (B) In the case of paragraph (c)(1)(0) of this section. (B) In the case of paragraph (c)(1)(0) of this section. (B) In the case of paragraph (c)(1)(0) of (D) of (D) of (D) of this section must be made by (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(0) (C) or (D) of this section. (B) Information provided to the receiving facility to meet the need(s). (B) Resident intergreentative information provided to the care of the resident. (B) Resident intergreentative information provided to the receiving must include a minimum of the following: (A) Contact information of the praditioner responsible for the care of the resident. (B) Resident intergreentative information (C) Ald special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, any other documentation, resplicable, and any other documentation, as applicable, to			495139	B. WING				-
LIFE CARE CENTER OF NEW MARKET NEW MARKET, VA 22844 (K4)ID PREFX TX6 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECOLLTORY OR LSC DENTERING INFORMATION) PD PREFX TX6 PROVDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECOLLTORY OR LSC DENTERING INFORMATION) PE PREFX TX6 PROVDER'S PLAN OF CORRECTION (EACH DEFICIENCY MIST BE PRECEDED BY FULL RECOLLTORY OR LSC DENTERING INFORMATION) PE PREFX TX6 PROVDER'S PLAN OF CORRECTION (CARS REFERENCED TO THE APPROPRIATE DEFICIENCY) OPENING (EACH DEFICIENCY MIST BE PRECEDED BY FULL RECOLLTORY OR LSC DENTERING INFORMATION) PE PREFX TX6 PROVDER'S PLAN OF CORRECTION (CARS REFERENCED TO THE APPROPRIATE DEFICIENCY) OPENING (CARS REFERENCED TO THE APPROPRIATE DEFICIENCY DEFICIENCY (A) (Through (F) of this section, the facility must ensure that the transfer or discharge is of paragraph (c)(1)(0) of this section, the specific resident need(s) hat cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). If The documentation required by paragraph (c) (C) (2)(0) of this section, (B) Inter ansfer or discharge is necessary under paragraph (c)(1)(1) (C) (C) (C) (C) (D) of the section (C) (C) (D) of the section (C) (C) (D) of the section (C) (C) (D) (C) (D) of the care of the resident. If Resident representative information provided to the receiving rowider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. If Resident representative information (C) (D) At special instructions or precautions for ongoing care, as appropriate. If Resident representative information (C) (D) applicable, and any other documentation, as applicable, and any other	NAME OF PF	ROVIDER OR SUPPLIER	•	•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
WEW MARKET, VA 2844 PREER/ TVG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PD PREER/ TAG PROVIDENTS FUN OF CONRECTION (EACH CORRECTIVE ACTION SHOULD BE CROBS-REFERENCED TO THE APROPRIATE DEFICIENCY) COMMENT DATE F 622 Continued From page 10 (i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. Documentation in the resident's medical record and appropriate information or provider. Documentation in the resident's medical record and the service available at the receiving facility to meet the need(s). F 622 (ii) The documentation required by paragraph (c) (2)(1) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident's medical record must include: (I)(1)(A) of this section. (B) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (2)(1) of this section. (iii) Information provided to the receiving facility to meet the need(s). F 622 (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information (I) All special instructions or precautions for ongoing care, as appropriat. (F) All other necessary information, (D) All special instructions or precautions for ongoing care, as appropriat. (F) All other necessary information, (D) All special instructions or precautions for ongoing care, as appropriat. (F) All other necessary information, including a copy					3	315 EAST LEE HIGHWAY		
Precinv TAG LEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC.IDENTIFYING INFORMATION) PRETIX TAG C(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 622 Continued From page 10 (i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(0) of this section. (B) In the case of paragraph (c)(1)(0) of this section. (B) In the case of paragraph (c)(1)(0) of this section. (B) In the case of paragraph (c)(1)(0) of this section. (B) In the case of paragraph (c)(1)(0) of this section. (B) In the case of paragraph (c)(1)(0) of this section. (B) In the case of paragraph (c)(1)(0) of this section. (B) In the case of paragraph (c)(1)(0) of this section. (B) In the case of paragraph (c)(1)(0) of this section and by (C) (2)(0) of this section must be made by (A) The resident service available at the receiving facility to meet the need(s). F 622 (ii) The documentation required by paragraph (c) (2)(1) of this section must be made by (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(0) (C) or (D) of this section: (B) Information provided to the receiving provider must include a minimum of the following: (A) Contact information (C) Advance Directive information, including a copy of the resident's applicable, and any other documentation, as applicable, to	LIFE CAR	E CENTER OF NEW MAR	RKET		r	NEW MARKET, VA 22844		
 (i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) in the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c) (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i) (C) or (D) of this section. (ii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident sidischarge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
On 1/5/22 at the end of day meeting at approximately 4:30 PM, ASM #1 and ASM #2 (Administrative Staff Member), the Executive	F 622	 (i)(A) through (F) of the ensure that the transfer documented in the reappropriate information receiving health care. Documentation in the must include: (A) The paragraph (c)(1)(i) of of paragraph (c)(1)(i) of of paragraph (c)(1)(i) of a paragraph (c)(1)(i) of a paragraph (c)(1)(i) of a paragraph (c)(1)(i) of a paragraph (c)(1)(i) of the service available is meet the need(s). (ii) The documentation (2)(i) of this section moresident's physician with section; and (B) A discharge is necessari (C) or (D) of this section provided to the receive minimum of the follow (A) Contact information (C) Advance Directive (D) All special instruction ongoing care, as appi (E) Comprehensive c (F) All other necessari copy of the resident's consistent with §483 any other documentate ensure a safe and effect on the follow of the resident's consistent with §483 any other documentate ensure a safe and effect on the follow of the resident's consistent with §483 any other documentate ensure a safe and effect on the follow of the follow of the resident's consistent with §483 any other documentate ensure a safe and effect on the follow of the follow of the resident's consistent with §483 any other documentate ensure a safe and effect on the follow of the follow of	his section, the facility must fer or discharge is sident's medical record and on is communicated to the institution or provider. resident's medical record e basis for the transfer per this section. (B) In the case (A) of this section, the d(s) that cannot be met, eet the resident needs, and at the receiving facility to n required by paragraph (c) nust be made by- (A) The when transfer or discharge is agraph (c) (1) (A) or (B) of A physician when transfer or ry under paragraph (c)(1)(i) on. (iii) Information ring provider must include a <i>ving</i> : on of the practitioner are of the resident. native information including e information tions or precautions for ropriate. are plan goals; y information, including a discharge summary, 21(c)(2) as applicable, and tion, as applicable, to ective transition of care."	F	622			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		495139	B. WING				C 106/2022	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	·		
LIFE CAR	E CENTER OF NEW MAP	RKET			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E ACTION SHOULD BE CO TO THE APPROPRIATE		
F 622	Director and Director were made aware of information was provi survey. References: (1) Tylenol: is used to pain. Information obtained in https://medlineplus.go tml (2) Urinalysis and Cul Urinalysis is the exam physical properties, s organisms, or particul urinalysis is easy, che recommended as par all patients and shoul warranted. A urine culture is a lal or other germs in a ur Sensitivity analysis de of antibiotics against such as bacteria that cultures. Information obtained https://wew.ncbi.nlm. Information obtained https://medlineplus.go (3) CBC: The CBC co diseases and disorde infections, clotting pro-	of Nursing, respectively, the findings. No further ded by the end of the or relieve mild to moderate from by/druginfo/meds/a681004.h lture and Sensitivity: nination of urine for certain olutes, cells, casts, crystals, late matter. Because eap, and productive, it is t of the initial examination of d be repeated as clinically b test to check for bacteria rine sample. etermines the effectiveness microorganisms (germs) have been isolated from from nih.gov/books/NBK302/ from py/ency/article/003751.htm from by/ency/article/003741.htm an help detect blood rs, such as anemia, oblems, blood cancers, and ders. This test measures	F	622				

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	-	D HUMAN SERVICES MEDICAID SERVICES			FC	NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) D.	ATE SURVEY DMPLETED C
		495139	B. WING _			01/06/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
LIFE CAR	E CENTER OF NEW MAR	RKET		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 CC ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 622 F 641 SS=B	Information obtained in https://www.nhlbi.nih. s (4) CMP: A comprehe group of blood tests. picture of your body's metabolism. Metaboli and chemical process energy. Information obtained in https://medlineplus.go (5) Rocephin: is use Information obtained in https://medlineplus.go tml Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mus resident's status. This REQUIREMENT by: Based on clinical rec interview, the facility s a significant change M resident assessment survey sample, Resid not coded as receivin The findings include: Resident #53 was add diagnoses that include	from gov/health-topics/blood-test ensive metabolic panel is a They provide an overall chemical balance and sm refers to all the physical ses in the body that use from ov/ency/article/003468.htm d to treat certain infections from ov/druginfo/meds/a685032.h ents of Assessments. t accurately reflect the ' is not met as evidenced ord review and staff staff failed to correctly code <i>I</i> DS (minimum data set) for 1 of 35 residents in the ent #53. Resident #53 was	F 6		et hospice on site. w all spice services urately. nator will coordinators hat review ant change in	2/18/22

Event ID: PC7S11

Facility ID: VA0145

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	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		495139			C 01/0	6/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
LIFE CAR	E CENTER OF NEW MAI	RKET		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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 641	change assessment is coded Resident #53 a interview for mental is - 15, 15 - being cogni decisions. Section O documentation of Re- services. The physician's order documented in part, ' Order Date: 12/7/202 The comprehensive of dated 12/7/2021 doct resident has a termin Anticipate weight loss participation in ADLs decline in participation decline in cognitive p 12/07/2021" On 1/06/2022 at 8:17 conducted with LPN of MDS coordinator. LF significant change as Resident #53 was co hospice services. LF significant change MI 12/8/2021 and stated and they must have r choose hospice servi they followed the RAU instrument) manual for assessments. LPN # correct the MDS to in	recent MDS, a significant with an ARD of 12/8/2021, as scoring a 15 on the brief status (BIMS) of a score of 0 tively intact for making daily failed to evidence sident #53 receiving hospice rs for Resident #53 'Admit for hospice services. 1." care plan for Resident #53 umented in part, "The al prognosis. Hospice, s, delayed healing, decline in (activities of daily living), n in activities of choice, rocessing. Date Initiated: f a.m., an interview was (licensed practical nurse) #2, PN #2 stated that the sessment completed for mpleted when they began PN #2 reviewed the	F 64	 in a hospice program. Any MDS Coordinator that has not complete education by 2/16/22, will not be to work until education is complete newly hired MDS nurses will recor- education during orientation that RAI manual for accurately coding change in condition consistent withospice services. Director of Nursing or designee without a sessessments of residents of a hospice program weekly x8 wetthen monthly x1 month. 4. Director of Nursing or Designet present findings of audit to the Q Assurance Performance Improvet (QAPI) committee for review and recommendations x3 months. Q/ Committee will consist of Execut Director, Director of Nursing, Sta Development Coordinator, Socia Services, MDS Coordinator, Pha Consultant, and Medical Director 	allowed ted. All eive reflects g a ith will audit enrolled in eks and ee will uality ement API ive ff I armacy	

Facility ID: VA0145

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		495139	B. WING				06/2022
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAR	E CENTER OF NEW MAR	RKET			815 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	October 2018, page 2 "A SCSA (significan assessment) is requir terminally ill resident of (Medicare-certified or provider) or changes remains a resident at must be within 14 day the hospice election (later than the date of statement, but not ear performed regardless was recently conducte ensure a coordinated hospice and nursing h On 1/6/2022 at appro (administrative staff m director and ASM #2, made aware of the fin No further information References: 1. congestive heart fa A condition in which the blood to meet the bood does not mean that ye about to stop working not able to pump blood affect one or both side information was obtai https://medlineplus.go	2-23 documented in part, t change in status red to be performed when a enrolls in a hospice program State-licensed hospice hospice providers and the nursing home. The ARD ys from the effective date of which can be the same or the hospice election rlier than). A SCSA must be of whether an assessment ed on the resident. This is to plan of care between the nome is in place" ximately 8:45 a.m., ASM nember) #1, the executive the director of nursing were adings. n was provided prior to exit.	F	641			

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						NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		· · · ·	TE SURVEY MPLETED	
		495139	B. WING			C 1/06/2022	
NAME OF P	ROVIDER OR SUPPLIER	•	STRE				
LIFE CAR	E CENTER OF NEW MA	RKET	315 I NEV				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 641	Continued From page		F 641				
	https://medlineplus.g	ov/chronickidneydisease.htm					
F 656 SS=D	Develop/Implement C CFR(s): 483.21(b)(1)	Comprehensive Care Plan	F 656			2/18/22	
	implement a compred care plan for each re- resident rights set for §483.10(c)(3), that in objectives and timefr- medical, nursing, and needs that are identif assessment. The cor describe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the r- under §483.10, inclu- treatment under §483. (iii) Any specialized s rehabilitative services provide as a result of recommendations. If findings of the PASAI rationale in the reside (iv)In consultation wit resident's representa (A) The resident's go desired outcomes.	ames to meet a resident's d mental and psychosocial fied in the comprehensive mprehensive care plan must g - are to be furnished to attain ent's highest practicable d psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). services or specialized s the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. th the resident and the					

Facility ID: VA0145

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		ND HUMAN SERVICES MEDICAID SERVICES					M APPROVE 0. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495139	B. WING			0	C I/06/2022	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LIFE CAR	E CENTER OF NEW MA	RKET	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 PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ACTION SHOULD BE COMPLE TO THE APPROPRIATE DATE		
F 656	Continued From page	e 16	F	656				
	community was asse	essed and any referrals to						
		es and/or other appropriate						
	entities, for this purpo	ose.						
		in the comprehensive care						
		in accordance with the						
	requirements set fort section.	h in paragraph (c) of this						
		T is not met as evidenced						
	by:	i is not met as evidenced						
		on, clinical record review,			1. MDS Coordinator corrected resi	dent		
		acility document review, the			#50 comprehensive care plan to re			
	facility staff failed to o	develop a care plan for side			use of side rails while surveyor was	s still on		
	rail use for 1 of 35 re Resident #50.	sidents in the survey sample;			site.			
	The findings include:				 MDS Coordinator will review all residents that have a physician ord side rail use. MDS Coordinator will 			
		lmitted to the facility on			each resident with a physician orde			
		noses of but not limited to			side rail use has a care plan develo	oped to		
	dementia, depression	•			convey order.			
		st recent MDS (Minimum ificant change assessment			2 Staff Dovelopment Coordinatory	vill		
		sment Reference Date) of			 Staff Development Coordinator v provide education to MDS Coordinator 			
	· ·	ent was coded as being			facility policy of "Care Planning - Ba			
		mpaired in ability to make			Comprehensive, and Routine Upda			
		The resident was coded as			Any MDS Coordinator that has not			
		or bathing and extensive			completed education by 2/16/22, w			
		er areas of activities of daily			be allowed to work until education i	S		
	living.				completed. All newly hired MDS			
	On 1/4/22 at 3:35 PM	A Resident #50 was			Coordinator(s) will receive education during orientation on the facility pol			
		ep, with the head of the bed			"Care Planning - Baseline,	юy.		
	elevated, and the hal	•			Comprehensive, and Routine Upda	ites".		
	bilaterally.							
	,				Director of Nursing or Designee wil	l audit		
	A review of the clinica	al record revealed an			10 different residents weekly x11 w	eeks		
	-	of Bed Rails form dated			for side rail orders compared to car	•		
	2/1/21 that document				then will x1 week ALL residents wit	h side		
	recommended at all f	times when resident is in			rail orders and ensure their			

Facility ID: VA0145

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMP	
		495139	B. WING			06/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LIFE CAR	E CENTER OF NEW MAP	RKET		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656 F 684 SS=D	reveal any evidence to revised to include the On 1/6/22 at 10:00 AI conducted with LPN # Nurse). She stated the plan was to set goals care for the resident. can update the care por rails should be care por should be. A review of the facility Baseline, Comprehent documented, "The must be updated with periodically." It was noted in the elect the resident had 4 ME date of the side rail evo observation on 1/4/22 On 1/5/22 at the end approximately 4:30 P (Administrative Staff ID Director and Director were made aware of information was provisurvey. Quality of Care CFR(s): 483.25 § 483.25 Quality of care	rehensive care plan failed to hat it was reviewed and use of side rails. M, an interview was t5 (Licensed Practical hat the purpose of the care for the resident and to guide She stated that any nurse plan. When asked if side lanned, she stated that they policy "Care Planning - usive, and Routine Updates" comprehensive Care Plan each MDS assessment and ectronic clinical record that DS's completed between the valuation of 2/1/21 and the comprehensing at M, ASM #1 and ASM #2 Member), the Executive of Nursing, respectively, the findings. No further ded by the end of the	F 64	comprehensive care plan accurately reflects side rail use. 4. Director of Nursing or Designee will present findings of audit to the Quality Assurance Performance Improvement (QAPI) committee for review and recommendations x3 months. QAPI Committee will consist of Executive Director, Director of Nursing, Staff Development Coordinator, Social Services, MDS Coordinator, Pharmac Consultant, and Medical Director.		2/18/22
	rails should be care p should be. A review of the facility Baseline, Comprehen documented, "The must be updated with periodically." It was noted in the ele the resident had 4 ME date of the side rail ev observation on 1/4/22 On 1/5/22 at the end approximately 4:30 P (Administrative Staff I Director and Director were made aware of information was provi survey. Quality of Care CFR(s): 483.25 § 483.25 Quality of care	lanned, she stated that they policy "Care Planning - isive, and Routine Updates" comprehensive Care Plan each MDS assessment and ectronic clinical record that DS's completed between the valuation of 2/1/21 and the c. of day meeting at M, ASM #1 and ASM #2 Member), the Executive of Nursing, respectively, the findings. No further ded by the end of the	F 6	Consultant, and Medical Director.	у	2/18/22

Facility ID: VA0145

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TATEMENT	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	IO. 0938-039 TE SURVEY MPLETED
		495139	B. WING		С	
	ROVIDER OR SUPPLIER	400100		STREET ADDRESS, CITY, STATE, ZIP CODE	•	1/06/2022
				315 EAST LEE HIGHWAY		
LIFE CAR	E CENTER OF NEW MA	RKET		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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 684	Continued From page 18 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow a physician's order to administer a medication for one of 35 residents in the survey sample, Resident #35. The facility staff failed to follow a physician's order to limit a resident's Tylenol dosage to 3000 mgs (milligrams) in a 24 hour period on 10/27/21, 10/29/21, 10/31/21, 11/1/21, 11/9/21, and 12/5/21.		F 684	1. Resident #35 physician ord reviewed. New order obtained discontinue Tylenol 650mg giv to equal 1,300mg by mouth ev as needed for pain. New order transcribed to administer Tylen give 2 tablets to equal 1,000mg times a day for pain. 2. Director of Nursing or Desig	to e 2 tablets ery 4 hours was iol 500mg g three	
	7/1/19, and most rec with diagnoses inclu- bilateral below the kr peripheral vascular of MDS (minimum data with an ARD (assess 11/15/21, the resider cognitive impairment having scored 15 our interview for mental s A review of Resident revealed the followin "Tylenol 8 Hour Arthu Release 650 mg (mil mouth every 6 hours	dmitted to the facility on ently readmitted on 8/7/20, ding arthritis, diabetes, nee amputations, and disease. On the most recent set), a quarterly assessment sment reference date) of at was coded as having no t for making daily decisions, t of 15 on the BIMS (brief status).		audit for unnecessary pain med all residents with a physician o includes Tylenol and paramete exceed 3,000mg in a 24 hour p Audit will consist of scheduled needed orders. Any resident th potential to receive unnecessa medications, including more th 3,000mg of Tylenol in a 24 hou medical provider will be notified order will be obtained to ensure resident does not exceed 3,000 Tylenol in a 24 hour period. (ie 500mg give 2 tabs to equal 1,0 mouth three times a day as nee 3. Staff Development Coordina provide education on facility po procedure ""General Dose Pre and Medication Administration"	dication on rder that rrs to not beriod. and as nat has ry pain an ur period, d and a new e that 000mg of ., Tylenol 000mg by eded). ator will blicy and paration	

Facility ID: VA0145

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ATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
		495139	B. WING		0	C 1/06/2022
NAME OF PF	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZI		
LIFE CARI	E CENTER OF NEW MA	RKET		315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
040.15	SI IMMADV S	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN		(ME)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 684	Continued From pag	ie 19	F 68	34		
	hours."			includes review of Unne	cessary Pain	
				Medication to all license	-	
		t #15's MARs (medication ds) for October, November,		licensed nurse that has education by 2/16/22, wi	•	
ar fo do 39	and December 2021	,		to work until education is		
		ident #35 received three		newly hired licensed nur		
		ition in 24 hours, totaling grams): 10/27/21, 10/29/21,		education during orienta facility policy and procee		
	10/31/21, 11/1/21, 1 ⁻			Dose Preparation and M Administration".		
		t #35's comprehensive care				
	in part: "Resident is	and updated 3/3/20 revealed, at risk for		Ongoing monitoring will residents weekly x11 we		
		in meds (medications) as		Tylenol orders will be rev		
	ordered.			week x1 week.		
	On 1/5/22 at 1:21 p.r	m., LPN (licensed practical		4. Director of Nursing or	Designee will	
	,	iewed. When asked to review		present findings of audit	-	
		rs and the MARs referenced It looks like he sometimes got		Assurance Performance (QAPI) committee for rev		
		ne should." When asked if the		recommendations x3 mo		
		s being followed, she stated:		Committee will consist o		
		en she administers an on, she looks back to		Director, Director of Nurs Development Coordinate		
		me it was administered. She		Services, MDS Coordina		
		ear; the resident is able to		Consultant, and Medical	Director.	
	-	urs apart in 24 hours; but ny more than that. She stated				
		ible for doing the math and				
	ensuring the residen	t does not get too much				
	medicine. She stated the resident's liver fu	d too much Tylenol can put Inction at risk.				
		., ASM (administrative staff				
	-	ecutive director, and ASM #2,				
	the director of nursin concerns.	g were notified of these				

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		D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 03/10/2022 M APPROVED O. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495139	B. WING			C / 06/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAR	E CENTER OF NEW MAP	RKET		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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684 F 695 SS=D	revealed, in part: "Prid medication, facility sta the correct medication correct route, at the c A review of the facility revealed no information responsibility of the fac physician's orders. No further information	cation Administration," or to administration of aff shouldverifythat it is n, at the correct dose, at the orrect time" policy, "Physician Orders,"	F 68			2/18/22
	needs respiratory can care and tracheal suc care, consistent with p practice, the compreh care plan, the residen and 483.65 of this suf This REQUIREMENT by: Based on observation interview, facility docu- record review, the fac respiratory treatment manner for one of 35 sample, Resident #90 occasions, Resident #	d tracheal suctioning. Irre that a resident who e, including tracheostomy tioning, is provided such professional standards of ensive person-centered ts' goals and preferences, opart. is not met as evidenced n, resident interview, staff Imment review, and clinical ility failed to store equipment in a sanitary residents in the survey		 Resident #90 CPAP was san stored per facility policy and pro while surveyor was still on site. While surveyors were still on residents utilizing respiratory tre equipment were assessed to en equipment was stored in a sanit manner per facility policy and pr Staff Development Coordinator provide education to all licensed 	site, all eatment sure their ary rocedure. will	

Event ID: PC7S11

Facility ID: VA0145

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TATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
		495139	B. WING		C 01/06/2022
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE
LIFE CAR	E CENTER OF NEW MAI	RKET		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 C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE COMPLETION OTHE APPROPRIATE DATE
F 695	9//24/18 with diagnoss brain injury, a stroke, recent MDS (minimur assessment with an A date) of 12/27/21, the having no cognitive in decisions, having sco BIMS (brief interview On 1/4/22 at 2:56 p.n Resident #90's CPAF uncovered, and in di pillows. Resident #90' wheelchair in his roor "always" cleans the O his pillow, uncovered A review of Resident revealed the following "CPAP/BIPAP: Press maskon while sleep awakeClean CPAP water, rinse and air d A review of Resident administration record and December 2021 revealed Resident #90 ordered, and that the A review of Resident plan dated 7/15/19 ar in part: "The resident status/difficulty breat	mitted to the facility on ses including a traumatic and diabetes. On the most m data set), a quarterly ARD (assessment reference e resident was coded as mpairment for making daily ored 15 out of 15 on the for mental status). n. and 1/5/22 at 10:22 a.m. P mask was observed rect contact with his bed D was sitting up in the m. He stated the staff CPAP mask and places it on #90's physician's orders g order, dated 4/9/20: ure setting 13-16. Full face bing/napping and off while mask with warm soapy ry as needed daily." #90's MARs (medication s) for October, November, and for January 2022 00 wore his CPAP as mask was cleaned daily. #90's comprehensive care ind updated 3/30/20 revealed, has altered respiratory	F 69	 on facility policy and proc Respiratory Equipment C Storage. Any licensed nu completed education by 2 be allowed to work until e completed. All newly hire nurses will receive educa orientation that reflects R Equipment Cleaning and Director of Nursing or De all residents with respirate equipment 5x per week x week x4 weeks, and wee ensure respiratory equipr a sanitary manner per fac procedure. 4. Director of Nursing or II present findings of audit to Assurance Performance (QAPI) committee for rev recommendations x3 mon Committee will consist of Director, Director of Nurs Development Coordinato Services, MDS Coordinat Consultant, and Medical I 	leaning and rse that has not 2/16/22, will not education is d licensed tion during espiratory Storage. signee will audit ory treatment 4 weeks, 2x per kly x4 weeks to nent is stored in cility policy and Designee will to the Quality Improvement iew and nths. QAPI Executive ing, Staff r, Social tor, Pharmacy

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/10/2022 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		495139	B. WING				C / 06/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				3	315 EAST LEE HIGHWAY		
LIFE CAR	E CENTER OF NEW MAR	RKET		N	NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	assistant) #1 was inter a CPAP mask should she stated it should be and preferably placed asked why the mask as she stated: "We don't She added the mask as and it needs to be clear On 1/5/22 at 1:21 p.m. nurse) #1 was intervise has specific bags for a equipment in resident the mask is washed, it then placed in the bag storage is "all about in" On 1/05/22 4:29 p.m., member) #1, the exect the director of nursing concerns. A review of the facility Administration Policy, information related to CPAP mask when not No further information (1) "CPAP (Continuou is a treatment that use your breathing airway CPAP machine that in device that fits over yo mouth, straps to posit connects the mask to motor that blows air in to treat sleep-related to	rviewed. When asked how be stored when not in use, e stored in a plastic bag, linside a drawer. When should be stored this way, want to have germs on it." goes on the resident's face, an to prevent infection. A., LPN (licensed practical ewed. She stated the facility storage of all respiratory rooms. She stated it after t should be air dried, and g. She stated CPAP mask affection control." ASM (administrative staff cutive director, and ASM #2, were notified of these r policy, "CPAP " failed to reveal an sanitary storage of the t in use by the resident. a was provided prior to exit. Is Positive Airway Pressure) es mild air pressure to keep s openIt involves using a accludes a mask or other our nose or your nose and ion the mask, a tube that the machine's motor, and a not the tube. CPAP is used	F	695			

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′	LE CONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY IPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	C	
		495139	B. WING		0	1/06/2022
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAR		RKET		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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 695	Continued From page	e 23	F 69	95		
	from the website					
	•	.gov/health-topics/cpap.		_		0/40/00
F 757 SS=D		e from Unnecessary Drugs -(6)	F 75			2/18/22
	unnecessary drugs.	sary Drugs-General. regimen must be free from An unnecessary drug is any				
	drug when used-					
	§483.45(d)(1) In exce duplicate drug therap	essive dose (including by); or				
	§483.45(d)(2) For exe	cessive duration; or				
	§483.45(d)(3) Withou	It adequate monitoring; or				
	§483.45(d)(4) Withou use; or	it adequate indications for its				
	§483.45(d)(5) In the p consequences which reduced or discontinu	indicate the dose should be				
	stated in paragraphs section.	ombinations of the reasons (d)(1) through (5) of this				
	This REQUIREMENT by:	Γ is not met as evidenced				
		view, facility document		1. Resident #35 physician ord		
1	failed to prevent a result of the second sec	edication for one of 35		reviewed. New order obtained discontinue Tylenol 650mg giv to equal 1,300mg by mouth ev	e 2 tablets very 4 hours	
		ey sample, Resident #35.		as needed for pain. New order		
	•	d to follow a physician's nt's Tylenol dosage to 3000		transcribed to administer Tyler give 2 tablets to equal 1,000m	-	
		iod on 10/27/21, 10/29/21,		times a day for pain.	y ແມ່ ເ ຮັ	

Event ID: PC7S11

Facility ID: VA0145

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA						OMB NO. 0938-039 (X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			C		
							B. WING
		NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	
LIFE CARE CENTER OF NEW MARKET				315 EAST LEE HIGHWAY			
	E CENTER OF NEW MAR	KKEI		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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	LD BE COMPLETIO	
F 757	Continued From page 24		F 75	7			
				2. Director of Nursing or De	signee will		
	The findings include:			audit all residents with a phy			
	Desidert #05			for Tylenol and parameters			
		mitted to the facility on ently readmitted on 8/7/20,		3,000mg in a 24 hour period consist of scheduled and as			
		ling arthritis, diabetes,		Tylenol. Any resident that ha			
	bilateral below the kn			receive more than 3,000mg			
		isease. On the most recent		24 hour period, medical pro			
		set), a quarterly assessment		notified and a new order wil	l be obtained		
		ment reference date) of		to ensure that resident does			
		t was coded as having no		3,000mg of Tylenol in a 24 l			
		for making daily decisions,		(ie., Tylenol 500mg give 2 ta			
	interview for mental s	of 15 on the BIMS (brief tatus).		1,000mg by mouth three tim needed).	ies a day as		
	A review of Resident #35's clinical record			3. Staff Development Coord	linator will		
		g order, dated 7/16/21:		provide education on facility			
		tis Pain Tablet Extended		procedure ""General Dose F			
		igrams) Give 2 tablets by		and Medication Administrati			
	-	as needed for pain. DO S (grams/1000 mgs) in 24		licensed nurses. Any license has not completed educatio			
	hours."	3 (grams/1000 mgs) m 24		will not be allowed to work u	-		
				is completed. All newly hired			
	A review of Resident	#15's MARs (medication		nurses will receive educatio			
	administration record	s) for October, November,		orientation that reflects facil	ity policy and		
	and December 2021			procedure for "General Dos	•		
		dent #35 received three		and Medication Administrati	on".		
	doses of this medication in 24 hours, totaling 3900 milligrams (3.9 grams): 10/27/21, 10/29/21,			Opening manifesting will in t	udo 10		
	10/31/21, 11/1/21, 11			Ongoing monitoring will incl residents weekly x11 weeks			
		, , , , , , , , , , , , , , , , , , ,		Tylenol orders will be review			
	A review of Resident	#35's comprehensive care		week x1 week.			
	plan dated 10/11/19 and updated 3/3/20 revealed,						
	in part: "Resident is a	t risk for		4. Director of Nursing or De			
		n meds (medications) as		present findings of audit to t	-		
	ordered.			Assurance Performance Im			
	On 1/5/22 -+ 1-24	DN /licensed are stical		(QAPI) committee for review			
		n., LPN (licensed practical ewed. When asked to review		recommendations x3 month Committee will consist of Ex			

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DEPART CENTER	PRINTED: 03/10/2022 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	
495139		495139	B. WING			C 01/06/2022	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CARE CENTER OF NEW MARKET				31 N			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 757	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	757	Director, Director of Nursing, Staff Development Coordinator, Social Services, MDS Coordinator, Pharmac Consultant, and Medical Director.	у	

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