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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495364	A. BUILDING ______ B. WING ______	C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN NECK SENIOR CARE COMMUNITY	**20 DELFAE DRIVE** **WARSAW, VA 22572**

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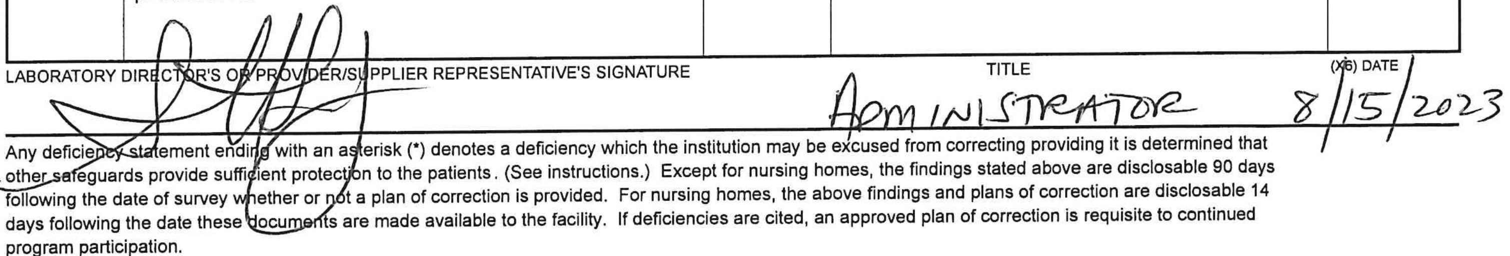
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 7/31/23 through 8/1/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. VA00059361 - unsubstantiated. VA00058619 - substantiated with deficiency. The census in this 80 certified bed facility was 74 at the time of the survey. The survey sample consisted of 9 resident reviews.	F 000		
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.	F 609	1.) The facility has reported the Facility Reported Incident that occurred on 6/26/2023 to the Office of Adult Protective Services. 2.) A 100% Audit was completed of Facility Reported Incidents reported in the last 6 months to ensure that they were reported appropriately. 3.) The Administrator will be reeducated by the Regional Director of Operations on appropriate reporting of Allegations of Abuse/Mistreatment as per the abuse policy. 4.) The Administrator/Designee will audit Facility Reported Incidents weekly for the next 4 weeks. Any trends will be reported to the Quality Assurance Performance Improvement Committee at least quarterly.	8/18/23 & ongoing



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 8/15/2023

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.

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F 609	Continued From page 1 §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 staff interview and facility documentation review, the facility staff failed to report an allegation of abuse to Adult Protective Services for 1 of 2 allegations of abuse reviewed. The findings included: For two Residents involved in an altercation resulting in one of the Residents being slapped in the face, the facility staff failed to report the incident of abuse to adult protective services. On 8/1/23, the survey team reviewed facility records with regards to Resident allegations of abuse and/or neglect. During this review, it was noted that on 6/26/23, there was an incident involving two Residents which resulted in one of the Residents slapping the other in the face. The facility provided a form that was completed with regards to the incident and an excerpt from the document read, "If applicable, date notification provided to: APS: N/A [adult protective services: not applicable]". On the afternoon of 8/1/23, an interview was conducted with the facility Administrator. The Administrator stated that all allegations of abuse are to be reported to adult protective services. When asked why this wasn't done in the instance on 6/26/23, the Administrator stated he wasn't	F 609		

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F 609	Continued From page 2 employed at the facility at the time and couldn't answer why it was not done. The Administrator further acknowledged that it should have been reported. The facility policy titled, "Abuse Investigating and Reporting" was received and reviewed. This policy read, "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state, and federal agencies...". An additional facility policy titled; "Abuse" was provided to the survey team. This policy read, "... 5. Investigation: Designated staff will immediately review and investigate all allegations or observations of abuse. a. The results of all investigations are to be communicated to the administrator or his or her designated representative and to other officials in accordance with State law...". On 8/15/23, during end of day meeting the facility Administrator and Director of Nursing were made aware of the findings. No further information was received.	F 609		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and	F 677	1.) Resident #1 discharged on 4/20/23 and no longer resides at the facility. 2.) The facility EMR has been reconfigured to enhance accuracy of ADL documentation. 3.) The Nurse Educator/Designee will reeducate all CNAs on ADL documentation and the Activities of Daily Living Policy.	08/21/23 & Ongoing

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F 677	Continued From page 3 facility documentation the facility staff failed to provide necessary services to maintain good nutrition, grooming, and personal and oral hygiene, for 1 Resident (#1) in a survey sample of 9 Residents. The findings included: For Resident #1 the facility failed to provide adequate hygiene and incontinent care. Resident #1 was a Resident at the facility from 3/22/23 until 4/20/23, she was at the facility for rehabilitation after a post fall fractured hip. Resident #1 had a BIMS (Brief Interview of Mental Status) score of 3 out of a possible 15 indicating severe cognitive impairment. A review of the Clinical record revealed that Resident #1 was incontinent of bowel and bladder. A review of the ADL (Activity of Daily Living) sheets in the POC (Point of Care) system revealed that Resident #1 was not charted or documented on by CNA's from 03/22/23 until 3/27/23. On 8/01/23 at 10 AM, an interview was conducted with the DON who was asked when a Resident is admitted how long is it before the care is documented in POC (Point of Care the CNA documentation system), the DON stated that it should not take more than the time it takes to get the admission completed . When asked would that be 24 hours? She stated that it would not even be that long. A review of the ADL sheets for March revealed the following:	F 677	4.) The DON/Designee will audit ADL Sheets daily for 4 weeks to ensure accuracy. Any trends will be reported to the Quality Assurance Performance Improvement Committee at least quarterly.	

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F 677	Continued From page 4 Personal Hygiene - 3/28/22 - 11 pm-7 am was marked N/A. On 3/29/23 - 3 pm -11 pm & 11 pm -7 am were marked N/A. For April 2023 - 3 pm -11 pm was marked N/A = 4 times and 11 pm -7 am shift was marked N/A =16 times On 8/1/23 at approximately 11:00 AM an interview was conducted with CNA B who stated that N/A would mean they didn't have to provide that type of care. When asked do you provide personal hygiene if a resident is incontinent has dementia and has a hip fracture CNA B stated that they would most probably need assistance if they had both of those issues. She further stated, "Even if they don't need to be changed you still have to check on them so if you put N/A it's like saying didn't need to check them." On 8/1/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 677		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered	F 791	1.) Resident #1 discharged from the facility on 4/20/23 and no longer resides in the facility. 2.) A 100% audit will be conducted on all residents with dentures to ensure their dentures are present. 3.) The Nurse Educator/Designee will reeducate all nursing staff on the proper procedure for reporting missing/lost dentures and the Emergency Dental Care Policy. 4.) The Director of Nursing/Designee will audit all residents with dentures daily for 4 weeks to ensure that the	08/21/23 & Ongoing

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F 791	Continued From page 5 under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interview clinical record review and facility documentation the facility staff failed to provide emergency dental services for 1 Resident (#1) in a survey sample of 9 Residents. The findings included For Resident #1 the facility failed to provide	F 791	resident's dentures are present according to plan of care. Any trends will be reported to the Quality Assurance Performance Improvement Committee at least quarterly.	

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F 791	Continued From page 6 emergency dental services to replace denture lost at the facility, and subsequently changed her diet to chopped to accommodate the missing bottom denture. On 7/31/23, a review of the clinical record revealed that Resident #1 was admitted to the facility with a top and bottom denture in place. According to the "Admission Assessment" the Resident had "upper and lower denture" and "wears all the time." Also, on an assessment dated 3/22/23 the diet was listed as, "Regular diet, regular consistency, regular thin liquids. Swallowing problem? No." A review of the Physician orders revealed that on 3/24/23 at 5:57 PM the diet order was changed as follows: "Regular diet, Mechanical Chopped texture, Regular/Thin consistency for family request; no denture" The following is an excerpt from the nutritionist notes dated 3/29/23 at 7:43 AM.: "Diet: Regular diet, Mechanical Chopped texture, Regular/Thin consistency, per family request d/t no denture." A review of the progress notes revealed the following excerpt from the nurse practitioner note on 3/31/23: "Denture Use: Meats changed to minced to help with chewing due to loss of denture." On 7/31/23 at approximately 11:00 AM, an interview was conducted with the DON who stated she was unaware of the denture being	F 791	Type text here	

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F 791	Continued From page 7 missing until after the Resident was discharged and the family contacted the DON via email. When asked if the physician orders reflect the change in diet by the dietician due to not having the denture would that indicate that someone on staff knew the denture was missing, she stated it would. On 8/1/23 during the end of day meeting the Administrator was made aware of the findings and no further information was provided	F 791		