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 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF NEW MARKET	315 EAST LEE HIGHWAY NEW MARKET, VA 22844

(X4) ID 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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/10/2023 through 07/12/2023. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 07/10/23 through 07/12/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints (VA00054836-unsubstantiated and VA00057423-substantiated with no deficiency) were investigated during the survey. The census in this 118 certified bed facility was 95 at the time of the survey. The survey sample consisted of 28 resident reviews.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607		8/26/23

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

Electronically Signed | 07/27/2023

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F 607	Continued From page 1 §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility failed to implement their abuse policy for investigating and reporting a resident to resident altercation for one of 28 residents in the survey sample, Resident #260. The findings include: For Resident #260 (R260), the facility staff failed to implement their abuse policy to investigate and report a resident to resident altercation that was reported to facility staff on 5/21/2021. On 5/21/2021, Resident #251 (R251) twisted R260's finger in their shared room. The facility policy "Area of Focus: Abuse & Neglect" dated 11/21/2022 documented in part, "...Residents must not be subjected to abuse by anyone. This includes but is not limited to staff,	F 607	1. Resident #260 no longer resides in the facility. 2. All residents have the ability to be affected by deficient practice of facility staff failing to implement facility policy titled, "Abuse - Reporting and Response". 3. Social Services Director or Designee will review facility policy "Abuse - Reporting and Response" with residents in the next Resident Council Meeting scheduled for July 26, 2023. Staff Development Coordinator will provide 100% staff education to all associates on the facility policy, "Abuse - Reporting and Response". Any staff member that has not completed education by 8/11/2023 will not be allowed to work	

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F 607	Continued From page 2 other residents, consultants, volunteers, staff from other agencies serving our residents, family members, the resident representative, friends, or any other individuals...In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken..." On R251's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/9/2022, the resident was assessed as being moderately impaired for making daily decisions. Section E documented R251 having physical and verbal behaviors directed towards others one to three days during the assessment period. On R260's most recent MDS, a quarterly assessment with an ARD (assessment reference	F 607	until education is completed. All newly hired staff members will complete Abuse and Neglect training during orientation. Director of Nursing or designee(s) will review behavior progress notes daily Monday thru Friday and will review weekend days on Monday mornings to validate no concerns were documented in medical records. Audit will occur 5x per week x 12 weeks. If non-compliance found, re-education will be provided. 4. Director of Nursing or designee will present findings of audit to the Quality Assurance Performance Improvement (QAPI) committee monthly 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 607	Continued From page 3	F 607		

date) of 11/14/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions.

R260 no longer resided at the facility and could not be observed or interviewed during the survey dates. The record was reviewed as a closed record.

The progress notes for R260 documented in part, - "5/21/2021 14:15 (2:15 p.m.) Resident was involved in an altercation with her roommate in which her roommate twisted her right pointer finger, the resident yelled for staff, staff attended to situation, the resident denied pain, no s/s (signs or symptoms) of injury from finger, full active ROM (range of motion), resident declined room change, resident placed on alert charting to monitor for any injury. The resident was safe prior to leaving the room."

The progress notes for R251 documented in part, - "5/21/2021 14:16 (2:16 p.m.) The resident has had behaviors today, during lunch meal while in dining room the resident threw her glass cup on the floor in which broke the glass, the resident also had altercation with her roommate in which the resident twisted the roommate's finger, the resident was removed from situation to ensure safety, resident did write on white board she was sorry, resident placed on alert charting and RP (responsible party) was notified of behaviors."

On 7/11/2023 at 4:10 p.m., a request was made to ASM (administrative staff member) #1, the executive director for evidence of reporting and investigation for the resident to resident altercation between R251 and R260 on

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F 607	Continued From page 4	F 607		

5/21/2021.

On 7/12/2023 at 8:32 a.m., an interview was conducted with ASM #2, the director of nursing who stated that they did not have any evidence of reporting or investigation for the resident to resident altercation between R251 and R260 on 5/21/2021. ASM #2 presented progress notes for R251 dated 5/21/2021-5/24/2021 documenting monitoring for behaviors, and for R260 dated 5/21/2021-5/23/2021 assessing for injury to the finger. ASM #2 stated that they were unable to find documentation that the incident had been reported to administrative staff. She stated that R260 had a motherly relationship with R251 and had refused to move to another room when offered. She stated that if the nurse felt that the situation was abusive they should report it and they had never had staff not report anything to them before. ASM #2 stated that she did not recall the incident on 5/21/2021 being reported to her.

On 7/12/2023 at 11:01 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that they remembered the incident they documented in the progress notes on 5/21/2021 but did not recall who reported it to them. She stated that she did not recall exactly what she did but the process was to go in and remove the resident from the situation to ensure that both residents were safe. She stated that the nurse assessed the resident for injury, notified the physician, the responsible party and the director of nursing and completed an incident report. When asked why they followed this process, she stated that it was to make sure everything was documented and to ensure follow through on the incident because they were pretty sure that it had

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F 607	Continued From page 5 to be reported. She stated that it would be considered a resident to resident altercation. On 7/12/2023 at 11:52 a.m., ASM #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.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		8/26/23

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F 609	Continued From page 6 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility failed to report a resident to resident altercation to the facility administrator and the State Survey Agency, for one of 28 residents in the survey sample, Resident #260. The findings include: For Resident #260 (R260), the facility staff failed to report a resident to resident altercation on 5/21/2021. On 5/21/2021, Resident #251 (R251) twisted R260's finger in their shared room. On R251's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/9/2022, the was assessed as being moderately impaired for making daily decisions. Section E documented R251 having physical and verbal behaviors directed towards others one to three days during the assessment period. On R260's most recent MDS, a quarterly assessment with an ARD (assessment reference date) of 11/14/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. R260 no longer resided at the facility and could not be observed or interviewed during the survey dates. The record was reviewed as a closed record. The progress notes for R260 documented in part,	F 609	1. Resident #260 no longer resides in the facility. 2. All residents have the ability to be affected by deficient practice of facility staff failing to report a resident to resident altercation to appropriate administrative team leaders. 3. Social Services Director or Designee will review facility policy "Abuse - Reporting and Response" with residents in the next Resident Council Meeting scheduled for July 26, 2023. Staff Development Coordinator will provide 100% staff education to all associates on the facility policy, "Abuse - Reporting and Response". Facility staff will be educated that a Risk Management Report must be completed for all resident to resident altercations. Any staff member that has not completed education by 8/11/2023 will not be allowed to work until education is completed. All newly hired staff members will complete Abuse and Neglect training during orientation. All incidents for Resident to Resident Altercation will be reviewed by the Director of Nursing to ensure proper and timely notification to Director of Nursing and Executive Director 5x per week for 4 weeks, 3x per week for 4 weeks, and 1x per week for 4 weeks. If non-compliance found, re-education will be provided.	

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F 609	Continued From page 7 - "5/21/2021 14:15 (2:15 p.m.) Resident was involved in an altercation with her roommate in which her roommate twisted her right pointer finger, the resident yelled for staff, staff attended to situation, the resident denied pain, no s/s (signs or symptoms) of injury from finger, full active ROM (range of motion), resident declined room change, resident placed on alert charting to monitor for any injury. The resident was safe prior to leaving the room." The progress notes for R251 documented in part, - "5/21/2021 14:16 (2:16 p.m.) The resident has had behaviors today, during lunch meal while in dining room the resident threw her glass cup on the floor in which broke the glass, the resident also had altercation with her roommate in which the resident twisted the roommate's finger, the resident was removed from situation to ensure safety, resident did write on white board she was sorry, resident placed on alert charting and RP (responsible party) was notified of behaviors." On 7/11/2023 at 4:10 p.m., a request was made to ASM (administrative staff member) #1, the executive director for evidence of reporting and investigation for the resident to resident altercation between R251 and R260 on 5/21/2021. On 7/12/2023 at 8:32 a.m., an interview was conducted with ASM #2, the director of nursing who stated that they did not have any evidence of reporting or investigation for the resident to resident altercation between R251 and R260 on 5/21/2021. ASM #2 presented progress notes for R251 dated 5/21/2021-5/24/2021 documenting monitoring for behaviors, and for R260 dated 5/21/2021-5/23/2021 assessing for injury to the	F 609	4. Director of Nursing or designee will present findings of audit to the Quality Assurance Performance Improvement (QAPI) committee monthly 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 609	Continued From page 8	F 609		

finger. ASM #2 stated that they were unable to find documentation that the incident had been reported to administrative staff. She stated that R260 had a motherly relationship with R251 and had refused to move to another room when offered. She stated that if the nurse felt that the situation was abusive they should report it and they had never had staff not report anything to them before. ASM #2 stated that she did not recall the incident on 5/21/2021 being reported to her.

On 7/12/2023 at 11:01 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that they remembered the incident they documented in the progress notes on 5/21/2021 but did not recall who reported it to them. She stated that she did not recall exactly what she did but the process was to go in and remove the resident from the situation to ensure that both residents were safe. She stated that the nurse assessed the resident for injury, notified the physician, the responsible party and the director of nursing and completed an incident report. When asked why they followed this process, she stated that it was to make sure everything was documented and to ensure follow through on the incident because they were pretty sure that it had to be reported. She stated that it would be considered a resident to resident altercation.

The facility policy "Area of Focus: Abuse & Neglect" dated 11/21/2022 documented in part, "...Residents must not be subjected to abuse by anyone. This includes but is not limited to staff, other residents, consultants, volunteers, staff from other agencies serving our residents, family members, the resident representative, friends, or any other individuals...Reporting Allegations: In

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F 609	Continued From page 9 response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken...All personnel will promptly report any incident or suspected incident of resident abuse and/or neglect, including injuries of unknown origin to their direct supervisor or Abuse Coordinator immediately..." On 7/12/2023 at 11:52 a.m., ASM #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.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse,	F 610		8/26/23

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F 610	Continued From page 10 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility document review and staff interview, it was determined that the facility failed to investigate a resident to resident altercation for one of 28 residents in the survey sample, Resident #260. The findings include: For Resident #260 (R260), the facility staff failed to investigate a resident to resident altercation that was reported to facility staff on 5/21/2021. On 5/21/2021, Resident #251 (R251) twisted R260's finger in their shared room. On R251's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/9/2022, the was assessed as being moderately impaired for making daily decisions. Section E documented R251 having physical and verbal behaviors	F 610	1. Resident #260 no longer resides in the facility. 2. All residents have the ability to be affected by deficient practice of facility staff failing to investigate a resident to resident altercation. 3. Social Services Director or Designee will review facility policy "Abuse - Reporting and Response" with residents in the next Resident Council Meeting scheduled for July 26, 2023. Staff Development Coordinator will provide 100% staff education to all associates on the facility policy, "Abuse - Reporting and Response". Staff education will include Facility Reportable Incidents and investigation protocol. Any staff	

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F 610	Continued From page 11 directed towards others one to three days during the assessment period. On R260's most recent MDS, a quarterly assessment with an ARD (assessment reference date) of 11/14/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. R260 no longer resided at the facility and could not be observed or interviewed during the survey dates. The record was reviewed as a closed record. The progress notes for R260 documented in part, - "5/21/2021 14:15 (2:15 p.m.) Resident was involved in an altercation with her roommate in which her roommate twisted her right pointer finger, the resident yelled for staff, staff attended to situation, the resident denied pain, no s/s (signs or symptoms) of injury from finger, full active ROM (range of motion), resident declined room change, resident placed on alert charting to monitor for any injury. The resident was safe prior to leaving the room." The progress notes for R251 documented in part, - "5/21/2021 14:16 (2:16 p.m.) The resident has had behaviors today, during lunch meal while in dining room the resident threw her glass cup on the floor in which broke the glass, the resident also had altercation with her roommate in which the resident twisted the roommate's finger, the resident was removed from situation to ensure safety, resident did write on white board she was sorry, resident placed on alert charting and RP (responsible party) was notified of behaviors."	F 610	member that has not completed education by 8/11/2023 will not be allowed to work until education is completed. All newly hired staff members will complete Abuse and Neglect training during orientation. Executive Director and Director of Nursing will receive written education on the facility policy of reporting allegations of abuse and neglect to include "In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: Have evidence that all alleged violations are thoroughly investigated. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken." All Resident to Resident Altercations will be reviewed by the Director of Nursing to ensure investigation was completed and Facility Reportable Incident was completed if indicated 5x per week for 4 weeks, 3x per week for 4 weeks, and 1x per week for 4 weeks. If non-compliance found, re-education will be provided. 4. Director of Nursing or designee will present findings of audit to the Quality Assurance Performance Improvement (QAPI) committee monthly x3 months.	

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	495139	A. BUILDING _____ B. WING _____	C 07/12/2023

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F 610	Continued From page 12 On 7/11/2023 at 4:10 p.m., a request was made to ASM (administrative staff member) #1, the executive director for evidence of reporting and investigation for the resident to resident altercation between R251 and R260 on 5/21/2021. On 7/12/2023 at 8:32 a.m., an interview was conducted with ASM #2, the director of nursing who stated that they did not have any evidence of reporting or investigation for the resident to resident altercation between R251 and R260 on 5/21/2021. ASM #2 presented progress notes for R251 dated 5/21/2021-5/24/2021 documenting monitoring for behaviors, and for R260 dated 5/21/2021-5/23/2021 assessing for injury to the finger. ASM #2 stated that they were unable to find documentation that the incident had been reported to administrative staff. She stated that R260 had a motherly relationship with R251 and had refused to move to another room when offered. She stated that if the nurse felt that the situation was abusive they should report it and they had never had staff not report anything to them before. ASM #2 stated that she did not recall the incident on 5/21/2021 being reported to her. On 7/12/2023 at 11:01 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that they remembered the incident they documented in the progress notes on 5/21/2021 but did not recall who reported it to them. She stated that she did not recall exactly what she did but the process was to go in and remove the resident from the situation to ensure that both residents were safe. She stated that the nurse assessed the resident for injury, notified the physician, the responsible party and the director	F 610	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 610	Continued From page 13	F 610		

of nursing and completed an incident report. When asked why they followed this process, she stated that it was to make sure everything was documented and to ensure follow through on the incident because they were pretty sure that it had to be reported. She stated that it would be considered a resident to resident altercation.

The facility policy "Area of Focus: Abuse & Neglect" dated 11/21/2022 documented in part, "...Investigate/Prevent/Correct Alleged Violation. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: Have evidence that all alleged violations are thoroughly investigated. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken...The facility does not condone resident abuse and/or neglect by anyone. This includes but is not limited to staff members, other residents, consultants, volunteers, staff from other agencies serving our residents, family members, the resident representative, sponsors, friends, or other individuals. All personnel will promptly report any incident or suspected incident of resident abuse and/or neglect, including injuries of unknown origin to their direct supervisor or Abuse Coordinator immediately..."

On 7/12/2023 at 11:52 a.m., ASM #1, the executive director and ASM #2, the director of nursing were made aware of the findings.

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F 610	Continued From page 14 No further information was provided prior to exit.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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 community was assessed and any referrals to	F 656		8/26/23

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F 656	Continued From page 15 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to implement the comprehensive care plan for two of 28 residents in the survey sample, Resident #4 and Resident #98. The findings include: 1. For Resident #4 (R4), the facility staff failed to implement the comprehensive care plan for the administration of physician ordered oxygen. R4 was admitted to the facility with diagnoses that included but were not limited to respiratory failure (1). R4's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 05/10/2023, coded R4 as scoring a 9 out of 15 on the brief interview for mental status (BIMS) which indicated the resident was moderately impaired of cognition for making daily decisions. Section O "Special Treatments, Procedures and Programs" coded R4 as receiving oxygen.	F 656	1. On 7/11/2023, resident #4 comprehensive care plan was reviewed by nursing team. Direct care staff were educated on physician order for oxygen at @2lpm and implementation of comprehensive care plan that is reflected on the resident kardex. On 7/11/2023, Resident #98 comprehensive care was reviewed by nursing team. NP was made aware that resident #98 is non-compliant with physician ordered fluid restriction. On 7/11/2023, resident #98 comprehensive care plan was updated to contain the verbiage "not compliant with fluid restriction at times". 2. MDS Coordinator will review all residents with oxygen orders to ensure comprehensive care plan reflects oxygen order and that it flows to the kardex for direct care staff to visualize. MDS Coordinator will review all residents with fluid restriction orders. MDS	

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F 656	Continued From page 16 On 07/10/2023 at approximately 2:43 p.m., R4 was observed lying in bed receiving oxygen by nasal cannula. The flow meter on the oxygen concentrator was set at four liters per minute. The physician's order for R4 dated 01/17/2023 documented, "Oxygen at 2 liters per minute PRN (as needed) per nasal cannula." The comprehensive care plan for R4 dated 02/28/2023 documented in part, "Focus. The resident has altered respiratory status/difficulty breathing r/t (related to) sleep apnea. Date Initiated: 02/28/2023." Under "Interventions / Tasks" it documented in part, "Administer medication/puffers as ordered. Date Initiated: 02/28/2023." On 07/11/23 at approximately 1:10 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked what the prescribed oxygen flow rate was for R4, she reviewed the electronic order and stated that the physician's order was for two liters per minute. When informed of the above observation LPN #1 stated that it was incorrect. When asked to describe the purpose of a resident's care plan, LPN #1 stated that it was to address any issues the resident may be having, for discharge purposes and for total care. After being informed of the above observation LPN #1 was asked if the care plan was being implemented for the administration of (R4's) oxygen; LPN #1 stated no. On 07/11/2023 at approximately 4:00 p.m., ASM (administrative staff member) #1, executive director, and ASM #2, director of nursing, were made aware of the above findings.	F 656	Coordinator will validate the residents that are non-compliant with fluid restriction and update their comprehensive care plan to reflect non compliance. MDS Coordinator will notify provider of residents that are found to be non compliant with fluid restriction. 3. Staff Development Coordinator will provide education to all nursing associates on facility policy "Resident Assessment Instrument & Care Plan Development" and using resident kardex tool. Any licensed nurse or certified nursing assistant that has not completed education by 8/11/2023, will not be allowed to work until education is completed. All newly hired licensed nurses or certified nursing assistants will receive education during orientation on "Resident Assessment Instrument & Care Plan Development" and using resident kardex tool. MDS Coordinator or Designee will audit all residents with physician orders for supplemental oxygen and compare to comprehensive care plan to ensure oxygen use and liter is carried over to the resident kardex for direct care staff utilization. Audit will occur 1x weekly x 12 weeks. If non-compliance found, re-education will be provided. MDS Coordinator or Designee will audit all residents with physician orders for fluid restriction and ensure resident compliance/non-compliance through	

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F 656	Continued From page 17 No further information was provided prior to exit. References: (1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. 2. For Resident #98 (R98), the facility staff failed to monitor compliance and/or non-compliance with ordered daily fluid restrictions per the plan of care. The comprehensive care plan for R98 documented in part, "At risk for weight fluctuation r/t (related to) current health status, sepsis, r (right) BKA (below the knee amputation), dyslipidema, DM II (type 2 diabetes mellitus), CKD III (chronic kidney disease stage 3), HTN (hypertension), CHF (congestive heart failure), Kidney stones, anemia, afib (atrial fibrillation), hypokalemia, Fluid restriction. Date Initiated: 06/28/2023. Revision on: 07/03/2023." Under "Interventions/Tasks" it documented in part, "...Honor fluid restriction, encourage resident to adhere to restriction. Date Initiated: 07/03/2023. Revision on: 07/03/2023." The care plan further documented "The resident has renal failure r/t ST (stage) III Kidney disease and kidney stones. Date Initiated: 07/03/2023. Revision on: 07/03/2023." Under "Interventions/Tasks" it documented in part, "...Fluids as ordered. Restrict or give as ordered. Date Initiated: 07/03/2023..." The physician's orders for R98 documented in part, "Fluid Restriction: 1500 ml (milliliter)/day From Dietary: breakfast 720ml, lunch 240ml, dinner 240ml. From Nursing: Days 150ml, Eves	F 656	validation of documentation on electronic medical record. Documentation will include provider notification. Audit will occur 5x per week x4 weeks, 3x per week x4 weeks, and 1x per week x4 weeks. If non-compliance found, re-education will be provided. 4. MDS Coordinator 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 656	Continued From page 18	F 656		

(evenings) 150ml, Nights 0ml every shift. Document amount consumed. Order Date: 06/28/2023."

The eMAR (electronic medication administration record) for R98 dated 6/1/2023-6/30/2023 documented in part, "Fluid Restriction: 1500 ml/day From Dietary: breakfast 720ml, lunch 240ml, dinner 240ml. From Nursing: Days 150ml, Eves 150ml, Nights 0ml. every shift. Document amount consumed. Order Date- 06/28/2023 1519 (3:19 p.m.)." The eMAR documented R98 having 680ml on days, 680 on evening and 240 on nights on 6/29/2023 for a total of 1600ml.

The eMAR for R98 dated 7/1/2023-7/31/2023 documented in part, "Fluid Restriction: 1500 ml/day From Dietary: breakfast 720ml, lunch 240ml, dinner 240ml. From Nursing: Days 150ml, Eves 150ml, Nights 0ml. every shift. Document amount consumed. Order Date- 06/28/2023 1519 (3:19 p.m.)." The eMAR documented the following:
- on 7/1/2023, 960ml on days, 720 on evening and 0 on nights for a total of 1680ml.
- on 7/2/2023, 1320ml on days, 720 on evening and 50 on nights for a total of 2090ml.
- on 7/4/2023, 1320ml on days, 560 on evening and 0 on nights for a total of 1880ml.
- on 7/5/2023, 960ml on days, 480 on evening and 240 on nights for a total of 1680ml.
- on 7/7/2023, 960ml on days, 820 on evening and 180 on nights for a total of 1960ml.
- on 7/10/2023, 960ml on days, 600 on evening and 240 on nights for a total of 1800ml.

The clinical record failed to evidence documentation of resident non-compliance with the fluid restrictions or physician notification of the

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F 656	Continued From page 19 resident's non-compliance with the fluid restrictions. On 07/11/2023 at approximately 1:10 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the purpose of a resident's care plan was to address any issues the resident may be having, for discharge purposes and for total care. She stated that the care plan was not being implemented if a treatment or a procedure documented on the care plan was not provided. On 7/11/2023 at 3:51 p.m., an interview was conducted with RN (registered nurse) #2, unit manager. RN #2 stated that fluid restrictions were monitored by the physician's order. She stated that the order advised the staff what amount of fluids were allowed by dietary and by nursing and they documented the total amount of fluids taken in each shift on the eMAR. She stated that R98 was on fluid restrictions and was allowed 1500ml/day between dietary and nursing. She reviewed R98's eMAR for July 2023 with daily amounts totaling over 1500ml's and stated that there should be skilled notes documenting non-compliance if the resident was taking in more than the allotted amount and the physician or nurse practitioner should be notified. On 7/11/2023 at approximately 4:07 p.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.	F 656		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		8/26/23

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F 692	Continued From page 20 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review it was determined that the facility staff failed to implement interventions to monitor compliance with ordered fluid restrictions for one of 28 residents, Resident #98. The findings include: For Resident #98 (R98), the facility staff failed to monitor compliance and/or non-compliance with ordered daily fluid restrictions. R98 was admitted to the facility with diagnoses that included but were not limited to chronic	F 692	1. Resident #98 electronic order for fluid restriction was verified by RN on 7/11/2023. NP was notified of non-compliance with fluid restriction. 2. All residents with physician orders for fluid restriction were audited on 7/11/2023 to ensure documented amounts for fluid restriction matched physician order. All residents were noted to be receiving the appropriate amounts of fluids based on order. 3. Staff Development Coordinator will provide education of the following facility	

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F 692	Continued From page 21 kidney disease, stage 3 (1) and congestive heart failure (2). The physician's orders for R98 documented in part, "Fluid Restriction: 1500 ml (milliliter)/day From Dietary: breakfast 720ml, lunch 240ml, dinner 240ml. From Nursing: Days 150ml, Eves (evenings) 150ml, Nights 0ml every shift. Document amount consumed. Order Date: 06/28/2023." The eMAR (electronic medication administration record) for R98 dated 6/1/2023-6/30/2023 documented in part, "Fluid Restriction: 1500 ml/day From Dietary: breakfast 720ml, lunch 240ml, dinner 240ml. From Nursing: Days 150ml, Eves 150ml, Nights 0ml. every shift. Document amount consumed. Order Date- 06/28/2023 1519 (3:19 p.m.)." The eMAR documented R98 having 680ml on days, 680 on evening and 240 on nights on 6/29/2023 for a total of 1600ml. The eMAR for R98 dated 7/1/2023-7/31/2023 documented in part, "Fluid Restriction: 1500 ml/day From Dietary: breakfast 720ml, lunch 240ml, dinner 240ml. From Nursing: Days 150ml, Eves 150ml, Nights 0ml. every shift. Document amount consumed. Order Date- 06/28/2023 1519 (3:19 p.m.)." The eMAR documented the following: - on 7/1/2023, 960ml on days, 720 on evening and 0 on nights for a total of 1680ml. - on 7/2/2023, 1320ml on days, 720 on evening and 50 on nights for a total of 2090ml. - on 7/4/2023, 1320ml on days, 560 on evening and 0 on nights for a total of 1880ml. - on 7/5/2023, 960ml on days, 480 on evening and 240 on nights for a total of 1680ml. - on 7/7/2023, 960ml on days, 820 on evening	F 692	policy to all licensed nurses, "Fluid Restriction Diet". Any licensed nurse that has not completed education before 8/11/2023, will not be allowed to work until education is completed. All newly hired nurses will receive education during orientation on the following policy, "Fluid Restriction Diet". Director of Nursing or Designee will audit 100% of residents with physician orders for Fluid Restriction to ensure documented amount of fluids for the day match physician order 5x per week 4 weeks, 3x per week x4 weeks, and weekly x4 weeks. If non-compliance found, re-education will be provided. Director of Nursing or Designee will audit 100% of residents with physician orders for Fluid Restriction to ensure documented amount of fluids for the day match physician order, if amount exceeds fluid restriction, Director of Nursing or Designee will ensure documentation is present in medical record to validate non-compliance and provider notification. Audit will occur 5x per week 4 weeks, 3x per week x4 weeks, and weekly x4 weeks. If non-compliance found, re-education will be provided. 4. Director of Nursing or designee will present findings of audit to the Quality Assurance Performance Improvement (QAPI) committee for review and recommendations at monthly meeting. QAPI committee will consist of Executive Director, Director of Nursing, Staff	

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	495139	A. BUILDING _____ B. WING _____	C 07/12/2023

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F 692	Continued From page 22 and 180 on nights for a total of 1960ml. - on 7/10/2023, 960ml on days, 600 on evening and 240 on nights for a total of 1800ml. The clinical record failed to evidence documentation of resident non-compliance with the fluid restrictions or notification of the physician of resident non-compliance with fluid restrictions. The comprehensive care plan for R98 documented in part,"The resident has renal failure r/t (related to) ST (stage) III Kidney disease and kidney stones. Date Initiated: 07/03/2023. Revision on: 07/03/2023." Under "Interventions/Tasks" it documented in part, "...Fluids as ordered. Restrict or give as ordered. Date Initiated: 07/03/2023..." On 7/11/2023 at 3:51 p.m., an interview was conducted with RN (registered nurse) #2, unit manager. RN #2 stated that fluid restrictions were monitored by the physician's order. She stated that the order advised the staff what amount of fluids were allowed by dietary and by nursing and they documented the total amount of fluids taken in each shift on the eMAR. She stated that R98 was on fluid restrictions and was allowed 1500ml/day between dietary and nursing. She reviewed R98's eMAR for July 2023 with daily amounts totaling over 1500ml's and stated that there should be skilled notes documenting non-compliance if the resident was taking in more than the allotted amount and the physician or nurse practitioner should be notified. The facility provided policy "Fluid-Restriction Diet" dated 4/24/2023 documented in part, "...Indication: A fluid restriction diet is indicated in individuals with congestive heart failure,	F 692	Development Coordinator, Social Services, MDS Coordinator, Pharmacy Consultant, and Medical Director.	

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F 692	Continued From page 23 hypertension, fluid retention, pulmonary edema, hyponatremia, and renal failure..." On 7/11/2023 at approximately 4:07 p.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. Reference: (1) chronic kidney disease Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html. (2) 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	F 692		
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,	F 695		8/26/23

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F 695	Continued From page 24 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to provide respiratory care and services per physician's order for one of 28 residents in the survey sample, Resident #4. The findings include: For Resident #4 (R4), the facility staff failed to maintain R4'S oxygen flow rate at two liters per minute according to the physician's orders. R4 was admitted to the facility with diagnoses that included but were not limited to respiratory failure (1). R4's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 05/10/2023, coded R4 as scoring a 9 out of 15 on the brief interview for mental status (BIMS) which indicated the resident was moderately impaired of cognition for making daily decisions. Section O "Special Treatments, Procedures and Programs" coded R4 as receiving oxygen. On 07/10/2023 at approximately 2:43 p.m., R4 was observed lying in bed receiving oxygen by nasal cannula. The flow meter on the oxygen concentrator was set at a flow rate of four liters per minute. The physician's order for R4 dated 01/17/2023 documented, "Oxygen at 2 liters per minute PRN (as needed) per nasal cannula."	F 695	1. Resident #4 electronic order for oxygen therapy was verified by RN on 7/11/2023 and flow meter on oxygen concentrator was 2 Lpm. 2. All residents with physician orders for supplemental oxygen were audited on 7/11/2023 to ensure flow meter on concentrators and/or tank regulators matched physician order. All residents were noted to be on the correct liter of oxygen as ordered. 3. Staff Development Coordinator will provide education of the following facility policy to all licensed nurses, "Oxygen Administration/Safety/Storage/Maintenanc e". Any licensed nurse that has not completed education before 8/11/2023, will not be allowed to work until education is completed. All newly hired nurses will receive education during orientation on the following policy, "Oxygen Administration/Safety/Storage/Maintenanc e". Director of Nursing or Designee will audit 100% of residents with physician orders for supplemental oxygen to ensure flow meter on concentrators and/or tank regulators match physician order 5x per week 4 weeks, 3x per week x4 weeks, and weekly x4 weeks. If non-compliance found, re-education will be provided. 4. Director of Nursing or designee will	

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F 695	Continued From page 25 The comprehensive care plan for R4 dated 02/28/2023 documented in part, "Focus. The resident has altered respiratory status/difficulty breathing r/t (related to) sleep apnea. Date Initiated: 02/28/2023." Under "Interventions / Tasks" it documented in part, "Administer medication/puffers as ordered. Date Initiated: 02/28/2023." On 07/11/23 at approximately 1:10 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked if she was familiar with R4 she stated yes. When asked what the prescribed oxygen flow rate was ordered for R4 LPN #1 reviewed the electronic order and stated that the physician's order was for two liters per minute. When informed of the above observation LPN #1 stated that it was incorrect. On 07/11/2023 at approximately 4:00 p.m., ASM (administrative staff member) #1, executive director, and ASM #2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. References: (1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.	F 695	present findings of audit to the Quality Assurance Performance Improvement (QAPI) committee for review and recommendations at monthly meeting. QAPI committee will consist of Executive Director, Director of Nursing, Staff Development Coordinator, Social Services, MDS Coordinator, Pharmacy Consultant, and Medical Director.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		8/26/23

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F 812	Continued From page 26 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined facility staff failed to store food in a sanitary manner in one of one facility kitchens. The findings include: On 07/10/2023 at approximately 10:15 a.m., an observation of the facility's kitchen was conducted with OSM (other staff member) #1, assistant dietary manager. The following concerns were identified: 1. The facility staff failed to discard food that was available for use, found in the walk-in refrigerator located in the facility kitchen. On 07/10/2023 at approximately 10:20 a.m., an observation of the inside of the facility's walk-in refrigerator revealed the following.	F 812	1. No residents were affected by the deficient practice of leftovers not being discarded after 72 hours. The shredded jack cheese, cheddar cheese, and ham salad had not been served to any resident since placement in the walk-in refrigerator located in the kitchen. Immediately after being notified, the assistant dietary manager discarded the shredded jack cheese, cheddar cheese, and ham salad. No residents were affected by the deficient practice of uncovered plated sliced cake that was prepared and available for use, found in the walk-in refrigerator located in the facility kitchen. Dietary assistant manager immediately covered the plated sliced cake when he was notified.	

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F 812	Continued From page 27 a. A food container on a shelf with approximately two cups of shredded jack cheese dated 06/20/2023. b. A food container on a shelf with approximately two quarts of cheddar cheese dated 07/03/2023. c. A food container on a shelf with approximately two quarts of ham salad dated 07/06/2023. On 07/10/2023 at approximately 11:00 a.m., an interview was conducted with OSM #1. When asked about the dates on the food containers stated above OSM #1 stated that the date indicated when the food was placed in the container and after three days from the date, the food should be discarded. He further stated that the above food items should have been discarded. When asked to describe the procedure they follow to prevent expired food from being used OSM #1 stated that the kitchen staff, including himself should be checking the dates daily. He further stated it was an oversight. The facility's policy "Food Safety" documented in part, "Cold Food Storage. 10. Leftovers are dated properly and discarded after 72 hours unless otherwise indicated." 2. The facility staff failed to cover food that was prepared and available for use, found in the walk-in refrigerator located in the facility kitchen. On 07/10/2023 at approximately 10:20 a.m., an observation of the inside of the facility's walk-in refrigerator revealed 2 - three-shelf carts. One cart contained three trays of approximately 96 plated sliced cake for the residents, uncovered,	F 812	No residents were affected by the deficient practice of uncovered four-ounce cups of beverages found in the walk-in refrigerator located in the facility kitchen. Dietary assistant manager immediately covered the four-ounce cups of beverages when he was notified. No residents were affected by the deficient practice of uncovered 3 two-quart pitchers containing beverages for the residents found in the reach-in refrigerator located in the facility kitchen. Dietary assistant manager immediately covered the 3 two-quart pitchers containing beverages when he was notified. 2. No residents were affected by the deficient practice of leftovers not being discarded after 72 hours. The shredded jack cheese, cheddar cheese, and ham salad had not been served to any resident since placement in the walk-in refrigerator located in the kitchen. Immediately after being notified, the assistant dietary manager discarded the shredded jack cheese, cheddar cheese, and ham salad. No residents were affected by the deficient practice of uncovered plated sliced cake that was prepared and available for use, found in the walk-in refrigerator located in the facility kitchen. Dietary assistant manager immediately covered the plated sliced cake when he was notified. No residents were affected by the	

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F 812	Continued From page 28 and the other cart contained two trays of approximately 18, four-ounce cups of beverages for the residents, uncovered. On 07/10/2023 at approximately 11:00 a.m., an interview was conducted with OSM #1. When asked about the food items listed above, he stated that the dessert plates and beverages should have been covered to prevent contamination. 3. The facility staff failed to cover beverages that were prepared and available for use, found in the reach-in refrigerator located in the facility kitchen. On 07/10/2023 at approximately 10:30 a.m., an observation of the inside of the facility's reach-in refrigerator revealed 3 two-quart pitchers containing beverages for the residents, uncovered. When asked about the beverage items listed above, he stated that the beverages should have been covered to prevent contamination. On 07/11/2023 at approximately 4:00 p.m., ASM (administrative staff member) #1, executive director, and ASM #2, director of nursing, were made aware of the above findings. No further information was provided prior to exit.	F 812	deficient practice of uncovered four-ounce cups of beverages found in the walk-in refrigerator located in the facility kitchen. Dietary assistant manager immediately covered the four-ounce cups of beverages when he was notified. No residents were affected by the deficient practice of uncovered 3 two-quart pitchers containing beverages for the residents found in the reach-in refrigerator located in the facility kitchen. Dietary assistant manager immediately covered the 3 two-quart pitchers containing beverages when he was notified. On July 10, 2023, Assistant Dietary Manager and associate completed 100% inspection of all items in the walk-in and reach-in refrigerators located in the facility kitchen. All items containing open dates, discard dates, or use by dates as indicated were initiated. On July 10, 2023, Assistant Dietary Manager and associate completed 100% inspection of all beverages and plated desserts in the walk-in and reach-in refrigerators located in the facility kitchen. There were no beverages or desserts to cover at the time of the audit. 3. Food Service Director will provide written education on facility policy "Food Safety" to all current dietary associates. Any dietary associate that has not completed education before 8/11/2023 will not be allowed to work until education is	

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F 812	Continued From page 29	F 812	completed. All newly hired dietary associated will receive education during orientation on the following policy, "Food Safety". Food Service Director or Designee will audit Walk-In and Reach-In Refrigerators following daily scheduled audit to ensure no oversights on leftovers for expired dates and use by dates 5x per week x4 weeks, 3x per week x4 weeks, and weekly x4 weeks. If non-compliance found, re-education will be provided. Food Service Director or Designee will audit Walk-In and Reach-In Refrigerators to ensure beverages are covered appropriately 5x per week x4 weeks, 3x per week x4 weeks, and weekly x4 weeks. If non-compliance found, re-education will be provided. Food Service Director or Designee will audit Walk-In and Reach-In Refrigerators to ensure all plated desserts are covered appropriately 5x per week x4 weeks, 3x per week x4 weeks, and weekly x4 weeks. If non-compliance found, re-education will be provided. 4. Food Service Director or designee will present findings of audits to the Quality Assurance Performance Improvement (QAPI) committee for review and recommendations in monthly meeting. QAPI committee will consist of Executive Director, Director of Nursing, Staff Development Coordinator, Social Services, MDS Coordinator, Pharmacy	

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F 812	Continued From page 30	F 812	Consultant, and Medical Director.	
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to evidence documentation of current bed/side rail inspections for three of 28 residents in the survey sample, Residents #17, #64 and #4. The findings include: 1. Resident #17 (R17) was observed lying in bed with the right and left upper bed rails raised on 07/10/2023 at 2:35 p.m. R17 was admitted to the facility with diagnosis that included but was not limited to: a history of falls. Review of the facility's bed inspections dated 2022 failed to evidence a bed inspection for R17. On 7/11/2023 at 3:11 p.m., an interview was conducted with OSM (other staff member) #2 maintenance director. When asked about the 2022 bed inspection for R17, he stated that he	F 909	1. Maintenance Director completed Bed Inspections of the Seven Zones of Entrapment for residents #17, #64, and #4 on 7/11/2023. All three resident inspections were unremarkable. Documentation was completed on paper report and entered into TELS System. 2. Maintenance Director and Assistants completed 100% Bed Inspections of the Seven Zones of Entrapment of the remaining residents on 7/12/2023. All resident inspections were unremarkable. Documentation was completed on paper report and entered into TELS System. 3. Executive Director will provide written education to Maintenance Director and Assistants on the facility policy for "Bed Inspection & Maintenance and Bed Rail Installation". Any plant personnel that has not completed education by 8/11/2023, will not be allowed to work until education is completed. All newly hired plant personnel	8/26/23

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F 909	Continued From page 31 was unable to locate documentation that a bed inspection was completed. The facility's policy "Bed Inspection & Maintenance and Bed Rail Inspection" documented in part, "Procedure. 5. Quarterly inspections of the Seven Zones of Entrapment are required for all beds and when there are any changes to the bedframe, mattresses or side rails." On 07/11/2023 at approximately 4:00 p.m., ASM (administrative staff member) #1, executive director, and ASM #2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. 2. Resident #64 (R64) was observed lying in bed with the right and left upper bed rails raised on 07/10/2023 at 2:37 p.m. R64 was admitted to the facility with diagnosis that included but was not limited to: a history of falls. Review of the facility's bed inspections dated 2022 failed to evidence a bed inspection for R64. On 7/11/2023 at 3:11 p.m., an interview was conducted with OSM (other staff member) #2 maintenance director. When asked about the 2022 bed inspection for R64, he stated that he was unable to locate documentation that a bed inspection was completed. On 07/11/2023 at approximately 4:00 p.m., ASM (administrative staff member) #1, executive director, and ASM #2, director of nursing, were	F 909	will receive education during orientation on the following policy "Bed Inspection & Maintenance and Bed Rail Installation". Executive Director or Designee will validate 3rd Quarter bed inspections are completed and documented on paper audit and in TELS system x1 quarter. If non-compliance found, re-education will be provided. 4. Executive Director or designee will present findings of audit to the Quality Assurance Performance Improvement (QAPI) committee for review and recommendations in August 2023 monthly meeting. 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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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 909	Continued From page 32 made aware of the above findings. No further information was provided prior to exit. 3. Resident #4 (R4) was observed lying in bed with the right and left upper bed rails raised on 07/10/2023 at 2:42 p.m. Review of the facility's bed inspections dated 2022 failed to evidence a bed inspection for R4. On 7/11/2023 at 3:11 p.m., an interview was conducted with OSM (other staff member) #2 maintenance director. When asked about the 2022 bed inspection for R4, he stated that he was unable to locate documentation that a bed inspection was completed. On 07/11/2023 at approximately 4:00 p.m., ASM (administrative staff member) #1, executive director, and ASM #2, director of nursing, were made aware of the above findings. No further information was provided prior to exit.	F 909		