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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3/14/23 through 3/16/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/14/23 through 3/16/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint, VA00058181, which was Substantiated with Deficiency, was investigated during the survey. The census in this 80 certified bed facility was 61 at the time of the survey. The survey sample consisted of 31 resident reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550	1. Resident #3, cover has been placed on the urine drainage system bag. 2. 100% audit has been completed on residents with a urine drainage system bag to ensure it is covered at all times. 3. Nurse Educator and/or designee educated all licensed nursing staff on properly covering urine drainage system bags for all residents.	4/20/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Erika D. Hanson — TITLE: Administrator — (X6) DATE: 3/31/2023

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.

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to care for Residents with dignity and respect for 1 Resident (#3) in a survey sample of 31 Residents. The findings include: For Resident #3 the facility staff failed to cover the urine drainage system bag.	F 550	4. The Director of Nursing and/or designee will audit all residents with a urine drainage system bag to ensure they are properly covered weekly x 4, bi-weekly x 4 weeks, and monthly x 1. 5. Data results will be analyzed and reviewed at centers monthly Quality Assurance and Performance Improvement meetings for 3 months with revisions to plan of correction as needed.	

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 On 3/14/23 the following observations were made: 8:45 AM, Resident was observed in his room, the door was open, and the Resident privacy curtain was open. Resident #3 was in bed, urine drainage system bag (Foley bag) was uncovered and attached to the side of the bed visible from the hallway. 11:45 AM, Resident #3 was observed in his room sitting up in the wheelchair urine drainage bag uncovered and hanging on side of the wheelchair. On 3/14/23 at 12:15 PM, an interview was conducted with Resident #3 who stated that "A lot of times they forget to put the cover over the drainage bag." On 3/14/23 at 12:00 PM, an interview was conducted with CNA B who stated that the "Foley bag should have a dignity bag to cover it even if they are in their room." On 3/15/23 an interview was conducted with LPN D who stated that the CNA's should cover the Foley bag when they are providing care and emptying the bag. On 3/15/23 a review of the care plan revealed the following interventions for Resident #3's urine drainage system: "Position catheter bag and tubing below the level of the bladder and away from entrance room door. Date Initiated: 03/10/2021 Revision on: 06/03/2022"	F 550		

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 "Check tubing for kinks each shift. Date Initiated: 03/10/2021 Revision on: 03/10/2021" "Dignity bag to cover drainage bag contents Date Initiated: 06/03/2022 CNA Catheter care Q shift and PRN Date Initiated: 06/03/2022." On 3/16/22 at approximately 11:00 AM, an interview was a conducted with the DON who stated it was the expectation that the Foley bags are covered. On 3/16/23 the Administrator was made aware of the concerns and no further information was provided	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580	1. Resident #375 no longer resides in the facility; test results confirmed as positive. 2. 100% audit completed on all current residents to ensure COVID-19 testing results were properly documented in the residents' clinical records and resident representative timely notified. 3. The Nurse Educator and/or designee educated all licensed nurses on properly documenting COVID-19 test results and timely resident representative notification.	4/20/2023

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and facility documentation, the facility staff failed to immediately notify the resident representative when there was a significant change in the Resident's condition for 1 Resident (#375) in a survey sample of 31 Residents. The findings included: For Resident #375 the facility staff failed to	F 580	4. The Director of Nursing and/or designee will audit all residents' test to ensure testing results are properly documented in the residents' clinical records and resident representative was timely notified weekly x 4, bi-weekly x 4 weeks, and monthly x 1. 5. Data results will be analyzed and reviewed at centers monthly Quality Assurance and Performance Improvement meetings for 3 months with revisions to plan of correction as needed.	

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5 immediately notify the Resident Representative when Resident #375 tested COVID positive. On 3/15/23 at 3:00 PM, a review of the clinical record revealed that Resident #375 was seen by the Nurse Practitioner (NP) on 2/22/23 and a COVID test was ordered due to cough and respiratory symptoms. The clinical record contained a document entitled "Covid 19 Rapid Test Site Result Data Form," excerpts are as follows: "Lab Result Information" "Date Specimen Collected: 2-22-23" "Specimen Source: Nares" "Performing Facility: [name redacted] Test Type: Rapid." "Test Result Date: 2-22-23" "Result (circle): Negative" "Patient is informed of results: Yes." "Ordering Provider [name redacted.]" "Comments: RR made aware." A review of the progress notes revealed Resident #375 continued to have respiratory symptoms and was subsequently retested for COVID on 2/24/23 excerpts from "Covid 19 Rapid Test Site Result Data Form," are as follows: "Lab Result Information" "Date Specimen Collected: 2-24-23" "Specimen Source: Nares" "Performing Facility: [name redacted] Test Type: Rapid." "Test Result Date: 2-24-23 @ 1700" "Result (circle): Positive" "Patient is informed of results: [this section left blank]." "Ordering Provider [name redacted]"	F 580		

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 6 "Comments: [comments section left blank]" A review of the clinical record revealed a document entitled "SNF / NF to Hospital Transfer Form," excerpts are as follows: "Page 1 Resident Representative: [name redacted] Tel. [phone number redacted] Notified of transfer? Yes Aware of clinical situation? Yes " A review of the Transfer Form revealed that nowhere on the form did it state the Resident's COVID positive Status. The SNF/NF Transfer to Hospital Form under the section entitled "Respiratory," there is no mention of Oxygen, under the section for" Isolation Precautions," the box is checked yes. The box for "Multiple Drug Resistant Organism," is checked "no" and the space for "other communicable diseases," was left blank. Excerpts from the progress notes are as follows: "2/24/23 at 1:33 PM - Resident not herself today. She refuses to eat and will open eyes when trying to arouse her but will not talk. VS [vital signs] 150/71 [blood pressure] 59, [pulse], 19[Respirations] 93% [oxygen saturation]. RR [Resident Representative] and NP [Nurse Practitioner] notified." "2/24/23 3:30 PM -Resident O2 stats [sic] [oxygen saturation] 79% on 2 liters oxygen bumped O2 up to 3 liters with no improvement. Spoke with on call Verbal order for Stat X-ray and Duo Neb treatment and place resident on 5 liters."	F 580		

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 7 "2/24/23 3:50 PM- upon finish neb treatment resident O2 stats [sic] are at 92% on 5 liters." "2/24/23 17:02 Resident sent to the ER for SOB and Low 02 saturation per on call physician [name redacted]. RP (Responsible Party) [RP name redacted] notified." NOTE: there is no mention of informing the RP of COVID Positive status. A review of the SBAR (Situation-Background-Appearance- Review) form sent to the MD the Resident COVID status did not appear on the form. The on-call physician gave an order to send to the ER. According to the SBAR the Resident was transported to the ER on 2/24/23 at 5:24 PM." "2/24/23 at 5:36 PM - Verbal orders from NP Duo neb Q 6 for wheezing and SOB (shortness of breath) Stat chest X ray, Pensioned 40 mg now and every day for 5 days, Paxlovid 300/100 BID x 5 days for Covid." A review of the facility Covid policy revealed: "7. Procedure when COVID-19 is suspected or confirmed: a. Notify physician, Director of Nursing, Infection Preventionist, and family. " On 3/16/23 at approximately 2:00 PM, an interview was conducted with the DON who stated that she could not provide any documentation that showed the Resident's Representative was notified of Resident #375's COVID positive status.	F 580		

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 8 On 3/16/23 during the end of day meeting the Administrator was made aware of the concerns and no further documentation was provided.	F 580		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the care plan for 2 (Resident #19 & #3) of 31	F 657	1. Resident #19 care plan has been updated with proper fall intervention. Resident #3 care plan has been updated with current wound status. 2. 100% audit has been completed on all residents with falls and wounds to ensure their care plan has been reviewed and revised with current intervention and/or status. 3. The Director of Nursing and/or designee educated the MDS (Minimum Data Set) Nurse and all licensed nurses on reviewing and revising care plans. 4. The Director of Nursing and/or designee will audit all residents with falls and wounds to ensure care plans are revised and reviewed appropriately weekly x 4, bi-weekly x 4 weeks, and monthly x 1. 5. Data results will be analyzed and reviewed at centers monthly Quality Assurance and Performance Improvement meetings for 3 months with revisions to plan of correction as needed.	4/20/2023

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 9 sampled residents. The findings include: 1. For Resident #19 the facility staff failed to review and revise the care plan after each fall. On 3/15/23 a review of the clinical record revealed that Resident #19 had post fall Morse Fall Risk Assessments on 2 occasions, 3/16/22 and again on 12/22/22. The Resident scored a 55 on both assessments. (Please note a score > 45 is high fall risk) A review of the care plan read: "FOCUS" "[Resident #19 name redacted] has a diagnosis of Parkinson's, dementia, Bipolar, anxiety, MDD [major depressive disorder] and osteoporosis. She utilizes assistance with ADL, exhibits with incontinence and utilizes antidepressants. date initiated 9/26/22. revision 12/23/22" "Fall 12/22" "GOAL" "Resident will be free of falls through the review date initiated 9/26/22 revision on 9/27/22 Target date 5/7/23." "Interventions" "MD / NP to evaluate medications date initiated 12/23/22." "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance date initiated 9/26/22."	F 657		

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 10 "Anticipate and meet the resident's needs date initiated 9/26/22." "Follow Facility fall protocol 9/26/22." On 3/16/23 at 10:45 AM, an interview was conducted with LPN B (unit manager) who stated that care plans are used to let staff know how to care for each Resident. When asked how often they should be updated she stated quarterly and with any changes. When asked who updates the care plans, she stated that the MDS Nurse updates them. When asked if a fall should be listed on the care plan, she stated that it should. When asked what else should be on the care plan when a resident has a fall, she stated the care plan should show the new interventions for that fall. On 3/16/23 at 11:00 AM, an interview was conducted with the DON who stated that care plans are updated quarterly and with any changes that affect the care of the Resident. When asked if falls should be included, she stated that they should. When asked if new interventions should be added with each fall, she stated that they should. When asked to review the Residents care plan and show where the interventions were for the fall on 3/16/22 she stated there were not interventions added after that fall. A review of the care plan policy read: "16. The care planning / Interdisciplinary Team is responsible for the review and updating of care plans:" "a. When requested by the resident / resident representative" "b. When there has been a significant change in	F 657		

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 11 the resident's condition" "c. When the desired outcome is not met;" "d. When goals, needs and preferences change"? "e. When the resident has been readmitted to the facility from a hospital stay" "f. At least quarterly and after each OBRA and MDS assessment." On 3/16/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 2. For Resident #3 the facility staff failed to review and revise the care plan to include the re-opening of a pressure ulcer. On 3/14/23 at approximately 2:00 PM, an interview was conducted with Resident #3 who stated that he has a pressure ulcer to the left ankle. Resident #3 stated that it was healed up in January 2023 however, it has reopened now. The Resident stated that when the wound healed, he switched from wearing "the cushion boots." to his regular shoes. He stated that he is quadriplegic and cannot feel his legs, so he was not aware that his foot was rubbing against the wheelchair. He stated that the wound is now infected, and he is taking antibiotics for it. He stated that he started taking Doxycycline for a staph infection in the wound. A review of the wound care doctor's notes on 1/3/23 stated that the left ankle wound was "resolved." A review of the progress notes revealed a Nurse Practitioner note that read:	F 657		

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 12 "3/1/23 at 12:00 AM - The patient is a long-term care resident of [facility name redacted]. Patient seen today by nursing request for complaint of left ankle swelling and wound. Nursing staff reports patient's ankle had healed well and patient begin wearing shoes instead of cushion boot. Patient denies any injury. Staff concerned patient's ankle may be rubbing against wheelchair causing friction. At this time left lateral ankle wound with erythematous wound bed surrounding maceration. Ordered consult with wound care specialist and wound culture. Patient to continue wearing cushion [sic] boot at this time to minimize pressure. Continue wound care orders." A review of the physician orders revealed: "Doxycycline Hyclate Tablet 100 MG (milligrams) Give 1 tablet by mouth two times a day for staph infection for 10 Days." The Doxycycline was started on 3/14/23 at 6:00 AM. A review of the care plan for Resident #3 read: "FOCUS: The resident has potential/actual impairment to skin integrity r/t decreased mobility Date Initiated: 06/03/2022 Revision on: 09/08/2022." "GOAL: The resident will have no complications r/t ankle wound through the review date. Date Initiated: 06/03/2022 Revision on: 09/08/2022 Target Date: 02/23/2023. " "INTERVENTIONS: Follow facility protocols for treatment of injury.	F 657		

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 13 Date Initiated: 06/03/2022. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD. Date Initiated: 06/03/2022." On 3/16/23 at 10:45 AM, an interview was conducted with LPN B (unit manager) who stated that care plans are used to let anyone know how to care for each Resident. When asked how often they should be updated she stated quarterly and with any changes. When asked who updates the care plans, she stated that the MDS Nurse updates them. When asked if wounds should be addressed on the care plan she stated that they should. On 3/16/23 at 11:00 AM, an interview was conducted with the DON who stated that care plans are updated quarterly and with any changes that affect the care of the Resident. When asked if wounds and wound care should be included, she stated that they should. A review of the care plan policy read: "16. The care planning / Interdisciplinary Team is responsible for the review and updating of care plans:" "a. When requested by the resident / resident representative" "b. When there has been a significant change in the resident's condition" "c. When the desired outcome is not met;" "d. When goals, needs and preferences change" "e. When the resident has been readmitted to the facility from a hospital stay" "f. At least quarterly and after each OBRA and MDS assessment."	F 657		

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 14 On 3/16/23 during the end of day meeting, the Administrator was made aware of the concerns and no further information was provided.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation, the facility staff failed to follow standards of nursing practice for 2 Residents (Resident #70 & #19) in a survey sample of 31 Residents. The findings included: 1. For Resident #70, the facility staff failed to administer medications, that were available for administration, as ordered by the physician. On 3/14/23 at 7:47 AM, LPN C was observed during medication administration of Resident #70's medication. LPN C administered the following medications to Resident #70, Eliquis/Apixaban, Losartan, Tamsulosin/Flomax, Miralax, Thiamin Mononitrate, multiple vitamin, and Levetiracetam/Keppra. Prednisone and Ativan were not administered to the Resident. Review of the clinical record of Resident #70 was conducted. This review revealed Resident #70 had physician orders dated 3/14/23, that read, "Prednisone Tablet- Give 40 mg by mouth one	F 658	1. Resident #70 medication stop date was extended by physician to receive the full dosage length of time. 2. 100% audit has been completed on the Medical Administration Record to ensure all medications have been administered as ordered by the physician. 3. The Nurse Educator and/or designee educated all licensed nurses on the process of receiving medication from the pharmacy and Omnicell contents in addition to properly documenting medication(s) given in the Medical Administration Record. 4. The Director of Nursing and/or designee will audit all residents Medical Administration Record to ensure all medications have been administered as ordered by the physician weekly x 4, bi-weekly x 4 weeks, and monthly x 1. 5. Data results will be analyzed and reviewed at centers monthly Quality Assurance and Performance Improvement meetings for 3 months with revisions to plan of correction as needed.	4/20/2023

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 15 time a day for pain for 7 Days" and an order that read, "Ativan Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth two times a day for anxiety for 5 Days". Review of the clinical record/medication administration record revealed that LPN C had marked a 9 for the administration of the prednisone and Ativan. The legend on the medication administration record indicated the following, "9=Other / See Progress Notes". Review of the progress notes revealed that an entry had been made into the nursing notes by LPN C that read, "med on order". On 3/14/23 at 10:39 AM, an interview was conducted with LPN C. Surveyor F indicated that a physician order for prednisone and Ativan had been noted and these medications were not observed to be administered. LPN C confirmed they were not administered and said, "it's still on order, it was ordered yesterday, I put in that it was on order". LPN C was asked what the process is when medications are not available. LPN C stated, "depending on how long it has gone without coming we would call the pharmacy to see what the ETA [estimated time of arrival] is". LPN C confirmed she had not called the pharmacy to follow-up at this time. On 3/16/23 at 10:03 AM, another interview was conducted with LPN C. LPN C was asked when the Omnicell can be used, LPN C said, "You can use the Omnicell at any time". When asked why she had not accessed the prednisone and Ativan for Resident #70 from the Omnicell on 3/14/23, LPN C said, "When I saw in the computer it was on order, I was assuming it would come that morning. I did access it that evening once I was	F 658		

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 16 made aware for the evening dose of Ativan". LPN C confirmed she had not notified the doctor of the doses not administered. During the above call, Surveyor F explained that Resident #70's order for the prednisone was for 7 days and was noted on the MAR as being available to be administered 3/14/23-3/20/23, since he missed doses on 3/14 and 3/15, he would only receive 5 days vs. the ordered 7 days. LPN C said, "We can get the doctor to extend the order, they are here today so I will take care of that". The facility had an Omnicell (dispensing system of on-hand medications available for administration) on-site. A listing of the Omnicell contents was provided to the survey team. Review of this document revealed that five (5) tablets of Prednisone 20mg were available in the Omnicell for administration. Additionally, nine (9) tablets of Lorazepam/Ativan 0.5mg were available in the Omnicell and available for administration. On 3/16/23 at 11:24 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that she expected the nursing staff to check to see if medications are available for administration in the Omnicell anytime they find something not on the medication cart while administering medications. If not available in the Omnicell, then she would expect them to call the pharmacy to let them know the medication is needed and then notify the doctor for further orders/direction. Review of the facility policy titled; "Administration Procedures for All Medications" was conducted.	F 658		

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 17 This policy read, "...III. 5 Rights (at a minimum). At a minimum, review the 5 rights at each of the following steps of medication administration. 1. Prior to removing the medication package/container from the cart/drawer: a. Check the MAR/TAR [medication administration record/treatment administration record] for the order...IV. Administration...13. Notify the attending physician and/or prescriber of: ... b. Held medications...". The facility policy titled; "Electronic Interim Box" was reviewed. This policy read, "The provider pharmacy will utilize an electronic interim box (i.e. ...Omnicell...) to provide an interim supply of medications for use in emergency and non-emergency dosing for nursing facility residents until the pharmacy is able to provide a regular supply of medication to the nursing facility resident...". On 3/16/23 at 11:30 AM, the Administrator and Director of Nursing (DON) were made aware of the above findings. No additional information was provided.	F 658		

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 18 2. For Resident #19 the facility staff administered Tylenol two times without documenting it in the MAR (Medication Administration Record). On 3/15/23 at 1:00 PM, during clinical record review it was discovered the Resident #19 was found on the floor on 12/22/22 at 2:30 PM and was medicated for headache twice with Tylenol. A review of the progress notes read: "12/22/22 3PM - Patient c/o (complaining of) headache since morning Tylenol were given and c/o headache after the fall Tylenol were given second dose. No sign of bruise and any bump on the head." On 3/15/23 3:00 PM, a review of the MAR revealed that no initials were present to indicate administration of Tylenol given on that day. On 3/16/23 at approximately 10:00 AM, an interview was conducted with LPN D who stated that all medications should be signed out on the MAR when given. When asked the danger of not signing off medications she stated that another nurse or the physician will not know if a medication was received or not. On 3/16/23 at approximately 1:00 PM, an interview was conducted with the DON who was asked the expectation of nurses when administering medications, she stated that rights of medication administration should be followed and that medications should be signed off after administering the medication. When asked why this is and she stated if you sign medications off before you give them hand and the Resident does not take them the MAR will not be accurate.	F 658		

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 19 If you give the medications without signing it off on the MAR, no one will know the meds have been given. Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Mosby's/ Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing Scope and Standards of Nursing Practice of (2004), apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation. On 3/16/23 during the end of day meeting the Administrator was made aware of the concern and no further information was provided.	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 20 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, the facility staff failed to provide respiratory care consistent with professional standards of practice for one Resident (Resident # 53) in a survey sample of 31 residents. Findings included: On initial tour on 3/13/2023 at 7:45 a.m., on Resident # 53's nightstand, a plastic bag with CPAP (Continuous Positive Airway Pressure) tubing and mask inside were observed with the date "2-6-23" on the outside of the bag. Resident # 91 was asked what was in the plastic bag. Resident # 53 stated it was her CPAP. When asked how often the CPAP was used, Resident # 91 stated she used it every night. Resident # 91 also stated "If I don't use it, I won't be able to sleep" Review of the clinical record revealed an order for BiPAP. The order read: "(Bi-level Positive Airway Pressure) "BI-PAP - WHILE SLEEPING WITH THE FOLLOWING SETTINGS: USE HOME SETTINGS at bedtime for AIRWAY PATENCY/ COPD OSA (Chronic Obstructive Pulmonary Disease/Obstructive Sleep Apnea)."	F 695	1. Resident #53 plastic bag with CPAP (Continuous Positive Airway Pressure) has been corrected. 2. 100% audit has been completed on all current residents with respiratory care equipment to ensure they are properly updated, labeled and dated. 3. The Nurse Educator and/or designee educated all licensed nursing staff on properly updating, labeling, and dating respiratory care equipment. 4. The Director of Nursing and/or designee will audit all residents with respiratory care equipment to ensure they are properly updated, labeled and dated weekly x 4, bi-weekly x 4 weeks, and monthly x 1. 5. Data results will be analyzed and reviewed at centers monthly Quality Assurance and Performance Improvement meetings for 3 months with revisions to plan of correction as needed.	4/20/2023

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 21 On 3/15/2023 at approximately 3:10 p.m., the Director of Nursing went to the room with the surveyor and observed the date of 2-6-23. The Director of Nursing stated the mask and tubing should be changed weekly and the date on the plastic bag should have the date it was changed. A copy of the Facility's Oxygen Administration Policy was requested and received Review of the facility's Oxygen Administration-CPAP/BiPAP Guidance policy revealed no documentation that the mask and tubing should be changed weekly. On 3/16/2023 at 1:00 p.m., an interview was conducted with Licensed Practical Nurse B who stated tubing and masks should be changed weekly. Licensed Practical Nurse B stated it was important due to infection control concerns. During the end of day debriefing on 3/15/2023 and 3/16/2023, the Administrator and Director of Nursing were informed of the findings. The Director of Nursing again stated the tubing should be changed weekly and dated. No further information was provided.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755	1. Resident #19 residents' Medication Administration Record was reviewed to ensure that all ordered medication is administered per physicians' order. 2. 100% audit has been completed on the current residents' Medication Administration Record to ensure	4/20/2023

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 22 a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to provide routine drugs and biologicals to meet the needs of 1 Resident (#19) in a survey sample of 31 Residents. The findings included: For Resident # 19 the facility staff failed to obtain and administer Marinol (a cannabis derivative used for appetite stimulation as well as for nausea), causing Resident #19 to miss 7 doses of her ordered medication.	F 755	all medications have been administered as ordered by the physician. 3. The Nurse Educator and/or designee educated all licensed nurses on the process of receiving medication from the pharmacy. 4. The Director of Nursing and/or designee will audit all residents Medication Administration Record to ensure all medications have been administered as ordered by the physician weekly x 4, bi-weekly x 4 weeks, and monthly x 1. 5. Data results will be analyzed and reviewed at centers monthly Quality Assurance and Performance Improvement meetings for 3 months with revisions to plan of correction as needed.	

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 23 On 3/15/23, during a clinical record review, it was found that Resident #19 had issues with weight loss. The Resident had been followed by the Dietician and the Nurse Practitioner for this issue. A review of the NP notes revealed that on 12/21/22, the Nurse Practitioner saw Resident #19 due to weight loss. This Resident had been ordered supplements prior to this date and continued to lose weight. The NP prescribed Marinol 2.5 mg before lunch and before dinner for appetite stimulation. On 3/15/23 during clinical a review of the progress notes the following notes were found regarding the order for Marinol 2.5 mg: "12/22/22 at 8:58 AM -Not given wait for pharm." "12/22/22 at 4:54 PM - Med unavailable." "12/24/22 at 3:32 PM - Not on hand" "12/25/22 at 12:08 PM - On order" "12/25/22 at 7:21 PM - Med on order" "12/26/22 at 12:21 PM - Med on back order from pharm. NP/RP aware med being delivered today." "12/26/22 at 4:34 PM - Unavailable." On 3/15/23 at approximately 1:30 PM, an interview was conducted with LPN C who stated that if meds were not available the nurse was supposed to check the stat box if it is not in there then call the pharmacy, and find out when it will be available. Then call the Nurse Practitioner or MD and let them know it's not available and ask if there is something else they would like to try until the medication becomes available. A review of the clinical record documented	F 755		

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 24 notification of NP / RP one time out of 7 missed doses of medication. On 3/16/23 at approximately 11:30 AM, an interview was conducted with the DON who stated that it is the expectation that nurses document any medications that are unavailable, call the pharmacy to see if it can come on the next run, call the MD ask if they want to substitute the med, and notify the Resident or the Resident Representative. On 3/16/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation, the facility staff failed to ensure the medication error rate was less than 5%. There were 2 medication errors (medications ordered that were not administered) in 30 opportunities, resulting in an 6.6% error rate. The findings included: On 3/14/23 at 7:47 AM, LPN C was observed during medication administration of Resident #70's medication.	F 759	1. Resident #70 has been assessed, no adverse reaction noted. 2. 100% audit has been completed on the Medical Administration Record to ensure all medications have been administered as ordered by the physician. 3. The Nurse Educator and/or designee educated all licensed nurses on the process of receiving medication from the pharmacy and Omnicell contents. 4. The Director of Nursing and/or designee will randomly observe nurse medication pass(es) to ensure all medication have been administered as ordered by the physician weekly x 4, bi-weekly x 4 weeks, and monthly x 1.	4/20/2023

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 25 Following the observation of medication administration a review/reconciliation of Resident #70's medications was conducted. This review revealed Resident #70 had physician orders dated 3/14/23, that read, "Prednisone Tablet-Give 40 mg by mouth one time a day for pain for 7 Days" and an order that read, "Ativan Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth two times a day for anxiety for 5 Days". During the observation of medication administration conducted 3/14/23 at 7:47 AM, LPN C had not administered prednisone or Ativan to Resident #70. Review of the clinical record/medication administration record revealed that LPN C had marked a "9" for the administration of the prednisone and Ativan. The legend on the medication administration record indicated the following, "9=Other / See Progress Notes". Review of the progress notes revealed that an entry had been made into the nursing notes by LPN C that read, "med on order". On 3/14/23 at 10:39 AM, an interview was conducted with LPN C. Surveyor F indicated that a physician order for prednisone and Ativan had been noted and these medications were not observed to be administered. LPN C said, "it's still on order, it was ordered yesterday, I put in that it was on order". LPN C was asked what the process is when medications are not available. LPN C stated, "depending on how long it has gone without coming we would call the pharmacy to see what the ETA [estimated time of arrival] is". When asked about the Omnicell and the use of medications in that dispensing system, LPN C	F 759	5. Data results will be analyzed and reviewed at the centers monthly Quality Assurance and Performance Improvement meetings for 3 months with revisions to plan of correction as needed.	

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 26 said, the Omnicell has medications but didn't indicate she would access that or look to see if medications were available for administration in the Omnicell. A listing of medications available in the Omnicell (dispensing system of on-hand medications available for administration) was provided to the survey team. Review of this document revealed that five (5) tablets of Prednisone 20mg were available in the Omnicell for administration. Additionally nine (9) tablets of Lorazepam/Ativan 0.5mg were available in the Omnicell and available for administration. On 3/16/23 at 11:24 AM, an interview was conducted with the Director of Nursing (DON). The DON stated she expected staff to see if any medication they needed for administration was available in the Omnicell. Review of the facility policy titled; "Administration Procedures for All Medications" was conducted. This policy read, "...III. 5 Rights (at a minimum). At a minimum, review the 5 rights at each of the following steps of medication administration. 1. Prior to removing the medication package/container from the cart/drawer: a. Check the MAR/TAR [medication administration record/treatment administration record] for the order...IV. Administration...13. Notify the attending physician and/or prescriber of: ... b. Held medications...". The facility policy titled; "Electronic Interim Box" was reviewed. This policy read, "The provider pharmacy will utilize an electronic interim box (i.e. ...Omnicell...) to provide an interim supply of medications for use in emergency and	F 759		

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 27 non-emergency dosing for nursing facility residents until the pharmacy is able to provide a regular supply of medication to the nursing facility resident...". On 3/16/23 at 11:30 AM, the Administrator and Director of Nursing (DON) were made aware of the above observations and findings from the medication administration observation and medication error rate of 6.6%. No additional information was provided.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761	1. All expired medications have been discarded. 2. 100% audit has been completed in all medication rooms, refrigerators and medication carts. 3. The Nurse Educator and/or designee educated all licensed nurses on discarded expired medications. 4. The Director of Nursing and/or designee will audit all medication rooms, refrigerators and medication carts to ensure all medications are within date weekly x 4, bi-weekly x 4 weeks, and monthly x 1. 5. Data results will be analyzed and reviewed at centers monthly Quality Assurance and Performance Improvement meetings for 3 months with revisions to plan of correction as needed.	4/20/2023

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 28 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to store medications in accordance with currently accepted professional principles in 1 of 1 medication room inspected. The findings included: 1. The facility staff failed to ensure medications and supplies stored in the medication room were not expired in 1 of 1 medication rooms inspected. On 03/14/23 at 10:22 AM, the medication room on the Dogwood unit was inspected in the presence of LPN F. The following items were noted to be available for facility staff's use and were expired: Vacuette Safety Blood collection set + Luer Adapter. Four (4) boxes, 50 count each for a total of 200, were all noted to be expired. The various expiration dates on each box were: 12/6/22, 12/1/22, 11/2/22, and 12/6/22. Mantacc: Miraclean Technology Co. Disposable sampling swab, 7 of 7 on-hand were expired. with an expiration date of 1/24/23. There was a single "BD Bactec Lytic/10 anaerobic culture vial, 40 ml", that expired 11/30/22, There was a single "BD Bactec plus aerobic culture vial", which expired 11/30/22. In the fridge, within the medication room, there	F 761		

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 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 29 was a vial of "Tuberculin Purified Protein Derivative, 5 TU/0.1 mL, that had on the box that it was opened 2/17/22. The box read, "Once entered, vial should be discarded after 30 days". LPN F confirmed all the above findings and expiration dates and removed each of the expired items from the medication storage room. On 3/16/23 at 11:24 AM, an interview was conducted with the facility's Director of Nursing (DON). The DON said that she has facility management check the medication carts weekly and the medication room monthly to ensure expired items are not available for use. A review was conducted of the facility policy titled, "Medication Storage". This policy read, "...4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed...". On 3/16/23 at 11:30 AM, the facility Administrator and Director of Nursing were made aware of the above findings. No further information was provided.	F 761		