DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	СОМ	E SURVEY PLETED
		495139	B. WING				C / 12/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 07	12/2025
	E CENTER OF NEW MAI	2KET		31	5 EAST LEE HIGHWAY		
				N	EW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E 0	000			
F 000	survey was conducte 07/12/2023. The faci compliance with 42 C	lity was in substantial FR Part 483.73, g-Term Care Facilities. No ness complaints were e survey.	F0	000			
	survey was conducte 07/12/23. Correction compliance with 42 C Term Care requireme survey/report will follo (VA00054836-unsubs	s are required for FR Part 483 Federal Long nts. The Life Safety Code w. Two complaints stantiated and tiated with no deficiency)					
F 607 SS=D	95 at the time of the s consisted of 28 reside	buse/Neglect Policies	F 6	07			8/26/23
	§483.12(b) The facilit implement written pol	y must develop and icies and procedures that:					
	§483.12(b)(1) Prohibine neglect, and exploitate misappropriation of re	ion of residents and					
	§483.12(b)(2) Establi to investigate any suc	sh policies and procedures ch allegations, and					
	§483.12(b)(3) Include paragraph §483.95,	training as required at					
		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE
Electroni	cally Signed						07/27/2023

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

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMF	PLETED
		495139	B. WING				C 12/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	E CENTER OF NEW MAR	2KET		3	15 EAST LEE HIGHWAY		
				N	IEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page	9 1	F	607			
	§483.12(b)(4) Establis QAPI program require	sh coordination with the ed under §483.75.					
	§483.12(b)(5) Ensure occurring in federally- facilities in accordanc Act. The policies and but are not limited to the §483.12(b)(5)(ii) Pos employee rights, as d (3) of the Act. §483.12(b)(5)(iii) Pro- retaliation, as defined (2) of the Act. This REQUIREMENT by: Based on staff intervi	reporting of crimes funded long-term care e with section 1150B of the procedures must include the following elements. ting a conspicuous notice of efined at section 1150B(d) hibiting and preventing at section 1150B(d)(1) and is not met as evidenced iew, clinical record review,			1. Resident #260 no longer resides in	the	
	that the facility failed to policy for investigating resident altercation for survey sample, Resident The findings include:				 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 Responses." 3. Social Services Director or Designed 	se".	
	to implement their abore report a resident to re- reported to facility sta 5/21/2021, Resident # finger in their shared The facility policy "Are Neglect" dated 11/21/ "Residents must no	¢251 (R251) twisted R260's room.			 will review facility policy "Abuse - Reporting and Response" with resident 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, "Abus Reporting and Response". Any staff member that has not completed education by 8/11/2023 will not be allowed to work 	ts e - tion	

Facility ID: VA0145

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TATEMENT (OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
		495139	B. WING		С
		495139	B. WING_		07/12/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
LIFE CAR	E CENTER OF NEW MAR	RKET		315 EAST LEE HIGHWAY NEW MARKET, VA 22844	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 607	Continued From page	• 2	F 60	7	
	other residents, const from other agencies as members, the resider any other individuals. of abuse, neglect, exp the facility must: Ensu- involving abuse, negle mistreatment, includir source and misappro- are reported immedia hours after the allegat that cause the allegat that cause the allegat in serious bodily injur- if the events that caus involve abuse and do injury, to the administ other officials (includir Agency and adult pro- law provides for juriso facilities) in accordance established procedured investigations to the a designated represent accordance with State Agency, within 5 work if the alleged violation corrective action mus On R251's most rece a quarterly assessme (assessment reference resident was assesse impaired for making of documented R251 has behaviors directed too days during the assess	ultants, volunteers, staff serving our residents, family at representative, friends, or In response to allegations poloitation, or mistreatment, ure that all alleged violations ect, exploitation or ng injuries of unknown priation of resident property, itely, but not later than 2 tion is made, if the events tion involve abuse or result y, or not later than 24 hours se the allegation do not onot result in serious bodily trator of the facility and to ng to the State Survey tective services where state diction in long-term care ce with State law through es. Report the results of all administrator or his or her ative and to other officials in e law, including to the State king days of the incident, and n is verified appropriate t be taken" nt MDS (minimum data set), ent with an ARD ce date) of 2/9/2022, the ed as being moderately daily decisions. Section E aving physical and verbal wards others one to three ssment period.		 until education is complete hired staff members will ca and Neglect training durin Director of Nursing or des review behavior progress Monday thru Friday and w weekend days on Monday validate no concerns were medical records. Audit wil week x 12 weeks. If non-co found, re-education will be 4. Director of Nursing or d present findings of audit to Assurance Performance II (QAPI) committee monthly QAPI committee will cons Director, Director of Nursi Development Coordinator Services, MDS Coordinator Consultant, and Medical D 	omplete Abuse g orientation. ignee(s) will notes daily vill review y mornings to a documented in I occur 5x per compliance a provided. lesignee will o the Quality mprovement y x3 months. ist of Executive ng, Staff , Social or, Pharmacy
	On R260's most rece assessment with an A	nt MDS, a quarterly ARD (assessment reference			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495139	B. WING				C 12/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
				3	315 EAST LEE HIGHWAY		
LIFE CAR	E CENTER OF NEW MAP	RKET		Ν	NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	15 on the BIMS (brief assessment, indicatin cognitively intact for n R260 no longer reside not be observed or in dates. The record wa record. The progress notes fo - "5/21/2021 14:15 (2 involved in an alterca which her roommate finger, the resident ye to situation, the reside (signs or symptoms) of active ROM (range of room change, resider monitor for any injury prior to leaving the ro The progress notes fo - "5/21/2021 14:16 (2 had behaviors today, dining room the reside the floor in which brok also had altercation w the resident twisted th resident was removed safety, resident placed (responsible party) wa On 7/11/2023 at 4:10 to ASM (administrativ	he resident scored 15 out of interview for mental status) ing the resident was naking daily decisions. The dat the facility and could terviewed during the survey as reviewed as a closed or R260 documented in part, c15 p.m.) Resident was tion with her roommate in twisted her right pointer elled for staff, staff attended ent denied pain, no s/s of injury from finger, full i motion), resident declined at placed on alert charting to . The resident was safe om." or R251 documented in part, c16 p.m.) The resident has during lunch meal while in ent threw her glass cup on ke the glass, the resident <i>v</i> ith her roommate in which he roommate's finger, the d from situation to ensure rite on white board she was I on alert charting and RP as notified of behaviors." p.m., a request was made e staff member) #1, the evidence of reporting and esident to resident	F	607			

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CENTER STATEMENT (AND PLAN OF		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495139	` <i>`</i>	G	NSTRUCTION		PRINTED: FORM A OMB NO. ((X3) DATE SU COMPLE C 07/12 E	
LIFE CAR	E CENTER OF NEW MAF	RKET			AST LEE HIGHWAY MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 607	5/21/2021. On 7/12/2023 at 8:32 conducted with ASM is who stated that they or reporting or investigat resident altercation be 5/21/2021. ASM #2 p R251 dated 5/21/2021 monitoring for behavio 5/21/2021-5/23/2021 finger. ASM #2 stated find documentation the reported to administra R260 had a motherly had refused to move offered. She stated the situation was abusive they had never had sit them before. ASM #2 recall the incident on her. On 7/12/2023 at 11:0 conducted with LPN (LPN #3 stated that the they documented in the 5/21/2021 but did not them. She stated that what she did but the p remove the residents we nurse assessed the re physician, the respon of nursing and comple When asked why they stated that it was to m documented and to en	a.m., an interview was #2, the director of nursing did not have any evidence of ion for the resident to etween R251 and R260 on resented progress notes for 1-5/24/2021 documenting ors, and for R260 dated assessing for injury to the that they were unable to at the incident had been ative staff. She stated that relationship with R251 and to another room when hat if the nurse felt that the they should report it and taff not report anything to stated that she did not 5/21/2021 being reported to 1 a.m., an interview was licensed practical nurse) #3. ey remembered the incident	F 6	70				

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	-	D HUMAN SERVICES				FORM): 07/28/2023 // APPROVED
STATEMENT C	FOR MEDICARE & I F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495139	B. WING				C 12/2023
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	TE, ZIP CODE	011	12/2020
LIFE CARI	E CENTER OF NEW MAR	RKET		15 EAST LEE HIGHWAY IEW MARKET, VA 22844	1		
			I	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page	- 5	F 607				
	to be reported. She s considered a resident	tated that it would be to resident altercation.					
	On 7/12/2023 at 11:52 executive director and nursing were made as	ASM #2, the director of					
	No further information	was provided prior to exit.					
F 609	Reporting of Alleged \		F 609				8/26/23
SS=D	CFR(s): 483.12(b)(5)(
		se to allegations of abuse, or mistreatment, the facility					
	involving abuse, negle mistreatment, includin source and misapprop are reported immedia hours after the allegat that cause the allegat serious bodily injury, of the events that cause abuse and do not resu the administrator of th officials (including to t adult protective service for jurisdiction in long-	ing injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in pr not later than 24 hours if the allegation do not involve ult in serious bodily injury, to be facility and to other he State Survey Agency and the swhere state law provides					
	designated representa accordance with State Survey Agency, within	the results of all Idministrator or his or her ative and to other officials in a law, including to the State of 5 working days of the eged violation is verified					

Facility ID: VA0145

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		ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 07/28/202 ORM APPROVE NO. 0938-039
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495139	B. WING				07/12/2023
NAME OF PI	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	ł	
LIFE CAR	E CENTER OF NEW MAI	RKET			15 EAST LEE HIGHWAY IEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 609	Continued From page	e 6	F	609			
	This REQUIREMENT	e action must be taken. Γ is not met as evidenced					
	and facility document	view, clinical record review, t review, it was determined to report a resident to			1. Resident #260 no longer resides facility.	s in the	
	resident altercation to and the State Survey	Agency, for one of 28 y sample, Resident #260.			 All residents have the ability to b affected by deficient practice of faci staff failing to report a resident to re 	lity	
	The findings include:				altercation to appropriate administrate team leaders.	ative	
	to report a resident to 5/21/2021. On 5/21/2 twisted R260's finger	R260), the facility staff failed o resident altercation on 2021, Resident #251 (R251) in their shared room.			3. Social Services Director or Desig will review facility policy "Abuse - Reporting and Response" with resid in the next Resident Council Meetin scheduled for July 26, 2023.	dents	
	a quarterly assessme (assessment reference assessed as being m making daily decision R251 having physica	ce date) of 2/9/2022, the was noderately impaired for ns. Section E documented I and verbal behaviors			Staff Development Coordinator will provide 100% staff education to all associates on the facility policy, "At Reporting and Response". Facility will be educated that a Risk Manag	staff ement	
	the assessment perio				Report must be completed for all re to resident altercations. Any staff m that has not completed education b	iember y	
	date) of 11/14/2022, 1	ARD (assessment reference the resident scored 15 out of f interview for mental status)			8/11/2023 will not be allowed to wo education is completed. All newly h staff members will complete Abuse Neglect training during orientation.	ired	
	cognitively intact for r	making daily decisions.			All incidents for Resident to Reside Altercation will be reviewed by the l	Director	
	not be observed or in dates. The record wa	ed at the facility and could nerviewed during the survey as reviewed as a closed			of Nursing to ensure proper and tim notification to Director of Nursing an Executive Director 5x per week for weeks 3x per week for 4 weeks at	nd 4	
	record. The progress notes for	or R260 documented in part,			weeks, 3x per week for 4 weeks, ar per week for 4 weeks. If non-compl found, re-education will be provided	iance	

Facility ID: VA0145

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					OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
					С
		495139	B. WING		07/12/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAR	E CENTER OF NEW MA	RKET		315 EAST LEE HIGHWAY NEW MARKET, VA 22844	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLET
F 609 Continued From page 7 - "5/21/2021 14:15 (2:15 p.m.) Reside involved in an altercation with her roo		:15 p.m.) Resident was	F 60	 4. Director of Nursing or designe present findings of audit to the Q 	
	finger, the resident ye to situation, the resid (signs or symptoms) active ROM (range o room change, residen monitor for any injury	elled for staff, staff attended ent denied pain, no s/s of injury from finger, full f motion), resident declined nt placed on alert charting to . The resident was safe		Assurance Performance Improve (QAPI) committee monthly x3 mc QAPI committee will consist of E Director, Director of Nursing, Sta Development Coordinator, Socia Services, MDS Coordinator, Pha Consultant, and Medical Director	ement onths. xecutive ff I rmacy
	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.					
	conducted with ASM who stated that they reporting or investiga resident altercation b 5/21/2021. ASM #2 p R251 dated 5/21/202 monitoring for behavi	a.m., an interview was #2, the director of nursing did not have any evidence of tion for the resident to etween R251 and R260 on resented progress notes for 1-5/24/2021 documenting ors, and for R260 dated assessing for injury to the			

Facility ID: VA0145

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/28/2023 / APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMF	SURVEY LETED
		495139	B. WING			_		C 12/2023
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
LIFE CAR	E CENTER OF NEW MAP	₹KET			315 EAST LEE HIGHWAY NEW MARKET, VA 2284	44		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 609	find documentation the reported to administra R260 had a motherly had refused to move a offered. She stated the situation was abusive they had never had set them before. ASM #2 recall the incident on her. On 7/12/2023 at 11:0 conducted with LPN (LPN #3 stated that the they documented in the 5/21/2021 but did not them. She stated that what she did but the p remove the residents we nurse assessed the re physician, the respon of nursing and comple When asked why they stated that it was to m documented and to en incident because they to be reported. She s considered a resident The facility policy "Are Neglect" dated 11/21/ "Residents must no anyone. This include other residents, consist from other agencies s members, the resident	A that they were unable to hat the incident had been ative staff. She stated that relationship with R251 and to another room when hat if the nurse felt that the they should report it and taff not report anything to stated that she did not 5/21/2021 being reported to 1 a.m., an interview was licensed practical nurse) #3. ey remembered the incident he progress notes on recall who reported it to it she did not recall exactly process was to go in and rom the situation to ensure ere safe. She stated that the esident for injury, notified the sible party and the director eted an incident report. y followed this process, she hake sure everything was nsure follow through on the y were pretty sure that it had stated that it would be t to resident altercation.	F	609				

Facility ID: VA0145

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	TEMENT OF DEFICIENCIES (*1) PROVIDERSUPPLENCLA (*2) MULTIPLE CONSTRUCTION ABS139 B. WING MEE OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CC FE CARE CENTER OF NEW MARKET STREET ADDRESS, CITY, STATE, ZIP CC V(A) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX CANTING NOR SUPPLEN PROVIDER OR SUPPLENT FE CARE CENTER OF NEW MARKET SUMMARY STATEMENT OF DEFICIENCIES ID V(A) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CO V(A) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CO V(A) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CO V(A) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CO V(A) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER OR SUPPLY V(A) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER OR SUPPLY V(BACKET, VA 22844 ID PROVIDER OR SUPPLY PROVIDER OR SUPPLY F 609 Continued From page 9 F 609 F 609 PROVIDER OR SUPPLY PROVIDER OR SUPPLY F 609 Continued From page 9 </th <th></th> <th>INTED: 07/28/2023 FORM APPROVED IB NO. 0938-0391</th>		INTED: 07/28/2023 FORM APPROVED IB NO. 0938-0391			
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /) DATE SURVEY COMPLETED
		495139	B. WING			C 07/12/2023
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING ANME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF NEW MARKET STREET CORRECTION NUMBER: LIFE CARE CENTER OF NEW MARKET SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH DEFICIENCY OR USC IDENTIFYING INFORMATION) F 609 Continued From page 9 response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: Ensure that al lelged 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 is made, if the events that cause and do not 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 resident provides for jurisdiction in long-term care facilities) in accordance with State Isw including to the State Agency, within 5 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 Isw, including to the State Agency, within 5 to other officials in accordance with State Isw, including to the State Agency, within 5 to other officials in accordance with State Isw, including to the State Agency, within 5 working days of						•••••
LIFE CAR	E CENTER OF NEW MA	RKET		315 EAST LEE HIGHWAY		
				NEW MARKET, VA 22844	۱ 	
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECT CROSS-REFERENC	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE	(X5) COMPLETION DATE
F 609	response to allegations of abuse, neglect,			09		
	exploitation, or mistre Ensure that all allege neglect, exploitation of injuries of unknown s of resident property, but not later than 2 h made, if the events th involve abuse or result not later than 24 hou the allegation do not result in serious bodi of the facility and to of State Survey Agency services where state in long-term care fact State law through est the results of all invest administrator or his of representative and to with State law, includ within 5 working days alleged violation is ve action must be taken report any incident of	eatment, the facility must: d violations involving abuse, or mistreatment, including ource and misappropriation are reported immediately, ours after the allegation is nat cause the allegation ult in serious bodily injury, or rs if the events that cause involve abuse and do not ly injury, to the administrator other officials (including to the and adult protective law provides for jurisdiction lities) in accordance with tablished procedures. Report stigations to the r her designated o other officials in accordance ing to the State Agency, s of the incident, and if the erified appropriate corrective All personnel will promptly suspected incident of				
	of unknown origin to Abuse Coordinator in On 7/12/2023 at 11:5	their direct supervisor or nmediately"				
	nursing were made a	-				
F 610 SS=D	Investigate/Prevent/0 CFR(s): 483.12(c)(2)	Correct Alleged Violation -(4)	F 6	10		8/26/23
	§483.12(c) In respon	se to allegations of abuse,				
	67(02-99) Previous Versions Ob	solete Event ID: VHK	0.44	Facility ID: VA0145		n sheet Page 10 of 3

Facility ID: VA0145

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/28/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495139	B. WING		C 07/12/2023
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAR	E CENTER OF NEW MAI	RKET		315 EAST LEE HIGHWAY	
				NEW MARKET, VA 22844	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 610	Continued From page	e 10	F 610		
		or mistreatment, the facility			
	§483.12(c)(2) Have e violations are thoroug	vidence that all alleged hly investigated.			
		t further potential abuse, or mistreatment while the gress.			
	designated represent accordance with Stat Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by: Based on clinical rec review and staff inter- the facility failed to im-	administrator or his or her ative and to other officials in e law, including to the State n 5 working days of the leged violation is verified e action must be taken. T is not met as evidenced cord review, facility document view, it was determined that vestigate a resident to or one of 28 residents in the		 Resident #260 no longer resid facility. All residents have the ability to affected by deficient practice of fa staff failing to investigate a reside resident altercation. 	be icility
	For Resident #260 (R to investigate a reside that was reported to f On 5/21/2021, Reside R260's finger in their On R251's most rece a quarterly assessment (assessment reference assessed as being m	nt MDS (minimum data set),		 3. Social Services Director or Deswill review facility policy "Abuse - Reporting and Response" with resin the next Resident Council Meets scheduled for July 26, 2023. Staff Development Coordinator w provide 100% staff education to a associates on the facility policy, "AREPORTING and Response". Staff ewill include Facility Reportable Ind 	sidents ting ill Ill Abuse - education

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Facility ID: VA0145

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			0.00		OMB NO. 0938	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
			-		С	
		495139	B. WING		07/12/202	3
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
LIFE CAR	E CENTER OF NEW MAI	RKET		315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPL THE APPROPRIATE DA	ETIO
F 610	Continued From page	e 11	F 6	10		
		ers one to three days during		member that has not com by 8/11/2023 will not be a until education is complet	llowed to work	
		ARD (assessment reference		hired staff members will c and Neglect training durin	omplete Abuse	
		the resident scored 15 out of f interview for mental status) og the resident was		Executive Director and Di will receive written educat	5	
	cognitively intact for r	making daily decisions.		policy of reporting allegati and neglect to include "In	ons of abuse response to	
	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		allegations of abuse, negl or mistreatment, the facilit evidence that all alleged v	y must: Have violations are		
	record. The progress notes for	or R260 documented in part,		thoroughly investigated. F potential abuse, neglect, o mistreatment while the inv	exploitation, or	
	involved in an alterca	2:15 p.m.) Resident was ttion with her roommate in twisted her right pointer		progress. Report the resu investigations to the admi or her designated represe	nistrator or his	
	finger, the resident ye to situation, the reside	elled for staff, staff attended ent denied pain, no s/s		other officials in accordan law, including to the State	ce with State	
	active ROM (range or room change, resider monitor for any injury	of injury from finger, full f motion), resident declined nt placed on alert charting to . The resident was safe		within 5 working days of the alleged violation is we appropriate corrective act taken."	erified	
	prior to leaving the ro The progress notes for	oom." or R251 documented in part,		All Resident to Resident A be reviewed by the Direct		
- "5/21/2021 14:16 (2:16 p.m.) T had behaviors today, during lun	during lunch meal while in		ensure investigation was Facility Reportable Incide	nt was		
	the floor in which bro	lent threw her glass cup on ke the glass, the resident vith her roommate in which		completed if indicated 5x weeks, 3x per week for 4 per week for 4 weeks. If n	weeks, and 1x	
	resident was remove	he roommate's finger, the d from situation to ensure		found, re-education will be	e provided.	
	sorry, resident placed	rrite on white board she was d on alert charting and RP as notified of behaviors."		4. Director of Nursing or c present findings of audit to Assurance Performance I	o the Quality	
	safety, resident did w sorry, resident placed	rrite on white board she was d on alert charting and RP			o the Quality mprovement	

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Facility ID: VA0145

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				LE CONSTRUCTION		NO. 0938-039		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED		
						С		
		495139	B. WING		0	7/12/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE			
LIFE CAR	E CENTER OF NEW MA	RKET		315 EAST LEE HIGHWAY NEW MARKET, VA 22844				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 610	Continued From pag	e 12	F 61	o				
	to ASM (administrative) executive director for investigation for the r	On 7/11/2023 at 4:10 p.m., a request was made o 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		QAPI committee will consist Director, Director of Nursing, Development Coordinator, S Services, MDS Coordinator, Consultant, and Medical Dire	Staff ocial Pharmacy			
	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.							
	conducted with LPN LPN #3 stated that the they documented in the 5/21/2021 but did not them. She stated that what she did but the remove the resident that both residents with the the the the nurse assessed the the	11 a.m., an interview was (licensed practical nurse) #3. hey remembered the incident the progress notes on t recall who reported it to at she did not recall exactly process was to go in and from the situation to ensure ere safe. She stated that the resident for injury, notified the asible party and the director						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/28/2023 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495139	B. WING		_		C 12/2023
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	E CENTER OF NEW MAR	DKET		315 EAST LEE HIGHWAY			
				NEW MARKET, VA 2284	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 610	Continued From page of nursing and comple When asked why they stated that it was to m documented and to er incident because they to be reported. She s considered a resident The facility policy "Are Neglect" dated 11/21/ "Investigate/Preven In response to allegat exploitation, or mistre Have evidence that al thoroughly investigate abuse, neglect, explo while the investigation results of all investigate his or her designated officials in accordance the State Survey Age the incident, and if the appropriate corrective facility does not conde neglect by anyone. T limited to staff member consultants, volunteer serving our residents, resident representative	e 13 eted an incident report. y followed this process, she hake sure everything was insure follow through on the y were pretty sure that it had stated that it would be to resident altercation. ea of Focus: Abuse & 2022 documented in part, t/Correct Alleged Violation. tions of abuse, neglect, atment, the facility must: Il alleged violations are ed. Prevent further potential itation, or mistreatment is in progress. Report the tions to the administrator or representative and to other e with State law, including to ncy, within 5 working days of e alleged violation is verified e action must be takenThe one resident abuse and/or his includes but is not ers, other residents, rs, staff from other agencies family members, the re, sponsors, friends, or	F 61	С		πE	DATE
	report any incident or resident abuse and/or of unknown origin to t Abuse Coordinator im On 7/12/2023 at 11:52	2 a.m., ASM #1, the d ASM #2, the director of					

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	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NETRUCTION	OMB NO. 0938-0	
D PLAN OF CO		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
					с	
		495139	B. WING		07/12/2023	
IAME OF PROV	DER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
	_		315 E	EAST LEE HIGHWAY		
IFE CARE C	ENTER OF NEW MAP	RKET	NEW	/ MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLET	
F 610 C	ontinued From page	e 14	F 610			
		was provided prior to exit.				
	6 Develop/Implement Comprehensive Care Plan		F 656		8/26/23	
	R(s): 483.21(b)(1)	•				
§4 im ca re §4 ob m ne as de (i) or ph re (ii)	plement a compreh re plan for each res sident rights set for 83.10(c)(3), that ind jectives and timefra edical, nursing, and eds that are identifi sessment. The con scribe the following The services that a maintain the reside ysical, mental, and quired under §483.2	cility must develop and densive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial died in the comprehensive mprehensive care plan must prehensive care plan must pare to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required				

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	RM APPROVED
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495139	B. WING		0.	C 7/12/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	· · ·	
LIFE CAR	E CENTER OF NEW MAR	RKET		315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	local contact agencie entities, for this purpo (C) Discharge plans i plan, as appropriate, requirements set forth section. §483.21(b)(3) The se by the facility, as outli care plan, must- (iii) Be culturally-comp This REQUIREMENT by: Based on observatio record review, and fa was determined that i implement the compro of 28 residents in the and Resident #98. The findings include: 1. For Resident #4 (R implement the compro administration of physe R4 was admitted to the included but were not (1). R4's most recent MD annual assessment were reference date) of 05, scoring a 9 out of 15 mental status (BIMS) was moderately impa-	 and/or other appropriate ase. in the comprehensive care in accordance with the in paragraph (c) of this rvices provided or arranged ned by the comprehensive betent and trauma-informed. is not met as evidenced in, staff interview, clinical cility document review, it facility staff failed to ehensive care plan for two survey sample, Resident #4 44), the facility staff failed to ehensive care plan for the sician ordered oxygen. the facility with diagnoses that a limited to respiratory failure S (minimum data set), an which indicated the resident ired of cognition for making ion O "Special Treatments, 	F 65	 1. On 7/11/2023, resident #4 comprehensive care plan was reiby nursing team. Direct care staff educated on physician order for of @2lpm and implementation of comprehensive care plan that is non the resident kardex. On 7/11/2023, Resident #98 comprehensive care was reviewed nursing team. NP was made awa resident #98 is non-compliant with physician ordered fluid restriction On 7/11/2023, resident #98 comprehensive care plan was up contain the verbiage "not complia fluid restriction at times". 2. MDS Coordinator will review a residents with oxygen orders to e comprehensive care plan reflects order and that it flows to the kard direct care staff to visualize. MDS Coordinator will review all re with fluid restriction orders. MDS 	f were bxygen at reflected ed by are that th th th th th th th th th th th th th	

Event ID: VHKQ11

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE	0. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G	()	PLETED
			A. DOILDING	J		С
		495139	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
				315 EAST LEE HIGHWAY		
LIFE CAR	E CENTER OF NEW MA	KKEI		NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 656	Continued From page	e 16	F 65	56		
	1.0	proximately 2:43 p.m., R4	1.00	Coordinator will validate	the residents that	
		n bed receiving oxygen by		are non-compliant with fl		
		flow meter on the oxygen		update their comprehens		
		at four liters per minute.		reflect non compliance.		
	The physician's orde	r for R4 dated 01/17/2023		MDS Coordinator will no	tify provider of	
		en at 2 liters per minute PRN		residents that are found		
	(as needed) per nasa	al cannula."		compliant with fluid restr	iction.	
	The comprehensive	care plan for R4 dated		3. Staff Development Co	ordinator will	
		nted in part, "Focus. The		provide education to all r		
		respiratory status/difficulty		associates on facility pol	-	
		to) sleep apnea. Date		Assessment Instrument		
	Tasks" it documented	" Under "Interventions /		Development" and using tool. Any licensed nurse		
		s ordered. Date Initiated:		nursing assistant that ha		
	02/28/2023."	bordorou. Dato milatou.		education by 8/11/2023,		
				allowed to work until edu		
		oximately 1:10 p.m., an		completed. All newly hire		
		cted with LPN (licensed		nurses or certified nursir	•	
	. ,	When asked what the		receive education during		
		ow rate was for R4, she		"Resident Assessment Ir		
		nic order and stated that the s for two liters per minute.		Plan Development" and kardex tool.	using resident	
		e above observation LPN #1				
		orrect. When asked to		MDS Coordinator or Des	ignee will audit all	
	describe the purpose	e of a resident's care plan,		residents with physician	orders for	
		was to address any issues		supplemental oxygen an		
	the resident may be l			comprehensive care pla		
		al care. After being informed		oxygen use and liter is c resident kardex for direc		
	care plan was being	ation LPN #1 was asked if the		utilization. Audit will occu		
		's) oxygen; LPN #1 stated		weeks. If non-complianc	-	
	no.	, , , ,		re-education will be prov		
		proximately 4:00 p.m., ASM		MDS Coordinator or Des		
		member) #1, executive		residents with physician		
		2, director of nursing, were		restriction and ensure re		
	made aware of the a	nove initialitys.		compliance/non-complia	nce unougn	

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	FED: 07/28/2023 RM APPROVED NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495139	B. WING				C 07/12/2023
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		PVET		3	15 EAST LEE HIGHWAY		
	E CENTER OF NEW MA	RREI		Ν	IEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 656	Continued From page	e 17	F	656			
	No further information References: (1) When not enough lungs into your blood obtained from the we https://www.nlm.nih.g ilure.html. 2. For Resident #98 to monitor complianc with ordered daily flui care. The comprehensive of documented in part, r/t (related to) current (right) BKA (below the dyslipidema, DM II (the CKD III (chronic kidner (hypertension), CHF Kidney stones, anem hypokalemia, Fluid re 06/28/2023. Revision "Interventions/Tasks" "Honor fluid restrict adhere to restriction. Revision on: 07/03/20 documented "The rest (stage) III Kidney disc Date Initiated: 07/03/ 07/03/2023." Under documented in part, or give as ordered. D	n was provided prior to exit. a oxygen passes from your . This information was bsite: gov/medlineplus/respiratoryfa (R98), the facility staff failed e and/or non-compliance id restrictions per the plan of care plan for R98 'At risk for weight fluctuation t health status, sepsis, r e knee amputation), ype 2 diabetes mellitus), ey disease stage 3), HTN (congestive heart failure), ia, afib (atrial fibrillation), estriction. Date Initiated: on: 07/03/2023." Under it documented in part, ion, encourage resident to Date Initiated: 07/03/2023. 023." The care plan further sident has renal failure r/t ST ease and kidney stones. 2023. Revision on: "Interventions/Tasks" it 'Fluids as ordered. Restrict ate Initiated: 07/03/2023"			 validation of documentation on electric medical record. Documentation will include provider notification. Audit with occur 5x per week x4 weeks, 3x per x4 weeks, and 1x per week x4 weeks non-compliance found, re-education be provided. 4. MDS Coordinator or designee will present findings of audit to the Qualit 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, Pharma Consultant, and Medical Director. 	ll week s. If will ty nt	
	part, "Fluid Restrictio From Dietary: breakfa	rs for R98 documented in n: 1500 ml (milliliter)/day ast 720ml, lunch 240ml, Nursing: Days 150ml, Eves					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE	
		495139	B. WING				C / 12/2023
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
	E CENTER OF NEW MAR	RKET			315 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 656	record) for R98 dated documented in part, " ml/day From Dietary: 240ml, dinner 240ml. Eves 150ml, Nights 0 amount consumed. C (3:19 p.m.)." The eM 680ml on days, 680 c on 6/29/2023 for a tot The eMAR for R98 da documented in part, " ml/day From Dietary: 240ml, dinner 240ml. Eves 150ml, Nights 0 amount consumed. C (3:19 p.m.)." The eM following: - on 7/1/2023, 960ml and 0 on nights for a - on 7/2/2023, 1320m and 50 on nights for a - on 7/5/2023, 960ml and 240 on nights for - on 7/10/2023, 960ml and 180 on nights for - on 7/10/2023, 960ml and 240 on nights for - on 7/10/2023, 960ml and 240 on nights for - on 7/10/2023, 960ml and 240 on nights for	ghts 0ml every shift. Insumed. Order Date: c medication administration 6/1/2023-6/30/2023 Fluid Restriction: 1500 breakfast 720ml, lunch From Nursing: Days 150ml, ml. every shift. Document Order Date- 06/28/2023 1519 AR documented R98 having on evening and 240 on nights cal of 1600ml. ated 7/1/2023-7/31/2023 Fluid Restriction: 1500 breakfast 720ml, lunch From Nursing: Days 150ml, ml. every shift. Document Order Date- 06/28/2023 1519 AR documented the on days, 720 on evening total of 1680ml. I on days, 560 on evening a total of 2090ml. I on days, 560 on evening a total of 1680ml. on days, 480 on evening a total of 1680ml. on days, 820 on evening a total of 1680ml. I on days, 600 on evening a total of 1800ml. I on days, 600 on evening a total of 1800ml.	F	656	6		
		r physician notification of the					

Facility ID: VA0145

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391	
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			PLETED C
		495139	B. WING				
NAME OF PF	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAR	E CENTER OF NEW MAR	RKET			15 EAST LEE HIGHWAY EW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 656	interview was conduct practical nurse) #1. L purpose of a resident any issues the reside discharge purposes a stated that the care p implemented if a treat documented on the car On 7/11/2023 at 3:51 conducted with RN (n manager. RN #2 stat were monitored by the stated that the order a amount of fluids were nursing and they doct fluids taken in each st stated that R98 was ca allowed 1500ml/day to She reviewed R98's ed daily amounts totaling that there should be s non-compliance if the than the allotted amoun nurse practitioner should On 7/11/2023 at apprentime that the state of the than the allotted amoun nurse practitioner should be stated that the state of the than the allotted amounts totaling that there should be stated that the shou	ance with the fluid proximately 1:10 p.m., an ted with LPN (licensed .PN #1 stated that the 's care plan was to address int may be having, for and for total care. She lan was not being tment or a procedure are plan was not provided. p.m., an interview was egistered nurse) #2, unit ted that fluid restrictions e physician's order. She advised the staff what allowed by dietary and by umented the total amount of hift on the eMAR. She on fluid restrictions and was between dietary and nursing. MAR for July 2023 with g over 1500ml's and stated skilled notes documenting resident was taking in more unt and the physician or build be notified. coximately 4:07 p.m., ASM hember) #1, the executive the director of nursing were	F	656			
F 692 SS=D			F	692			8/26/23

Facility ID: VA0145

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE	
		495139	B. WING				C 12/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CI	ITY, STATE, ZIP CODE	1	
	E CENTER OF NEW MAP	RKET		315 EAST LEE HIGH NEW MARKET, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	(EACH C	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD I FERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 692	Continued From page	20	F	92			
	(Includes naso-gastric both percutaneous er percutaneous endoso enteral fluids). Based comprehensive asses ensure that a resident §483.25(g)(1) Maintai of nutritional status, s desirable body weigh balance, unless the re demonstrates that this preferences indicate of §483.25(g)(2) Is offer maintain proper hydra §483.25(g)(3) Is offer there is a nutritional p provider orders a ther This REQUIREMENT by: Based on clinical rec and facility document that the facility staff fa- interventions to monit fluid restrictions for or #98. The findings include: For Resident #98 (R9	essment, the facility must t- ins acceptable parameters uch as usual body weight or t range and electrolyte esident's clinical condition is is not possible or resident otherwise; ed sufficient fluid intake to ation and health; ed a therapeutic diet when roblem and the health care rapeutic diet. is not met as evidenced ord review, staff interview, review it was determined uiled to implement or compliance with ordered he of 28 residents, Resident 8), the facility staff failed to nd/or non-compliance with		restriction was 7/11/2023. NF non-compliand 2. All residents fluid restriction to ensure doct restriction mat residents were	⁴⁹⁸ electronic order for fl s verified by RN on ⁹ was notified of ce with fluid restriction. s with physician orders f n were audited on 7/11/2 umented amounts for flu tched physician order. A e noted to be receiving t mounts of fluids based o	or 1023 id II ne	
		the facility with diagnoses e not limited to chronic			opment Coordinator will ation of the following faci	lity	

Facility ID: VA0145

If continuation sheet Page 21 of 33

		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
					С
		495139	B. WING		07/12/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAR	E CENTER OF NEW MAI	RKET		315 EAST LEE HIGHWAY NEW MARKET, VA 22844	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO
F 692	Continued From page	e 21	F 69	2	
1 002	kidney disease, stage failure (2). The physician's order part, "Fluid Restrictio From Dietary: breakfa dinner 240ml. From N (evenings) 150ml, Nig Document amount co 06/28/2023." The eMAR (electronic record) for R98 dated documented in part, ' ml/day From Dietary: 240ml, dinner 240ml. Eves 150ml, Nights 0 amount consumed. C (3:19 p.m.)." The eM 680ml on days, 680 c on 6/29/2023 for a to	e 3 (1) and congestive heart rs for R98 documented in n: 1500 ml (milliliter)/day ast 720ml, lunch 240ml, Nursing: Days 150ml, Eves ghts 0ml every shift. onsumed. Order Date: c medication administration d 6/1/2023-6/30/2023 'Fluid Restriction: 1500 breakfast 720ml, lunch From Nursing: Days 150ml, 0ml. every shift. Document Order Date- 06/28/2023 1519 IAR documented R98 having on evening and 240 on nights	F 09.	 policy to all licensed nurses, "Fluid Restriction Diet". Any licensed nurses not completed education befor 8/11/2023, will not be allowed to veducation is completed. All newly nurses will receive education duri orientation on the following policy Restriction Diet". Director of Nursing or Designee wa 100% of residents with physician for Fluid Restriction to ensure documented amount of fluids for the match physician order 5x per weeks, 3x per week x4 weeks, an weekly x4 weeks. If non-complian found, re-education will be provided Director of Nursing or Designee wa 100% of residents with physician for Fluid Restriction to ensure documented amount of fluids for the match physician or der 5x per week weeks, and weekly x4 weeks. If non-compliant found, re-education will be provided Director of Nursing or Designee was 100% of residents with physician for Fluid Restriction to ensure documented amount of fluids for the match physician order, if amount of fluids for the match physician order, if amount of fluids for the match physician order, if amount of fluids for the match physician order fluids for the match physician order, if amount of fluids for the match physician order fluids for the match physician order, if amount of fluids for the match physician order fluids for the matche physician order fluids for the matche physician order flui	urse that pre vork until hired ng , "Fluid vill audit orders he day k 4 d ice ed. vill audit orders he day
	documented in part, ' ml/day From Dietary: 240ml, dinner 240ml. Eves 150ml, Nights 0 amount consumed. C (3:19 p.m.)." The eM following: - on 7/1/2023, 960ml and 0 on nights for a - on 7/2/2023, 1320m and 50 on nights for a - on 7/4/2023, 1320m and 0 on nights for a	'Fluid Restriction: 1500 breakfast 720ml, lunch From Nursing: Days 150ml, Oml. every shift. Document Order Date- 06/28/2023 1519 IAR documented the on days, 720 on evening total of 1680ml. I on days, 720 on evening a total of 2090ml. I on days, 560 on evening total of 1880ml. on days, 480 on evening		 fluid restriction, Director of Nursin Designee will ensure documentat present in medical record to valida non-compliance and provider noti Audit will occur 5x per week 4 we per week x4 weeks, and weekly x weeks. If non-compliance found, re-education will be provided. 4. Director of Nursing or designee present findings of audit to the Qu Assurance Performance Improver (QAPI) committee for review and recommendations at monthly mee QAPI committee will consist of Ex 	g or ion is ate fication. eks, 3x 4 e will iality ment eting.

Facility ID: VA0145

If continuation sheet Page 22 of 33

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		10. 0938-039 TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED	
						С	
		495139	B. WING		0	7/12/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
LIFE CAR	E CENTER OF NEW MA	RKET		315 EAST LEE HIGHWAY NEW MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 692	Continued From page	e 22	F 69	2			
	and 180 on nights for	r a total of 1960ml.		Development Coordinator, So	ocial		
	0	nl on days, 600 on evening		Services, MDS Coordinator, F			
	and 240 on nights for	r a total of 1800ml.		Consultant, and Medical Dire	ctor.		
	The clinical record fa	iled to ovidence					
	documentation of resident non-compliance with						
		or notification of the physician					
		liance with fluid restrictions.					
	The comprehensive	care plan for R98					
	-	The resident has renal					
	failure r/t (related to)						
	disease and kidney s						
		on: 07/03/2023." Under					
		it documented in part, Restrict or give as ordered.					
	Date Initiated: 07/03/						
	On 7/11/2023 at 3:51	p.m., an interview was					
	conducted with RN (r	egistered nurse) #2, unit					
	-	ted that fluid restrictions					
		e physician's order. She					
		advised the staff what					
		e allowed by dietary and by umented the total amount of					
		hift on the eMAR. She					
		on fluid restrictions and was					
		between dietary and nursing.					
		eMAR for July 2023 with					
		g over 1500ml's and stated					
		skilled notes documenting					
	-	e resident was taking in more ount and the physician or					
	nurse practitioner sho						
	The facility provided	policy "Fluid-Restriction Diet"					
	dated 4/24/2023 doc						
		restriction diet is indicated in					
	individuals with cong	estive heart failure					

Facility ID: VA0145

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495139	B. WING				C 12/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAR	E CENTER OF NEW MAR	RKET			815 EAST LEE HIGHWAY NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 692	hypertension, fluid ref hyponatremia, and re On 7/11/2023 at appr (administrative staff n director and ASM #2, made aware of the fir No further information Reference: (1) chronic kidney dis Kidneys are damaged they should. This info the website:	tention, pulmonary edema, nal failure" oximately 4:07 p.m., ASM nember) #1, the executive the director of nursing were adings.	F	692			
F 695 SS=D	blood to meet the boo does not mean that ye about to stop working not able to pump bloo affect one or both side information was obtai https://medlineplus.go Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care an The facility must ensu- needs respiratory car care and tracheal suc- care, consistent with practice, the compre-	he heart can't pump enough dy's needs. Heart failure our heart has stopped or is . It means that your heart is od the way it should. It can es of the heart. This ned from the website: ov/heartfailure.html tomy Care and Suctioning	F	695			8/26/23

Facility ID: VA0145

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	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-039 TE SURVEY	
and plan of	CORRECTION	IDENTIFICATION NUMBER:		<u> </u>	COMPLETED		
		495139	B. WING		0	C 7/12/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
	E CENTER OF NEW MAI	PKET		315 EAST LEE HIGHWAY			
				NEW MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 695	Continued From page	e 24	F 69	15			
	and 483.65 of this su		1 00				
	This REQUIREMENT	Γ is not met as evidenced					
	by:						
		n, staff interview, clinical cility document review, it		1. Resident #4 electronic orc oxygen therapy was verified			
		facility staff failed to provide		7/11/2023 and flow meter on	•		
		services per physician's		concentrator was 2 Lpm.	oxygon		
	order for one of 28 re						
	sample, Resident #4.			2. All residents with physiciar	n orders for		
				supplemental oxygen were a			
	The findings include:			7/11/2023 to ensure flow met			
				concentrators and/or tank reg	-		
		, the facility staff failed to n flow rate at two liters per		matched physician order. All were noted to be on the corre			
		he physician's orders.		oxygen as ordered.			
	R4 was admitted to th	he facility with diagnoses that		3. Staff Development Coordir	nator will		
		t limited to respiratory failure		provide education of the follo			
	(1).			policy to all licensed nurses,	"Oxygen		
				Administration/Safety/Storage			
		S (minimum data set), an		e". Any licensed nurse that h			
		vith an ARD (assessment		completed education before a			
		/10/2023, coded R4 as on the brief interview for		will not be allowed to work ur is completed. All newly hired			
		which indicated the resident		receive education during orie			
	· · · ·	aired of cognition for making		the following policy, "Oxygen			
		ion O "Special Treatments,		Administration/Safety/Storage			
	Procedures and Prog	grams" coded R4 as		e".			
	receiving oxygen.						
	0 07//0/005			Director of Nursing or Design			
		proximately 2:43 p.m., R4		100% of residents with physic			
		n bed receiving oxygen by ow meter on the oxygen		for supplemental oxygen to e meter on concentrators and/o			
		at a flow rate of four liters		regulators match physician o			
	per minute.			week 4 weeks, 3x per week >	•		
				and weekly x4 weeks. If non-			
	The physician's order	r for R4 dated 01/17/2023		found, re-education will be pr	•		
		n at 2 liters per minute PRN					
	(as needed) per nasa	al cannula."		4. Director of Nursing or desi	gnee will		

Facility ID: VA0145

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					FORM	APPROVED	
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY			
CORRECTION	IDENTIFICATION NOMBER.		NG		COMPLETED		
	495139	B. WING _				_ 12/2023	
ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
E CENTER OF NEW MAR	RKET		31	5 EAST LEE HIGHWAY			
1			NE				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	x			(X5) COMPLETION DATE	
Continued From page The comprehensive of 02/28/2023 document resident has altered ro breathing r/t (related t Initiated: 02/28/2023.' Tasks" it documented medication/puffers as 02/28/2023." On 07/11/23 at approxinterview was conduc practical nurse) #1. V familiar with R4 she s what the prescribed of for R4 LPN #1 review stated that the physic per minute. When inf observation LPN #1 s On 07/11/2023 at app (administrative staff m director, and ASM #2, made aware of the ab No further information References: (1) When not enough lungs into your blood. obtained from the well	e 25 are plan for R4 dated ted in part, "Focus. The espiratory status/difficulty to) sleep apnea. Date " Under "Interventions / in part, "Administer ordered. Date Initiated: ximately 1:10 p.m., an ted with LPN (licensed When asked if she was tated yes. When asked oxygen flow rate was ordered ed the electronic order and ian's order was for two liters formed of the above stated that it was incorrect. oroximately 4:00 p.m., ASM nember) #1, executive , director of nursing, were bove findings. n was provided prior to exit.		595	DEFICIENCY) present findings of audit to the Quality Assurance Performance Improvement (QAPI) committee for review and recommendations at monthly meeting. QAPI committee will consist of Executi Director, Director of Nursing, Staff Development Coordinator, Social	ve		
ilure.html. Food Procurement,St CFR(s): 483.60(i)(1)(2	ore/Prepare/Serve-Sanitary 2)	F 8	312			8/26/23	
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER E CENTER OF NEW MAR SUMMARY ST, (EACH DEFICIENC) REGULATORY OR I Continued From page The comprehensive of 02/28/2023 document resident has altered r breathing r/t (related to Initiated: 02/28/2023. Tasks" it documented medication/puffers as 02/28/2023." On 07/11/23 at appro- interview was conduce practical nurse) #1. V familiar with R4 she s what the prescribed of for R4 LPN #1 review stated that the physic per minute. When info observation LPN #1 s On 07/11/2023 at appro- (administrative staff in director, and ASM #2 made aware of the at No further information References: (1) When not enough lungs into your blood. obtained from the wel- https://www.nlm.nih.g ilure.html. Food Procurement,St CFR(s): 483.60(i) Food safet	IDENTIFICATION NUMBER: 495139 ROVIDER OR SUPPLIER E CENTER OF NEW MARKET SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 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/respiratoryfa ilure.html. Fourement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	IN PROVIDER/SUPPLIER/CLIA (X2) MULT CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT A BUILDI 495139 B. WING ROVIDER OR SUPPLIER E CENTER OF NEW MARKET ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 25 F 6 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/respiratoryfa ilure.html. F 8 Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) F	SPOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER: (X2) MULTIPLE A BUILDING	SS FOR MEDICARE & MEDICAID SERVICES DF DEFICIENCIES (X1) PROVIDENSUPPLIENCLIA (X2) MULTIPLE CONSTRUCTION A 95139 a. BUILDING	SS FOR MEDICARE & MEDICAID SERVICES OMB NC OF DEFICIENCIES (X) PROVIDERSUPLEXCLA (2) MULTIPLE CONSTRUCTION (X) DRV A BULLING (X) PROVIDERSUPLEXCLA (X) PROVIDERSUPLEXCLA (X) DRV A BULLING (X) PROVIDERSUPLEXCLA (X) PROVIDERSUPLEXCLA (X) DRV ROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 315 EAST LEE HIGHWAY (X) DRV RECENTER OF NEW MARKET SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION RECENT OF NEW MARKET SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION Continued From page 25 ID PREEX PREEX PROVIDERS PLAN OF CORRECTION Continued From page 25 F 695 PREEX PREEX CARSS-REPRENCED TO THE APHYORMARE The comprehensive care plan for R4 dated 02/28/2023 documented in part, "Focus. The resident has attend respiratory status" difficulty breating if (related to) sleep apnea. Date Initiated: 02/28/2023." F 695 Thask" it documented in part, "Administer medication/puffers as ordered. Date Initiated: 02/28/2023." Services, MDS Coordinator, Pharmacy Consultant, and Medical Director. On 07/11/20 at approximately 1:10 p.m., an interview was conducted with LPN (icensed provement. Social Services, MDS Coordinator, Pharmacy Consultant, and Medical Director. Services, MDS Coordinator, Pharmacy Consultant, and Medical Director. On 07/11/2023 at approx	

Facility ID: VA0145

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1) PROVIDER/SUPPLIER/CLIA (X2) MULTI		(X3) DA	IO. 0938-039 TE SURVEY MPLETED
		495139	B. WING		0	C 7/12/2023
NAME OF P	ROVIDER OR SUPPLIER	•	- I	STREET ADDRESS, CITY, STATE, ZIP		
	E CENTER OF NEW MA	RKET		315 EAST LEE HIGHWAY		
				NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIOI DATE
F 812	Continued From page	e 26	F 8	12		
	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			 No residents were affed deficient practice of leftowe discarded after 72 hours. jack cheese, cheddar cheat salad had not been served since placement in the wat located in the kitchen. Imm being notified, the assistant manager discarded the shi cheese, cheddar cheese, No residents were affected deficient practice of uncow sliced cake that was prepatavailable for use, found in refrigerator located in the to Dietary assistant manager 	ers not being The shredded ese, and ham d to any resident lk-in refrigerator nediately after nt dietary redded jack and ham salad. d by the ered plated ared and the walk-in facility kitchen.	

Facility ID: VA0145

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/28/2023 M APPROVED O. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495139	B. WING				C / 12/2023	
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LIFE CAR	E CENTER OF NEW MAN	RKET			15 EAST LEE HIGHWAY IEW MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 812	Continued From page	e 27	F	812				
	 ² 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." 				No residents were affected by the deficient practice of uncovered four-occups of beverages found in the walk-refrigerator located in the facility kitch Dietary assistant manager immediate covered the four-ounce cups of bever when he was notified. No residents were affected by the deficient practice of uncovered 3 two-quart pitchers containing beverage for the residents found in the reach-in refrigerator located in the facility kitch Dietary assistant manager immediate covered the 3 two-quart pitchers containing beverages when he was notified. 2. No residents were affected by the deficient practice of leftovers not bein discarded after 72 hours. The shredog jack cheese, cheddar cheese, and has salad had not been served to any resistince placement in the walk-in refriger located in the kitchen. Immediately a being notified, the assistant dietary manager discarded the shredded jac cheese, cheddar cheese, and ham set No residents were affected by the deficient practice of uncovered plated sliced cake that was prepared and	in hen. ely rages ges hen. ely led am sident erator fter k alad.		
	walk-in refrigerator lo	le for use, found in the cated in the facility kitchen. proximately 10:20 a.m., an			available for use, found in the walk-ir refrigerator located in the facility kitch Dietary assistant manager immediate	nen.		
	observation of the ins refrigerator revealed	side of the facility's walk-in 2 - three-shelf carts. One trays of approximately 96			covered the plated sliced cake when was notified.			
		the residents, uncovered,			No residents were affected by the			

Facility ID: VA0145

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		ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 07/28/2023 RM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1)				PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495139	B. WING		a	C 7/12/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		
				315 EAST LEE HIGHWAY		
	E CENTER OF NEW MAR	KKE I		NEW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 812	((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 81		ncovered four-ounce and in the walk-in the facility kitchen. ager immediately be cups of beverages ected by the ncovered 3 ntaining beverages d in the reach-in the facility kitchen. ager immediately art pitchers when he was sistant Dietary te completed 100% in the walk-in and located in the facility aining open dates, by dates as d. sistant Dietary te completed 100% ages and plated n and reach-in n the facility kitchen. ages or desserts to e audit. tor will provide acility policy "Food	
				Any dietary associate completed education I not be allowed to work	before 8/11/2023 will	

Event ID: VHKQ11

Facility ID: VA0145

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE 8				PRINTED: 07/28/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495139	B. WING		C 07/12/2023
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
	PVET	3	15 EAST LEE HIGHWAY	
LIFE CARE CENTER OF NEW MA	RKEI	N	IEW MARKET, VA 22844	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION
F 812 Continued From page	je 29	F 812		on during cy, "Food nee will frigerators to ensure xpired week x4 and ance rided. nee will frigerators ed reeks, 3x y x4 d, nee will frigerators e covered reeks, 3x y x4 d, signee will frigere vill frigeretors e covered reeks, 3x y x4 d, signee will frigeretors e covered frigeretors e covered frigeretors e coveretor frigeretors e coveretor frigeretors e coveretor frigeretors e coveretor frigeretors frigeretor frigeret

Event ID: VHKQ11

Facility ID: VA0145

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	-	ND HUMAN SERVICES					MAPPROVE D. 0938-039
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY	
		495139	B. WING				C 12/2023
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				31	5 EAST LEE HIGHWAY		
LIFE CAR	E CENTER OF NEW MAI	RKEI		N	EW MARKET, VA 22844		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page	e 30	F	812			
					Consultant, and Medical Director.		
F 909			F	909			8/26/23
SS=D	CFR(s): 483.90(d)(3)						
	§483.90(d)(3) Condu						
	bed frames, mattress						
		ntenance program to identify					
	areas of possible ent and mattresses are u						
	separately from the b						
		ails, mattress, and bed					
	frame are compatible						
	by:	Γ is not met as evidenced					
	Based on observatio			1. Maintenance Director completed Be	ed		
		d clinical record review, it			Inspections of the Seven Zones of		
		the facility staff failed to			Entrapment for residents #17, #64, and	1 #4	
		tion of current bed/side rail of 28 residents in the survey			on 7/11/2023. All three resident		
	sample, Residents #				inspections were unremarkable. Documentation was completed on pape	er	
		,			report and entered into TELS System.		
	The findings include:						
	1 Decident #17 /D17	7) was abaamind himm in had			2. Maintenance Director and Assistants		
		7) was observed lying in bed upper bed rails raised on			completed 100% Bed Inspections of th Seven Zones of Entrapment of the	e	
	07/10/2023 at 2:35 p.				remaining residents on 7/12/2023. All		
					resident inspections were unremarkabl		
		the facility with diagnosis			Documentation was completed on pape	er	
	that included but was falls.	s not limited to: a history of			report and entered into TELS System.		
	10113.				3. Executive Director will provide writte	n	
		's bed inspections dated			education to Maintenance Director and		
	2022 failed to eviden	ce a bed inspection for R17.			Assistants on the facility policy for "Bed		
	On 7/11/2022 at 2.14	n m. on intorview wee			Inspection & Maintenance and Bed Ra		
		p.m., an interview was (other staff member) #2			Installation". Any plant personnel that h not completed education by 8/11/2023,		
		. When asked about the			not be allowed to work until education i		
	2022 bed inspection for R17, he stated that he		1				1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495139		A. BUILDI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			PRINTED: 07/28/202 FORM APPROVE OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C 07/12/2023		
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 15 EAST LEE HIGHWAY			
LIFE CAR	E CENTER OF NEW MAR	₹KET			EW MARKET, VA 22844			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
F 909	was unable to locate of inspection was completed in spection was completed in part, " inspections of the Sevare required for all be changes to the bedfrarails." On 07/11/2023 at app (administrative staff m director, and ASM #2, made aware of the above and a severe of the above a severe a severe and a severe a se	documentation that a bed eted. Bed Inspection & d Rail Inspection" Procedure. 5. Quarterly ven Zones of Entrapment ds and when there are any ame, mattresses or side proximately 4:00 p.m., ASM member) #1, executive , director of nursing, were bove findings. In was provided prior to exit.) was observed lying in bed upper bed rails raised on m. the facility with diagnosis not limited to: a history of s bed inspections dated ce a bed inspection for R64. p.m., an interview was (other staff member) #2 . When asked about the for R64, he stated that he documentation that a bed	F	909	 will receive education during orie on the following policy "Bed Inspection Maintenance and Bed Rail Install Executive Director or Designee we validate 3rd Quarter bed inspection completed and documented on prevent and in TELS system x1 quanon-compliance found, re-educate be provided. 4. Executive Director or designee present findings of audit to the Quarter be provided. 4. Executive Director or designee present findings of audit to the Quarter be provided. 4. Executive Director or designee present findings of audit to the Quarter be provided. 4. Executive Director, precision of the present findings of audit to the Quarter be provided. 4. Executive Director, Director of Nustiff Development Coordinator, Services, MDS Coordinator, Phare Consultant, and Medical Director 	ection & lation". vill ons are aper arter. If tion will e will uality ement 3 month nsist of ursing, Social rmacy	k ⇒	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/28/2023 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495139	B. WING		_	07/1	; 2/2023
NAME OF PI	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	••••	
LIFE CAR	E CENTER OF NEW MAR	RKET		15 EAST LEE HIGHWAY	4		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	-	PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		COMPLETION DATE
F 909	Continued From page	32	F 909				
	made aware of the at						
	No further informatior	n was provided prior to exit.					
		vas observed lying in bed					
	with the right and left 07/10/2023 at 2:42 p.	upper bed rails raised on m.					
		s bed inspections dated ce a bed inspection for R4.					
	conducted with OSM maintenance director						
	(administrative staff n	proximately 4:00 p.m., ASM nember) #1, executive , director of nursing, were pove findings.					
	No further informatior	n was provided prior to exit.					

Facility ID: VA0145

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