STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495139	A. BUILDING _____ B. WING _____	C 01/06/2022

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

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E 000	Initial Comments An unannounced Emergency Preparedness Survey was conducted 1/4/22 through 1/6/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/4/22 through 1/6/22. One complaint (VA00054010- unsubstantiated) was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 118 certified bed facility was 87 at the time of the survey. The survey sample consisted of 30 current resident reviews and 5 closed record reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, the facility staff failed to assess 1 of 35 residents in the survey sample for safe self administration of medications, Resident #31. Resident #31 was observed with prescribed medications unsecured and unsupervised by staff in their room.	F 554	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 and follow facility policy and procedure. Care plan for resident #31 will be reviewed and revised as indicated.	2/18/22

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

Electronically Signed | 01/18/2022

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F 554	Continued From page 1 The findings include: Resident #31 was admitted to the facility with diagnoses that include but were not limited to Parkinson's disease (1), dysphagia (2) and atrial fibrillation (3). Resident #31's most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 11/12/2021 coded Resident #31 as scoring a 15 on the BIMS (brief interview for mental status) assessment, 15- being cognitively intact for making daily decisions. Resident #31 was observed on 1/4/2022 at approximately 3:13 p.m. Resident #31 was out of bed sitting in a motorized wheelchair. The overbed table was in front of Resident #31 with a medication cup containing two visible medication tablets, and a second medication cup containing applesauce. At that time an interview was conducted with Resident #31. Resident #31 stated that the nurse had left the medications for her earlier to take after eating. Resident #31 stated that she had recently visited the neurologist who had advised her to wait at least 30 minutes after eating any protein to take her medication for Parkinson's disease and proceeded to take the medications on the bed side table with the applesauce. The eMAR (electronic medication administration record) dated 1/1/2022-1/31/2022 for Resident #31 documented medications most recently administered to Resident #31 at 1:00 p.m. on 1/4/2022. The comprehensive care plan for Resident #31	F 554	2. Resident's that have a BIM score of 15, independent, and wish to self administer medication will have a Self Assessment of Medication Administration completed. Any resident that meets criteria to self administer, their care plan will be updated to reflect assessment. 3. Staff Development Coordinator will provide education of the following facility policies to all licensed nurses: "Self Administration of Medication", "General Dose Preparation and Medication Administration", and "Storage of Medications". Any licensed nurse that has not completed education by 2/16/22, will not be allowed to work until education is completed. All newly hired nurses will receive education during orientation on the following facility policies: "Self Administration of Medication", "General Dose Preparation and Medication Administration", and "Storage of Medications". Staff Development Coordinator will review Residents Right to self administer medications in next Resident Council Meeting. Unit Manager or Designee will review self administration of medication during quarterly care meetings to identify any residents that may wish to self administer medications in the future. Director of Nursing or Designee will audit Medication self administration is complete and accurate and audit care plan reflects	

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F 554	Continued From page 2 failed to evidence documentation of self-administration of medications. Review of Resident #31's clinical record failed to evidence an assessment for self-administration of medications or a physician's order for medications to be safely left at Resident #31's bedside for her to take unsupervised. On 1/5/2022 at approximately 1:20 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated that Resident #31 had an order in place to give her medications as a bolus with applesauce but the medications were not supposed to be left unattended at the bedside. RN #2 stated that they were not aware that Resident #31 wished to take the medications 30 minutes after proteins until 1/4/2022. RN #2 stated that they should have brought the medication for Parkinson's back to Resident #31 after she had finished eating rather than leave them in the room. RN #2 stated that they completed self-administration of medication assessments on residents who could demonstrate taking their medications independently and normally did these on residents with inhalers or anyone who was leaving the facility with a medication. RN #2 stated that they did not have an assessment completed for Resident #31. On 1/5/2022 at approximately 4:00 p.m., a request was made for the facility policies on medication administration, medication storage and self administration of medication by residents. The facility policy, "General Dose Preparation and Medication Administration" dated 12/1/07	F 554	self administration for all residents identified. Audit will be completed weekly x 12 weeks. 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, Pharmacy Consultant, and Medical Director.	

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documented in part, "...Facility staff should not leave medications or chemical unattended..."

The facility policy, "Self Administration of Medications" dated 11/28/16 documented in part, "...2. Facility, in conjunction with the Interdisciplinary Care Team, should assess and determine, with respect to each resident, whether Self-Administration of medications is safe and clinically appropriate, based on the resident's functionality and health condition...11. Facility should document the Self-Administration of medications in the resident's care plan. 12. Facility should document the self-storage of medications in the resident's care plan."

The facility policy, "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" dated 12/1/07 documented in part, "...Facility should not administer/provide bedside medications or biologicals without a Physician/Prescriber order and approval by the Interdisciplinary Care Team and Facility administration..."

On 1/5/2022 at approximately 4:30 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern.

No further information was provided prior to exit.

References:

1. Parkinson's disease
A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

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F 554	Continued From page 4 2. dysphagia A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. 3. atrial fibrillation A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html>.	F 554		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party	F 622		2/18/22

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payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(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.
(i) 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)

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F 622	Continued From page 6 (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. (iii) 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 including contact information (C) Advance Directive 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's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to evidence that the physician wrote a note, and comprehensive care plan goals were provided to the receiving facility upon a hospital transfer, for 1 of 35 residents in the survey sample, Resident #39. The findings include: Resident #39 was admitted to the facility on 6/21/19, hospitalized on 11/7/21 and readmitted on 11/10/21. Resident #39 had the diagnoses of but not limited to high blood pressure, congestive heart failure, and stroke. The most recent MDS	F 622	1. Resident #39 safely returned to facility on 11/10/2021. 2. Director of Nursing or Designee will audit all facility initiated transfers/discharges from 1/6/2022 to current to ensure the following criteria has been met: *Provider has a documented progress note present in the resident medical record that reflects needs for transfer/discharge. *Evidence present in the medical record that facility staff sent comprehensive care plan for resident to	

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F 622	Continued From page 7 (Minimum Data Set) was 5-day readmission assessment with an ARD (Assessment Reference Date) of 11/17/21. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance for all areas of activities of daily living except for eating, which required limited assistance. A review of the clinical record revealed the following nurse's notes: 11/7/21 at 2:47 AM: "resident continues with confusion and lethargy this shift. resident had increased confusion, alert but not oriented to person, place, time and situation. resident repeating "I dont (sic) know". resident's pupils reactive bilaterally, unable to follow simple commands like gripping fingers. resident states "no" to c/o (complaints of) pain. bil (bilateral) lung sounds clear, no respiratory distress noted. resident's BS (blood sugar): 201, Temp elevated at 101.6, room was very warm d/t (due to) roommate increasing temp (temperature) of room. resident given tylenol (1) per md (medical doctor) order, covid tested per facility protocol with negative results. resident's temp decreased to 99.5. resident now alert and oriented to person, able to answer simple questions appropriately, and follow commands. resident is resting quietly in bed with eyes closed with no pain or discomfort noted." 11/7/21 at 12:39 PM: "Daughter (name) expressed concern about her dads confusion. This nurse called on call provider who ordered UA C&S (2 - urinalysis with culture and sensitivity) , CBC (3 - complete blood count), CMP (4 - complete metabolic panel), CXR (chest x-ray)	F 622	receiving facility. 3. Staff Development Coordinator will provide education to Universal Health Providers to reflect evidence of provider progress note following facility initiated transfer/discharge. Staff Development Coordinator will provide education to all licensed nurses that resident medical record must contain evidence that comprehensive care plan was sent to receiving facility following a facility initiated transfer/discharge. Any licensed nurse that has not received the education before 2/15/22 will not be allowed to work until education is complete. All newly hired licensed nursed will receive education in new hire orientation. Director of Nursing or Designee will audit all facility initiated transfers/discharges to ensure medical record reflects evidence of the the following criteria: *Provider has a documented progress note present in the resident medical record that reflects needs for transfer/discharge. *Evidence present in the medical record that facility staff sent comprehensive care plan for resident to receiving facility. Audit will be conducted 5x per week x4 weeks, weekly x4 weeks, then x1 for 1 month. 4. Director of Nursing or Designee will	

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F 622	Continued From page 8 and 1 gram of Rocephin (5) IM x 1 (intramuscularly for one dose). Daughter (name) informed about new orders. No concerns at this time." 11/7/21 at 2:56 PM: "Resident was covid and flu tested during shift and was negative. MD/NP (nurse practitioner) aware, RP (responsible party) and resident aware of results." 11/7/21 at 7:01 PM: "Resident is very lethargic and is unable to arouse at this time. Resident not eating or drinking d/t not being awake. UA in house done and looks positive. IM Rocephin administered @ (at) 1750 (5:50 PM) in right buttocks. Per Daughter requests, sending out to ER (emergency room) (name of hospital) for evaluation." 11/7/21 at 8:38 PM: "RP-Daughter, (name), was in facility visiting resident when it was decided to send resident out to ER. RP aware are requested resident to be sent out @ 1930. On Call Dr (doctor) (name) aware of resident being sent out." 11/8/21 at 12:47 AM: "resident admitted to (name of hospital) for urosepsis." The above notes did not evidence what documentation was provided to the receiving hospital. There was no note located in the clinical record from the physician regarding this hospitalization. Further review of the clinical record revealed the Nursing Home to Hospital Transfer Form. This form documented resident demographics information, contact person, primary care physician, code status, clinical information,	F 622	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, Pharmacy Consultant, and Medical Director.	

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allergies, precautions, alerts, devices, treatments, etc. However, it did not document that the comprehensive care plan goals were provided to the hospital.

In addition, there was no evidence the physician wrote a note regarding this hospitalization.

On 1/6/22 at 10:00 AM, an interview was conducted with LPN #5 (Licensed Practical Nurse). She stated that a check list is completed when residents are transferred and that a copy of the checklist is kept in the clinical record. She stated that upon a transfer, the facesheet, medication list, care plan, nurses notes, transfer form, and pertinent labs are sent to the hospital and that the physician should write a note. LPN #5 was asked for a copy of this checklist.

On 1/6/22 at 10:17 AM, in a follow up interview with LPN #5, she provided the checklist. A review of this checklist revealed that comprehensive care plan goals were listed. However, when asked if a copy of a completed checklist was in the clinical record for Resident #39 regarding the hospital transfer of 11/7/21, she stated that it was not. When asked if the physician wrote a note, she stated that he had not.

A review of the facility policy, "Transfers and Discharges" documented, "....The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility....Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)

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(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. (iii) 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 including contact information
(C) Advance Directive 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's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care."

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

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Director and Director of Nursing, respectively, were made aware of the findings. No further information was provided by the end of the survey.
References:

(1) Tylenol: is used to relieve mild to moderate pain.
Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html

(2) Urinalysis and Culture and Sensitivity:
Urinalysis is the examination of urine for certain physical properties, solutes, cells, casts, crystals, organisms, or particulate matter. Because urinalysis is easy, cheap, and productive, it is recommended as part of the initial examination of all patients and should be repeated as clinically warranted.
A urine culture is a lab test to check for bacteria or other germs in a urine sample.
Sensitivity analysis determines the effectiveness of antibiotics against microorganisms (germs) such as bacteria that have been isolated from cultures.

Information obtained from https://www.ncbi.nlm.nih.gov/books/NBK302/
Information obtained from https://medlineplus.gov/ency/article/003751.htm
Information obtained from https://medlineplus.gov/ency/article/003741.htm

(3) CBC: The CBC can help detect blood diseases and disorders, such as anemia, infections, clotting problems, blood cancers, and immune system disorders. This test measures many different parts of your blood.

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LIFE CARE CENTER OF NEW MARKET	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 622	Continued From page 12 Information obtained from https://www.nhlbi.nih.gov/health-topics/blood-tests (4) CMP: A comprehensive metabolic panel is a group of blood tests. They provide an overall picture of your body's chemical balance and metabolism. Metabolism refers to all the physical and chemical processes in the body that use energy. Information obtained from https://medlineplus.gov/ency/article/003468.htm (5) Rocephin: is used to treat certain infections Information obtained from https://medlineplus.gov/druginfo/meds/a685032.html	F 622		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to correctly code a significant change MDS (minimum data set) resident assessment for 1 of 35 residents in the survey sample, Resident #53. Resident #53 was not coded as receiving hospice services. The findings include: Resident #53 was admitted to the facility with diagnoses that included but were not limited to CHF (congestive heart failure) (1) and chronic kidney disease (2).	F 641	1. MDS coordinator corrected resident #53 MDS to accurately reflect hospice services while surveyor still on site. 2. MDS coordinator will review all residents currently under hospice services to ensure MDS is coded accurately. 3. Staff Development Coordinator will provide education to all MDS coordinators on RAI Manual pages 2-23 that review coding accurately for significant change in status that includes resident(s) that enrolls	2/18/22

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F 641	Continued From page 13 Resident #53's most recent MDS, a significant change assessment with an ARD of 12/8/2021, coded Resident #53 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section O failed to evidence documentation of Resident #53 receiving hospice services. The physician's orders for Resident #53 documented in part, "Admit for hospice services. Order Date: 12/7/2021." The comprehensive care plan for Resident #53 dated 12/7/2021 documented in part, "The resident has a terminal prognosis. Hospice, Anticipate weight loss, delayed healing, decline in participation in ADLs (activities of daily living), decline in participation in activities of choice, decline in cognitive processing. Date Initiated: 12/07/2021..." On 1/06/2022 at 8:17 a.m., an interview was conducted with LPN (licensed practical nurse) #2, MDS coordinator. LPN #2 stated that the significant change assessment completed for Resident #53 was completed when they began hospice services. LPN #2 reviewed the significant change MDS with the ARD of 12/8/2021 and stated that hospice was not coded and they must have missed clicking the box to choose hospice services. LPN #2 stated that they followed the RAI (resident assessment instrument) manual for completion of the MDS assessments. LPN #2 stated that they would correct the MDS to include hospice services. According to the RAI Manual, Version 1.16, dated	F 641	in a hospice program. Any MDS Coordinator that has not completed education by 2/16/22, will not be allowed to work until education is completed. All newly hired MDS nurses will receive education during orientation that reflects RAI manual for accurately coding a change in condition consistent with hospice services. Director of Nursing or designee will audit MDS assessments of residents enrolled in a hospice program weekly x8 weeks and then monthly x1 month. 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, Pharmacy Consultant, and Medical Director.	

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F 641	Continued From page 14	F 641		

October 2018, page 2-23 documented in part, "...A SCSA (significant change in status assessment) is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). A SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place..."

On 1/6/2022 at approximately 8:45 a.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:

1. congestive heart failure
A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html

2. chronic kidney disease
Kidneys are damaged and can't filter blood as they should. This information was obtained from the website:

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F 641	Continued From page 15 https://medlineplus.gov/chronickidneydisease.html.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		2/18/22

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F 656	Continued From page 16 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview, and facility document review, the facility staff failed to develop a care plan for side rail use for 1 of 35 residents in the survey sample; Resident #50. The findings include: Resident #50 was admitted to the facility on 9/24/18 with the diagnoses of but not limited to dementia, depression, osteoporosis, and COVID-19. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 11/23/21. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and extensive assistance for all other areas of activities of daily living. On 1/4/22 at 3:35 PM, Resident #50 was observed in bed asleep, with the head of the bed elevated, and the half length side rails up bilaterally. A review of the clinical record revealed an Evaluation For Use of Bed Rails form dated 2/1/21 that documented, "Bed rail(s) are recommended at all times when resident is in	F 656	1. MDS Coordinator corrected resident #50 comprehensive care plan to reflect use of side rails while surveyor was still on site. 2. MDS Coordinator will review all residents that have a physician order for side rail use. MDS Coordinator will ensure each resident with a physician order for side rail use has a care plan developed to convey order. 3. Staff Development Coordinator will provide education to MDS Coordinator on facility policy of "Care Planning - Baseline, Comprehensive, and Routine Updates. Any MDS Coordinator that has not completed education by 2/16/22, will not be allowed to work until education is completed. All newly hired MDS Coordinator(s) will receive education during orientation on the facility policy: "Care Planning - Baseline, Comprehensive, and Routine Updates". Director of Nursing or Designee will audit 10 different residents weekly x11 weeks for side rail orders compared to care plan then will x1 week ALL residents with side rail orders and ensure their	

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F 656	Continued From page 17 bed." A review of the comprehensive care plan failed to reveal any evidence that it was reviewed and revised to include the use of side rails. On 1/6/22 at 10:00 AM, an interview was conducted with LPN #5 (Licensed Practical Nurse). She stated that the purpose of the care plan was to set goals for the resident and to guide care for the resident. She stated that any nurse can update the care plan. When asked if side rails should be care planned, she stated that they should be. A review of the facility policy "Care Planning - Baseline, Comprehensive, and Routine Updates" documented, "....The comprehensive Care Plan must be updated with each MDS assessment and periodically." It was noted in the electronic clinical record that the resident had 4 MDS's completed between the date of the side rail evaluation of 2/1/21 and the observation on 1/4/22. 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 Director and Director of Nursing, respectively, were made aware of the findings. No further information was provided by the end of the survey.	F 656	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, Pharmacy Consultant, and Medical Director.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		2/18/22

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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 (millligrams) 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. The findings include: Resident #35 was admitted to the facility on 7/1/19, and most recently readmitted on 8/7/20, with diagnoses including arthritis, diabetes, bilateral below the knee amputations, and peripheral vascular disease. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/15/21, the resident was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). A review of Resident #35's clinical record revealed the following order, dated 7/16/21: "Tylenol 8 Hour Arthritis Pain Tablet Extended Release 650 mg (milligrams) Give 2 tablets by mouth every 6 hours as needed for pain. DO NOT EXCEED 3 GMS (grams/1000 mgs) in 24	F 684	1. Resident #35 physician orders were reviewed. New order obtained to discontinue Tylenol 650mg give 2 tablets to equal 1,300mg by mouth every 4 hours as needed for pain. New order was transcribed to administer Tylenol 500mg give 2 tablets to equal 1,000mg three times a day for pain. 2. Director of Nursing or Designee will audit for unnecessary pain medication on all residents with a physician order that includes Tylenol and parameters to not exceed 3,000mg in a 24 hour period. Audit will consist of scheduled and as needed orders. Any resident that has potential to receive unnecessary pain medications, including more than 3,000mg of Tylenol in a 24 hour period, medical provider will be notified and a new order will be obtained to ensure that resident does not exceed 3,000mg of Tylenol in a 24 hour period. (ie., Tylenol 500mg give 2 tabs to equal 1,000mg by mouth three times a day as needed). 3. Staff Development Coordinator will provide education on facility policy and procedure ""General Dose Preparation and Medication Administration" that	

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F 684	Continued From page 19 hours." A review of Resident #15's MARs (medication administration records) for October, November, and December 2021 revealed that on the following dates, Resident #35 received three doses of this medication in 24 hours, totaling 3900 milligrams (3.9 grams): 10/27/21, 10/29/21, 10/31/21, 11/1/21, 11/9/21, and 12/5/21. A review of Resident #35's comprehensive care plan dated 10/11/19 and updated 3/3/20 revealed, in part: "Resident is at risk for pain/discomfort...Pain meds (medications) as ordered. On 1/5/22 at 1:21 p.m., LPN (licensed practical nurse) #1 was interviewed. When asked to review Resident #35's orders and the MARs referenced above, she stated: "It looks like he sometimes got more [Tylenol] than he should." When asked if the physician's order was being followed, she stated: "No." She stated when she administers an as-needed medication, she looks back to determine the last time it was administered. She stated the order is clear; the resident is able to get two doses six hours apart in 24 hours; but should not receive any more than that. She stated the nurse is responsible for doing the math and ensuring the resident does not get too much medicine. She stated too much Tylenol can put the resident's liver function at risk. On 1/05/22 4:29 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were notified of these concerns. A review of the facility policy, "General Dose	F 684	includes review of Unnecessary Pain Medication to all licensed nurses. Any licensed nurse that has not completed education by 2/16/22, will not be allowed to work until education is completed. All newly hired licensed nurses will receive education during orientation that reflects facility policy and procedure for "General Dose Preparation and Medication Administration". Ongoing monitoring will include 10 residents weekly x11 weeks, and then all Tylenol orders will be reviewed 1x per week x1 week. 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, Pharmacy Consultant, and Medical Director.	

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F 684	Continued From page 20 Preparation and Medication Administration," revealed, in part: "Prior to administration of medication, facility staff should...verify...that it is the correct medication, at the correct dose, at the correct route, at the correct time..." A review of the facility policy, "Physician Orders," revealed no information related to the responsibility of the facility staff to follow the physician's orders. No further information was provided prior to exit.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility failed to store respiratory treatment equipment in a sanitary manner for one of 35 residents in the survey sample, Resident #90. On two separate occasions, Resident #90's CPAP (continuous positive airway pressure) (1) mask was observed uncovered, and lying in contact with his pillows. The findings include:	F 695	1. Resident #90 CPAP was sanitized and stored per facility policy and procedure while surveyor was still on site. 2. While surveyors were still on site, all residents utilizing respiratory treatment equipment were assessed to ensure their equipment was stored in a sanitary manner per facility policy and procedure. Staff Development Coordinator will provide education to all licensed nurses	2/18/22

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F 695	Continued From page 21 Resident #90 was admitted to the facility on 9//24/18 with diagnoses including a traumatic brain injury, a stroke, and diabetes. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/27/21, the resident was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). On 1/4/22 at 2:56 p.m. and 1/5/22 at 10:22 a.m. Resident #90's CPAP mask was observed uncovered, and in direct contact with his bed pillows. Resident #90 was sitting up in the wheelchair in his room. He stated the staff "always" cleans the CPAP mask and places it on his pillow, uncovered. A review of Resident #90's physician's orders revealed the following order, dated 4/9/20: "CPAP/BIPAP: Pressure setting 13-16. Full face mask...on while sleeping/napping and off while awake...Clean CPAP mask with warm soapy water, rinse and air dry as needed daily." A review of Resident #90's MARs (medication administration records) for October, November, and December 2021 and for January 2022 revealed Resident #90 wore his CPAP as ordered, and that the mask was cleaned daily. A review of Resident #90's comprehensive care plan dated 7/15/19 and updated 3/30/20 revealed, in part: "The resident has altered respiratory status/difficulty breathing related to sleep apnea...Clean CPAP per protocol...Store CPAP per protocol." On 1/5/22 at 1:19 p.m., CNA (certified nursing	F 695	on facility policy and procedure for Respiratory Equipment Cleaning and Storage. Any licensed nurse that has not completed education by 2/16/22, will not be allowed to work until education is completed. All newly hired licensed nurses will receive education during orientation that reflects Respiratory Equipment Cleaning and Storage. Director of Nursing or Designee will audit all residents with respiratory treatment equipment 5x per week x4 weeks, 2x per week x4 weeks, and weekly x4 weeks to ensure respiratory equipment is stored in a sanitary manner per facility policy and procedure. 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, Pharmacy Consultant, and Medical Director.	

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F 695	Continued From page 22	F 695		

assistant) #1 was interviewed. When asked how a CPAP mask should be stored when not in use, she stated it should be stored in a plastic bag, and preferably placed inside a drawer. When asked why the mask should be stored this way, she stated: "We don't want to have germs on it." She added the mask goes on the resident's face, and it needs to be clean to prevent infection.

On 1/5/22 at 1:21 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated the facility has specific bags for storage of all respiratory equipment in resident rooms. She stated it after the mask is washed, it should be air dried, and then placed in the bag. She stated CPAP mask storage is "all about infection control."

On 1/05/22 4:29 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were notified of these concerns.

A review of the facility policy, "CPAP Administration Policy," failed to reveal an information related to sanitary storage of the CPAP mask when not in use by the resident.

No further information was provided prior to exit.

(1) "CPAP (Continuous Positive Airway Pressure) is a treatment that uses mild air pressure to keep your breathing airways open...It involves using a CPAP machine that includes a mask or other device that fits over your nose or your nose and mouth, straps to position the mask, a tube that connects the mask to the machine's motor, and a motor that blows air into the tube. CPAP is used to treat sleep-related breathing disorders including sleep apnea." This information is taken

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F 695	Continued From page 23 from the website https://www.nhlbi.nih.gov/health-topics/cpap.	F 695		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to prevent a resident from receiving unnecessary pain 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 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 757	1. Resident #35 physician orders were reviewed. New order obtained to discontinue Tylenol 650mg give 2 tablets to equal 1,300mg by mouth every 4 hours as needed for pain. New order was transcribed to administer Tylenol 500mg give 2 tablets to equal 1,000mg three times a day for pain.	2/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495139	A. BUILDING _____ B. WING _____	C 01/06/2022

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

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F 757	Continued From page 24 The findings include: Resident #35 was admitted to the facility on 7/1/19, and most recently readmitted on 8/7/20, with diagnoses including arthritis, diabetes, bilateral below the knee amputations, and peripheral vascular disease. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/15/21, the resident was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). A review of Resident #35's clinical record revealed the following order, dated 7/16/21: "Tylenol 8 Hour Arthritis Pain Tablet Extended Release 650 mg (milligrams) Give 2 tablets by mouth every 6 hours as needed for pain. DO NOT EXCEED 3 GMS (grams/1000 mgs) in 24 hours." A review of Resident #15's MARs (medication administration records) for October, November, and December 2021 revealed that on the following dates, Resident #35 received three doses of this medication in 24 hours, totaling 3900 milligrams (3.9 grams): 10/27/21, 10/29/21, 10/31/21, 11/1/21, 11/9/21, and 12/5/21. A review of Resident #35's comprehensive care plan dated 10/11/19 and updated 3/3/20 revealed, in part: "Resident is at risk for pain/discomfort...Pain meds (medications) as ordered. On 1/5/22 at 1:21 p.m., LPN (licensed practical nurse) #1 was interviewed. When asked to review	F 757	2. Director of Nursing or Designee will audit all residents with a physician order for Tylenol and parameters to not exceed 3,000mg in a 24 hour period. Audit will consist of scheduled and as needed Tylenol. Any resident that has potential to receive more than 3,000mg of Tylenol in a 24 hour period, medical provider will be notified and a new order will be obtained to ensure that resident does not exceed 3,000mg of Tylenol in a 24 hour period. (ie., Tylenol 500mg give 2 tabs to equal 1,000mg by mouth three times a day as needed). 3. Staff Development Coordinator will provide education on facility policy and procedure ""General Dose Preparation and Medication Administration" to all licensed nurses. Any licensed nurse that has not completed education by 2/16/22, will not be allowed to work until education is completed. All newly hired licensed nurses will receive education during orientation that reflects facility policy and procedure for "General Dose Preparation and Medication Administration". Ongoing monitoring will include 10 residents weekly x11 weeks, and then all Tylenol orders will be reviewed 1x per week x1 week. 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	

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F 757	Continued From page 25 Resident #35's orders and the MARs referenced above, she stated: "It looks like he sometimes got more [Tylenol] than he should." When asked if the physician's order was being followed, she stated: "No." She stated when she administers an as-needed medication, she looks back to determine the last time it was administered. She stated the order is clear; the resident is able to get two doses six hours apart in 24 hours; but should not receive any more than that. She stated the nurse is responsible for doing the math and ensuring the resident does not get too much medicine. On 1/05/22 4:29 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were notified of these concerns. A review of the facility policy, "General Dose Preparation and Medication Administration," revealed, in part: "Prior to administration of medication, facility staff should...verify...that it is the correct medication, at the correct dose, at the correct route, at the correct time..." No further information was provided prior to exit.	F 757	Director, Director of Nursing, Staff Development Coordinator, Social Services, MDS Coordinator, Pharmacy Consultant, and Medical Director.	