PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495400	B. WING		10/18/2023
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12425 VILLAGE LOOP CULPEPER, VA 22701	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
E 000	Initial Comments		E 00	00	
F 000	survey was conducted 10/18/23. The facility compliance with 42 C Requirement for Long emergency preparedr investigated during the INITIAL COMMENTS. An unannounced Me survey was conducted 10/18/23. Corrections compliance with 42 C Term Care requireme survey/report will follow investigated during the The census in this 47 at the time of the surve consisted of 19 current seven closed record resistance.	was in substantial FR Part 483.73, p-Term Care Facilities. No ness complaints were e survey. dicare/Medicaid standard d 10/16/23 through s are required for FR Part 483 Federal Long nts. The Life Safety Code w. No complaints were e survey. certified bed facility was 39 rey. The survey sample nt resident reviews and eviews.	F 00		10/21/22
	CFR(s): 483.20(c) §483.20(c) Quarterly A facility must assess quarterly review instru- and approved by CMS once every 3 months. This REQUIREMENT	Review Assessment a resident using the ument specified by the State S not less frequently than	F 63	88	10/31/23
AROPATORY	review, and clinical refailed to complete quaset) assessments in a 26 residents in the su #48, #36 and #51.	ew, facility document cord review, the facility staff arterly MDS (minimum data timely manner for four of rvey sample, Residents #1,		Facility staff failed to complete quarterly MDS assessments in a time manner for four out of 26 residents. identified residents were found not to affected by the deficient practice. TITLE	The

Electronically Signed 11/02/2023

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.

	(X3) DATE SURVEY COMPLETED	
495400 B. WING 10/18/	8/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12425 VILLAGE LOOP CULPEPER, VA 22701		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
The findings include: The findings include: 1. For Resident #1 (R1), the facility staff failed to complete the resident's quarterly MDS with an ARD (assessment reference date) of 9/7/23 within 14 days. A review of R1's clinical record revealed a quarterly MDS assessment with an ARD of 9/7/23. Further review of R1's clinical record revealed the MDS was not completed until 9/30/23 (23 days). On 10/17/23 at 2:50 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 stated MDS assessments should be completed within 14 days from the ARD. RN #1 stated MDS assessment should be completed within 14 days from the ARD. RN #1 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual when completing MDS assessments. On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the above concern. The CMS RAI manual documented, "Completion Timing: - For all non-Admission OBRA (Omnibus Budget Reconciliation Act) and PPS (Prospective Payment System) assessment Reference Date (ARD)." 2. For Resident #48 (R48), the facility staff failed to complete the resident's quarterly MDS with an ARD of 81/17/23 within 14 days.		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PI	ROVIDER OR SUPPLIER PEPER		STREET ADDRESS, CITY, STATE, ZIP CODE 12425 VILLAGE LOOP CULPEPER, VA 22701		10/10/2020		
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F 638	Continued From pa	ge 2	F 638	3			
	quarterly MDS asse 8/17/23. Further re	linical record revealed a essment with an ARD of view of R48's clinical record was not completed until					
	conducted with RN MDS coordinator). assessments shoul from the ARD. RN CMS (Centers for M Services) RAI (Res	O p.m., an interview was (registered nurse) #1 (the RN #1 stated MDS d be completed within 14 days #1 stated she references the Medicare and Medicaid ident Assessment Instrument) eleting MDS assessments.					
	staff member) #1,th	27 p.m., ASM (administrative e executive director and ASM ursing were made aware of					
		6 (R36), the facility staff failed ident's quarterly MDS with an nin 14 days.					
	quarterly MDS asse 8/31/23. Further re	linical record revealed a essment with an ARD of view of R36's clinical record was not completed until					
	conducted with RN MDS coordinator). assessments shoul from the ARD. RN CMS (Centers for M Services) RAI (Res	0 p.m., an interview was (registered nurse) #1 (the RN #1 stated MDS d be completed within 14 days #1 stated she references the Medicare and Medicaid ident Assessment Instrument) bleting MDS assessments.					

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F 638	Continued From pag	ge 3	F 63	38			
	staff member) #1,the	7 p.m., ASM (administrative executive director and ASM ursing were made aware of					
		(R51), the facility staff failed dent's quarterly MDS with an in 14 days.					
	quarterly MDS asses 8/24/23. Further rev	nical record revealed a ssment with an ARD of riew of R51's clinical record ras not completed until					
	conducted with RN (MDS coordinator). Fassessments should from the ARD. RN #CMS (Centers for MServices) RAI (Residual)	p.m., an interview was registered nurse) #1 (the RN #1 stated MDS) be completed within 14 days #1 stated she references the edicare and Medicaid dent Assessment Instrument) eting MDS assessments.					
	staff member) #1,the #2, the director of nu the above concern.	7 p.m., ASM (administrative executive director and ASM ursing were made aware of					
F 640 SS=B	Encoding/Transmitti CFR(s): 483.20(f)(1)	ng Resident Assessments I-(4)	F 64	10		10/31/23	
	a facility completes a	ing data. Within 7 days after a resident's assessment, a the following information for					

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F 640	(iv) Quarterly review (v) A subset of items reentry, discharge, a (vi) Background (factis no admission asses §483.20(f)(2) Transmafter a facility complia facility must be care CMS System inform contained in the MD standard record layou and that passes stare CMS and the State. §483.20(f)(3) Transmafter a facility assessment, a facility encoded, accurate, a the CMS System, in (i) Admission assess (iii) Annual assessment (iv) Significant correction (v) Significant corrections (vi) Quarterly review (vii) A subset of item reentry, discharge, a (viii) Background (fainitial transmission of does not have an acceptable (vi) Data for the subset of the control of the	sment. ent updates. ge in status assessments. assessments. s upon a resident's transfer, and death. e-sheet) information, if there essment. mitting data. Within 7 days etes a resident's assessment, pable of transmitting to the ation for each resident S in a format that conforms to outs and data dictionaries, andardized edits defined by mittal requirements. Within ty completes a resident's ty must electronically transmit and complete MDS data to cluding the following: ment. ent. ge in status assessment. ction of prior full assessment. ction of prior quarterly s upon a resident's transfer,	F 640			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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for a State which has by CMS, in the form approved by CMS. This REQUIREMEN by: Based on staff inte and clinical record r to transmit MDS (m assessments in a tiresidents in the sun #48, #36, #51, #56 The findings include 1. For Resident #1 transmit a quarterly (assessment refere days of completion. A review of R1's clir resident's quarterly ARD of 9/7/23 was Further review of R MDS was not transmidays). On 10/17/23 at 2:50 conducted with RN MDS coordinator). assessments should	as an alternate RAI approved that specified by the State and and specified by the State and art specified by the specified by the specified by the State and art specified by the State an	F 640		ents ential ential ential ential ential ential ential
references the CMS Medicaid Services) Instrument) manual assessments. On 10/18/23 at 12:2	Conters for Medicare and RAI (Resident Assessment when transmitting MDS P.m., ASM (administrative		will audit 100% of completed mds's fo timely transmission bimonthly x3 mon To begin week of 10/30/23. All finding be reported to the D.O.N. and then to QAPI Committee for continued review oversight. Any untimely mds transmissifindings will be immediately addressed	r ths. s will o and sion
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF STATE OF STATE OF SUPPLIER OF SUMMARY S (EACH DEFICIEN REGULATORY OF STATE OF STATE OF SUMMARY S (EACH DEFICIEN REGULATORY OF STATE OF STATE OF SUMMARY S (EACH DEFICIEN REGULATORY OF STATE OF STATE OF SUMMARY S (EACH DEFICIEN REGULATORY OF STATE OF STATE OF STATE OF SUMMARY OF STATE OF SUMMARY OF SUMMARY OF SUMMARY OF STATE OF SUMMARY OF SUMARY OF SUMARY OF SUMMARY OF SUMARY OF	ROVIDER OR SUPPLIER PEPER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to transmit MDS (minimum data set) assessments in a timely manner for six of 26 residents in the survey sample, Residents #1, #48, #36, #51, #56 and #55. The findings include: 1. For Resident #1 (R1), the facility staff failed to transmit a quarterly MDS with an ARD (assessment reference date) of 9/7/23 within 14 days of completion. A review of R1's clinical record revealed the resident's quarterly MDS assessment with an ARD of 9/7/23 was completed on 9/30/23. Further review of R1's clinical record revealed the MDS was not transmitted until 10/17/23 (17 days). On 10/17/23 at 2:50 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 stated MDS assessments should be transmitted within 14 days from the completion date. RN #1 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual when transmitting MDS	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to transmit MDS (minimum data set) assessments in a timely manner for six of 26 residents in the survey sample, Residents #1, #48, #36, #51, #56 and #55. The findings include: 1. For Resident #1 (R1), the facility staff failed to transmit a quarterly MDS with an ARD (assessment reference date) of 9/7/23 within 14 days of completion. A review of R1's clinical record revealed the resident's quarterly MDS assessment with an ARD of 9/7/23 was completed on 9/30/23. Further review of R1's clinical record revealed the MDS was not transmitted until 10/17/23 (17 days). On 10/17/23 at 2:50 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 stated MDS assessments should be transmitted within 14 days from the completion date. RN #1 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual when transmitting MDS assessments. On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1,the executive director and ASM	ROWIDER OR SUPPLIER ### SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to transmit MDS (minimum data set) assessments in a timely manner for six of 26 residents in the survey sample, Residents #1, #48, #36, #51, #56 and #55. The findings include: 1. For Resident #1 (R1), the facility staff failed to transmit a quarterly MDS with an ARD (assessment reference date) of 9/7/23 within 14 days of completion. A review of R1's clinical record revealed the resident's quarterly MDS assessment with an ARD of 9/7/23 was completed on 9/30/23. Purther review of R1's clinical record revealed the mDS was not transmitted until 10/17/23 (17 days). A review of R1's clinical record revealed the mDS was not transmitted until 10/17/23 (17 days). A review of R1's clinical record revealed the mDS was not transmitted until 10/17/23 (17 days). A review of R1's clinical record revealed the mDS was not transmitted until 10/17/23 (17 days). A review of R1's clinical record revealed the mDS was not transmitted within 14 days from the completion date. RN #1 stated MDS assessments should be transmitted within 14 days from the completion date. RN #1 stated MDS assessments should be transmitted within 14 days from the completion date. RN #1 stated MDS assessments should be transmitted within 14 days from the completion date. RN #1 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment instrument) manual when transmitting MDS assessments in the process and to ensure timely transmission of mds assessments be reported to the D. O. A. and then to QAPI Committee for continued review ove

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F 640	the above concern. The CMS RAI manual "Comprehensive ass transmitted electronic Care Plan Completio days). All other MDS submitted within 14 control Date." 2. For Resident #48 to transmit a quarterl 8/17/23 within 14 day. A review of R48's clir resident's quarterly NARD of 8/17/23 was Further review of R48 the MDS was not train days). On 10/17/23 at 2:50 conducted with RN (MDS coordinator). Fassessments should days from the complereferences the CMS Medicaid Services) Funstrument) manual vassessments. On 10/18/23 at 12:27 staff member) #1, the	al documented, essments must be cally within 14 days of the on Date (V0200C2 + 14 assessments must be days of the MDS Completion (R48), the facility staff failed y MDS with an ARD of ys after the completion date. Inical record revealed the MDS assessment with an completed on 9/15/23. B's clinical record revealed insmitted until 10/17/23 (32 p.m., an interview was registered nurse) #1 (the	F	640	5. 12/1/23 and ongoing			
	to transmit a quarterl	(R36), the facility staff failed y MDS with an ARD of ys after the completion date.						

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F 640	Continued From pa	nge 7	F 640		
	resident's quarterly was completed on R36's clinical recor transmitted until 10 On 10/17/23 at 2:5 conducted with RN MDS coordinator). assessments shouldays from the compreferences the CM: Medicaid Services)	dinical record revealed the MDS with an ARD of 8/31/23 9/18/23. Further review of d revealed the MDS was not /17/23 (29 days). D. p.m., an interview was (registered nurse) #1 (the RN #1 stated MDS d be transmitted within 14 oletion date. RN #1 stated she S (Centers for Medicare and RAI (Resident Assessment I when transmitting MDS			
	staff member) #1,th #2, the director of r the above concern. 4. For Resident #5 to transmit a quarte 8/24/23 within 14 d A review of R51's oresident's quarterly was completed on	1 (R51), the facility staff failed erly MDS with an ARD of ays after the completion date. clinical record revealed the MDS with an ARD of 8/24/23 9/18/23. Further review of d revealed the MDS was not			
	conducted with RN MDS coordinator). assessments shouldays from the compreferences the CMS	0 p.m., an interview was (registered nurse) #1 (the RN #1 stated MDS d be transmitted within 14 bletion date. RN #1 stated she S (Centers for Medicare and RAI (Resident Assessment			

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F 640	Continued From page	∍ 8	F 6	40		
	Instrument) manual v assessments.	when transmitting MDS				
	staff member) #1,the	p.m., ASM (administrative executive director and ASM rsing were made aware of				
	to transmit a dischard	R56), the facility staff failed ge MDS assessment when ed to an assisted living				
		_				
	conducted with RN (r MDS coordinator). R	a.m., an interview was egistered nurse) #1 (the N #1 stated R56's discharge en transmitted and was not.				
	staff member) #1,the	p.m., ASM (administrative executive director and ASM rsing were made aware of				
	to transmit a dischard	R55), the facility staff failed ge MDS assessment when ed to an assisted living				
		_				
	On 10/18/23 at 11:10	a.m., an interview was				

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F 640	MDS coordinator). R MDS should have be On 10/18/23 at 12:27 staff member) #1,the	e 9 egistered nurse) #1 (the N #1 stated R55's discharge en transmitted and was not. p.m., ASM (administrative executive director and ASM rsing were made aware of	F 6	i40			
F 656 SS=D	CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The faci implement a comprehe care plan for each res- resident rights set for §483.10(c)(3), that in- objectives and timefra- medical, nursing, and needs that are identifi assessment. The con- describe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483. provided due to the re under §483.10, include treatment under §483. (iii) Any specialized s rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the reside	ensive Care Plans cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's I mental and psychosocial fied in the comprehensive inprehensive care plan must g- are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6). ervices or specialized is the nursing facility will PASARR a facility disagrees with the RR, it must indicate its	F6	56			10/31/23

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F 656	desired outcomes. (B) The resident's properties of the resident's properties of the resident set of the resident set of the resident set of the requirements of the requirements set of the requirements set of the requirement set of the requirements set of the requiremen	tative(s)- totals for admission and preference and potential for acilities must document at's desire to return to the desire and/or other appropriate pose. In the comprehensive care and accordance with the accordance with the accordance with the accordance with the accordance by the comprehensive accordance by the comprehensive accordance with the accordance with accordance with accordance with a secondance with a secondance with an ARD accordance with accordance with the accordance with	F 6	1. Facility staff failed to impleme comprehensive care plan for thre residents, in the areas of required slow sip cup for fluid intake, appli palm protectors and provision of medication regimen. Immediate a were taken to address and correctidentified issues upon discovery, identified residents were found not affected by the deficient practice. 2. All residents have the potential affected by this deficient practice audit is being conducted to ensure resident's comprehensive care plus being implemented in the areas of assistive devices, adaptive device bowel regimen. To be completed 11/1/23.	ee of 26 d use of ication of bowel actions ct the 3 The ot to be . If to be actions are lans are of	

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NAME OF P	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP C 12425 VILLAGE LOOP CULPEPER, VA 22701	•		
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F 656	sitting up in bed. He regular cup with a s two-handled slow si overbed table adjace nurse) #2 was obseresident's room as hiquid through the st A review of R34's cl following physician's Diet, Mechanical Sc Sip Cup." The revier physician's order dailiquid30 mls (millill skin health." A review of R34's co 9/14/23 revealed, infor fluids." On 10/17/23 at 3:35 nurse) #2 was interpurpose of the care best to meet a resid nurses and CNAs (care responsible for incomplete to make the care best to meet a resid nurses and CNAs (care responsible for incomplete to make the care best to meet a resid nurse and contain the care best to meet a resid nurse and	p.m., R34 was observed was drinking a liquid from a tandard plastic straw. A p cup was observed on R34's ent to his bed. RN (registered rved walking out of the ne was finishing sipping the raw. inical record revealed the sorder dated 7/6/23: "Regular off, Ground. Thin Liquids. Slow walso revealed the following sted 6/6/23: "Pro-Statoral iters) by mouth twice a day for omprehensive care plan dated a part: "Provide slow sip cup if p.m., LPN (licensed practical viewed. She stated the plan is to tell the staff how tent's needs. She stated the certified nursing assistants) implement the care plan. in p.m., ASM (administrative ne executive director, #2, the ASM #3, the assisted living	F 6	3. All Licensed Staff will be by DON or designee, on th of implementing an effectiv comprehensive care plan in use of slow sip cups for flui application of palm protector provision of bowel medicating Re-education to be completed 11/22/23. 4. DON or designee will consider to ensure that care plan into being implemented approper to be completed weekly and the monthly x2 months. Is during audits will be address immediately. Results of the reviewed and discussed at Committee for continued recoversight. Audits to begin with 11/27/23. 5. 12/1/23 and ongoing	e requirements re n the areas of id intake, ors, and ion regimen. eted by mplete audit of plan of (including tion regimens, rerventions are riately. Audits weeks and ssues identified ssed e audits will be the QAPI eview and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495400	B. WING _			10/18/2023	
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 12425 VILLAGE LOOP CULPEPER, VA 22701	E		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R 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 656	2. For Resident #12 to implement the ca left palm protectors On the most recent quarterly assessme	e plan of care." on was provided prior to exit. (R12), the facility staff failed re plan to apply both right and	F 6	556			
	requiring the extens members for dressi as having impairme sides of her upper each on 10/16/23 at 11:2 was observed in he palm protectors on 8:34 a.m., R12 was	ive assistance of two staff ng and personal hygiene, and nt in range of motion on both					
	following physician palm protector splin at bedtime. Resider as resident will allow to)contracture." Tof 10/16/23 and 10	inical record revealed the order dated 1/11/23: "Bilateral ts. Apply in morning. Remove at to wear throughout the day wFor pain r/t (related he resident's progress notes 1/17/23 contained no to the resident's palm					
	revealed, in part: "[F protectors during th	are plan dated 2/11/23 R12] wearsbilateral palm e dayBilateral palm the morning and remove at					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	1, ,	(X3) DATE SURVEY COMPLETED		
		495400	B. WING _			10/18/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12425 VILLAGE LOOP CULPEPER, VA 22701	'	10/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 656	Continued From page	ge 13	F 6	56			
	nurse) #2 was intenfamiliar with caring an order for the pair the resident should. She stated the purp the staff how best to She stated the nurs nursing assistants) implementing the carrow of 10/18/23 at 12:2 staff member) #1, the director of nursing, administrator, and Limprovement nurse, concerns. No further information as For Resident #51 to implement the replan for bowel medion A review of R51's column of the physician's order das suppository, ten mill suppository rectally no bowel movement R51's comprehensing documented, "Potel Elimination as related ConstipationAdmin by the physician"	are plan. 27 p.m., ASM (administrative ne executive director, #2, the ASM #3, the assisted living .PN #1, the quality were informed of these on was provided prior to exit. (R51), the facility staff failed sident's comprehensive care cation. inical record revealed a sted 4/4/23 for a bisacodyl ligrams- administer one one time a day as needed for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495400	B. WING			10/	18/2023
NAME OF PI	ROVIDER OR SUPPLIER			12	REET ADDRESS, CITY, STATE, ZIP CODE 2425 VILLAGE LOOP ULPEPER, VA 22701	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	24-hour report sheet a suppository was not a 7/7/23 (five days after bowel movement). On 10/18/23 at 11:18 conducted with LPN (LPN #3 stated the puit, "Kind of describes do to take care of the plan of care." LPN #3 residents' care plans LPN #3 reviewed R5′ stated a suppository sta	al record and review of a dated 7/7/23 revealed a administered to R51 until or the resident had not had a a.m., an interview was licensed practical nurse) #3. rpose of the care plan is that what you are supposed to m [the residents]. It's the B stated nurses can access in the computer system. It's bisacodyl order and should have been given to see days of the resident not ment. p.m., ASM (administrative executive director) and of nursing) were made oncern. It Revision (i)-(iii) ensive Care Plans orehensive care plan must of days after completion of essessment. See execution of the completion of essessment. See with responsibility for the days of the executive for the completion of essessment.		356			10/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495400	B. WING		1	0/18/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE CULF	DEDED			12425 VILLAGE LOOP		
THE COLF	FEFER			CULPEPER, VA 22701		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	Continued From page	e 15	F 65	57		
	(E) To the extent practitude resident and their An explanation must medical record if the and their resident reprot practicable for the resident's care plan. (F) Other appropriate disciplines as determor as requested by the (iii)Reviewed and revited team after each assecomprehensive and cassessments. This REQUIREMENT by: Based on observation	cticable, the participation of resident's representative(s). be included in a resident's participation of the resident presentative is determined at development of the resident professionals in ined by the resident's needs are resident. Itself by the interdisciplinary sement, including both the		Facility staff failed to review the comprehensive care plan facility.		
	facility staff failed to r	eview and revise the plan for one of 26 residents		residents for the use of floor m Immediate action was taken to and correct the identified issue discovery on 10/16/23. The ide	nats. o address e upon	
	The findings include:			plan was revised on 10/26/23 Coordinator.		
	,	17), the facility staff failed to resident's comprehensive of floor mats.		All residents with order for fl have the potential to be affected deficient practice. 100% of		
	physician's order date next to the bed while R47's comprehensive	nical record revealed a ed 3/16/22 for floor mats the resident is in the bed. e care plan dated 2/3/22 mentation regarding floor		comprehensive care plans well by Unit Manager on 10/26/23, that all appropriate resident careflect use of floor mats. 3. MDS Coordinator re-educate the careflect approach on 10/26/23 regarding.	to ensure ireplans ed by	
	a.m., R47 was obser	a.m. and 10/17/23 at 8:54 wed lying in bed. A mat was a side of the bed, but a mat de of the bed.		D.O.N., on 10/26/23, regarding requirements of reviewing and careplans regarding floor mat 4. DON or designee will complete.	revising usage.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
		495400	B. WING _			10/18/2023	
NAME OF PI	ROVIDER OR SUPPLIER PEPER			STREET ADDRESS, CITY, STATE, ZIP CODE 12425 VILLAGE LOOP CULPEPER, VA 22701			
(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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 684 SS=D	conducted with LPN (LPN #2 stated the purity letters about how to a the best." LPN #2 stated the purity letters about how to a the best." LPN #2 stated the purity letters about how to a use of floor mats, so a simplement the mats. On 10/17/23 at 4:38 process at 4:38 pr	c.m., an interview was (licensed practical nurse) #2. rpose of the care plan is that meet their [residents'] needs ated residents' care plans nd revised to include the everyone knows to c.m., ASM (administrative executive director and ASM rsing were made aware of d, "Comprehensive re Planning" documented, interdisciplinary Team is view and updating of care are indamental principle that int and care provided to ed on the comprehensive dent, the facility must ensure extreatment and care in essional standards of inensive person-centered sidents' choices. T is not met as evidenced iew, facility document review wiew, the facility staff failed		50% of resident careplans weekly weeks, then monthly x2 months, residents that have floor mats ore Care plans found to have missing information will be corrected imm Results of the audits will be revied discussed at QAPI meeting for correview and oversight. Audits to be week of 11/27/23. 5. 12/1/23 and ongoing 1. Facility staff failed to provide a services to promote a resident's level of well-being for one of 26 reby failing to administer a bisacod	for those dered. gediately. wed and ontinued begin care and highest esidents;	11/1/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495400	B. WING _				10/18/2023
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>'</u>	10/10/2020
				1	2425 VILLAGE LOOP		
THE CULI	PEPER			C	CULPEPER, VA 22701		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 684	Continued From pag	ne 17	F	684			
		vey sample, Resident #51.			suppository per the physician's order.	The	
	Tesidents in the surv	rey sample, resident #01.			identified resident was found not to be		
	The findings include	:			affected by this deficient practice.		
	For Resident #51 (R	R51), the facility staff failed to			2. All residents have the potential to be	Э	
	1	dyl suppository per the			affected. All residents with orders for		
	physician's order.	, , .			bisacodyl suppository, were reviewed	to	
					ensure orders are being followed		
	A review of R51's cli	inical record revealed a			appropriately. Review was completed	on	
		ted 4/4/23 for a bisacodyl			10/26/23 by Nurse Manager. No further	:r	
		igrams- administer one			deficient practice was identified.		
		one time a day as needed for					
	no bowel movement	t in three days.			3. Re-education will be provided to all		
					Licensed Nurses regarding proper boy		
		owel movement records			regimen protocol and requirements of		
		nt did not have a bowel			following physician orders. Re-educati		
		23 until 7/9/23. Further			will be completed by 11/22/23, by D.O	.IN.	
		cal record and review of a			or designee.		
		t dated 7/7/23 revealed a administered to R51 until			4. Audit will be conducted by D.O.N. o	r	
	1	er the resident had not had a			designee, on 50% of residents on prn	1	
		R51 did not have a bowel			bowel regimen to ensure physician ord	lers	
	movement until 7/9/2				are being followed. Audits to begin we		
	movement and 770/	20.			of 11/27/23, will be completed weekly		
	On 10/18/23 at 11:1	8 a.m., an interview was			weeks, and then monthly x2 months.		
		(licensed practical nurse) #3.			identified deficient practice will be	,	
		omputer generates a list of			addressed immediately. All audit resul	ts	
	I .	not had a bowel movement in			will be reviewed and discussed at QAF		
	two days. LPN #3 s	tated if a resident has not had			Meeting for continued review and		
	a bowel movement i	in two days, then the nurses			oversight.		
	activate standing or	ders or reach out to the					
	physician. LPN #3 r	reviewed R51's bisacodyl			5. 12/1/23 and ongoing		
		suppository should have been					
	•	t three days after not having a					
	bowel movement.						
	On 10/18/23 at 12:2	7 p.m., ASM (administrative					
	I .	ne executive director) and					
		r of nursing) were made					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		495400	B. WING _		10/18/2023	
NAME OF PI	ROVIDER OR SUPPLIER PEPER			STREET ADDRESS, CITY, STATE, ZIP CODE 12425 VILLAGE LOOP CULPEPER, VA 22701		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 689 SS=D	Impaction" documer be notified of signs a constipation. Const oral laxative, suppose the physician" Free of Accident Hat CFR(s): 483.25(d)(1) §483.25(d) Accident The facility must ens §483.25(d)(1) The reas free of accident his spervision and assaccidents. This REQUIREMEN by: Based on observati document review and facility staff failed to for one of 26 resider Resident #47. The findings include For Resident #47 (Rimplement physician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further review of R47's cliphysician's order danext to the bed while Further R47's cliphysician's order danext to the base o	ed, "Constipation/Fecal ated, "IV. Nurse in charge will and symptoms of ipation will be treated with sitory or enema as ordered by zards/Supervision/Devices)(2) s. sure that - esident environment remains azards as is possible; and resident receives adequate istance devices to prevent T is not met as evidenced on, staff interview, facility d clinical record review, the implement a fall intervention ats in the survey sample,	F 6		s. or mat er bed. ed by fied tted by oor mats by the ch orders on	

A95400 NAME OF PROVIDER OR SUPPLIER THE CULPEPER B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 12425 VILLAGE LOOP	10/18/2023
12425 VILLAGE LOOP	-
CULPEPER, VA 22701	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORR PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 689 Continued From page 19 On 10/16/23 at 11:34 a.m. and 10/17/23 at 8:54 a.m., R47 was observed lying in bed. A mat was observed on the right side of the bed, but a mat was not on the left side of the bed, but a mat was conducted with LPN (licensed practical nurse) #2. LPN #2 stated the nurses are aware of the need for floor mats via physician's orders and then the nurses tell the certified nursing assistants who needs floor mats. LPN #2 reviewed R47's physician's order for floor mats and stated that if plural floor mats are ordered then that would mean a floor mat should be placed on each side of the bed. On 10/17/23 at 4:38 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Fall Management Program" documented, "Other potential fall preventative interventions for residents at high risk: b) Floor mats" F 697 S=D \$483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility 1. Facility staff failed to apply and staff failed to	uired entions per plan. by D.O.N. 100% of ce x4 weeks ny issues be s of the API v and eek of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495400	B. WING		1	0/18/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 12425 VILLAGE LOOP CULPEPER, VA 22701		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 697	Continued From pag	e 20	F 69	7		
	document review, an facility staff failed to a prevent pain for one sample, Resident #1. The findings include: For Resident #12 (Rapply both right and prevent pain. On the most recent Magnetic part of the prevent passessment facility assessment facility assessment.	d clinical record review, the apply an adaptive device to of 26 residents in the survey 2.		device to prevent pain for one residents. The adaptive device immediately placed on resider ordered, upon discovery. The resident was found not to be a the deficient practice. 2. All residents with adaptive or prevent pain have the potential affected. 100% of residents what adaptive devices were audited 10/27/23 by Nurse Manager, the proper application of adaptive physician order, no other deficients.	e was int as identified affected by devices to al to be ith orders for d on to ensure devices per	
	requiring the extension members for dressing as having impairment sides of her upper extension of the control o	ve assistance of two staff g and personal hygiene, and t in range of motion on both		found. 3. All licensed Nurses will be a by D.O.N. or designee, regard requirements of following physicor pain management, to incluance applying palm protectors per of Re-education will be complete 11/22/23.	re-educated ding sician orders de properly orders.	
	not on her left. A review of R12's clir following physician o palm protector splints at bedtime. Resident as resident will allow to)contracture." The for 10/16/23 and 10/1 information related to protectors. A review of R12's call	nical record revealed the rder dated 1/11/23: "Bilateral s. Apply in morning. Remove to wear throughout the dayFor pain r/t (related e resident's progress notes 17/23 contained no the resident's palm		4. D.O.N. or designee will aud residents with orders for adaptor pain management, to ensuadaptive devices are being apphysician order to prevent pailissues identified during the auaddressed immediately. Audit completed weekly x4 weeks a monthly x2 months. Results o will be reported to the QAPI of for continued review and over Audits to begin week of 11/27.	tive devices ure the oplied per n. Any udits, will be s will be und then f the audits committee sight.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		495400	B. WING		10/1	8/2023
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12425 VILLAGE LOOP CULPEPER, VA 22701		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 697	bedtimefor pain." On 10/17/23 at 3:35 purse) #2 was intervifamiliar with caring for an order for the palm the resident should heresident refuses or wourse should write a She stated R12 has and the palm protection of the contracture. On 10/18/23 at 12:27 staff member) #1, the director of nursing, A administrator, and LF	c.m., LPN (licensed practical ewed. She stated she is r R12. She stated if there is protectors on both hands, ave them on both hands. If a ill not tolerate them, the progress note indicating this. contractures in both hands, ors can aid in relieving the executive director, #2, the SM #3, the assisted living	F 69	97		
F 810 SS=D	concerns. In response to a requiregarding palm prote provided the policy, "this policy revealed in applying palm protect physician. No further information Assistive Devices - ECFR(s): 483.60(g) §483.60(g) Assistive The facility must provided appropriate assistance	lest for the facility policy ctors, the facility staff Skin Integrity." A review of o information related to tors as ordered by the n was provided prior to exit. ating Equipment/Utensils	F 81	10	1	1/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495400	B. WING _			10/	18/2023
NAME OF P	ROVIDER OR SUPPLIER PEPER			STREET ADDRESS, CITY, STATE, ZIP CODE 12425 VILLAGE LOOP CULPEPER, VA 22701			
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 810	This REQUIREMENT by: Based on observation document review, and facility staff failed to undevice for one of 26 ms ample, Resident #34. The findings include: For Resident #34 (R3 a slow sip cup for fluit. On the most recent the significant change as (assessment reference coded as being as being paired for making of coded as coughing on when swallowing medical modes and regular cup with a status two-handled slow sip overbed table adjace nurse) #2 was observed the sidner of R34's clinfollowing physician's Diet, Mechanical Soft Sip Cup." The review physician's order date liquid30 mls (millilite skin health."	n, staff interview, facility d clinical record review, the use an adaptive feeding esidents in the survey 4. 34), the facility failed to utilize ds on 10/16/23. MDS (minimum data set), a sessment with an ARD ce date) of 6/19/23, R34 was sing severely cognitively daily decisions. He was rechoking during meals or dications. D.m., R34 was observed was drinking a liquid from a undard plastic straw. A cup was observed on R34's not to his bed. RN (registered wed walking out of the e was finishing sipping the	F	810	1. Facility staff failed to use an adaptir feeding device (slow sip cup for fluids) one of 26 residents. This was address immediately with on duty nurse, upon notification of findings, on 10/16/23. The identified resident was found not to be affected by the deficient practice. 2. All residents with orders for adaptive feeding devices have the potential to be affected by the deficient practice. 1000 residents with adaptive feeding devices have been evaluated for proper use pophysician order, audit was completed 10/30/23. 3. All Licensed staff will be re-educate D.O.N. or designee, on the requirement of consistently following physician order all adaptive feeding devices. This re-education will be completed by 11/22/23. 4. D.O.N. or designee will audit 100% residents with orders for adaptive feed devices to ensure these devices are butilized per physician orders. Audit will 100% weekly x4 weeks, and then mor x2 months. Audits to begin week of 11/27/23. Any deficient findings will be addressed immediately. All audit resul will be reported to the QAPI Committe for continued review and oversight. 5. 12/1/23 and ongoing	for ed ed ee e e e e e e e e e e e e e e e	

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED	
	495400	B. WING _	B. WING		10/18/2023	
			STREET ADDRESS, CITY, STATE, ZIP CODE 12425 VILLAGE LOOP CULPEPER, VA 22701			
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	X (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
9/14/23 revealed, in profer fluids." On 10/16/23 at 3:50 profer fluids." On 10/16/23 at 3:50 profer fluids." On 10/18/23 at 10:18 practical nurse from the time." On 10/18/23 at 11:18 practical nurse from the top anything about him is medical record. She sip cup appears as a screen. On 10/18/23 at 12:27 staff member from the top anything about him is medical record. She sip cup appears as a screen. On 10/18/23 at 12:27 staff member from the top anything about him is medical record. She sip cup appears as a screen. A review of the policy from the policy frogram," revealed in responsible for observing feeding needs and response feeding needs and response from the policy from the policy from the policy feeding needs and response feeding needs and response from the policy from the policy from the policy feeding needs and response from the policy fr	art: "Provide slow sip cup a.m., RN #2 was ed she "thought" R34 was the slow sip cup for fluids e overbed table. She stated: ealize what he needed at the a.m., LPN (licensed interviewed. She stated for s, including the slow sip of his information when accessed on the electronic etated his order for a slow warning at the top of the p.m., ASM (administrative executive director, #2, the SM #3, the assisted living N #1, the quality were informed of these , "Adaptive Feeding part: "Nursing staffwill be ving individualized resident sponse to any modifications	F &	310			
Food Procurement,St CFR(s): 483.60(i)(1)(2	ore/Prepare/Serve-Sanitary 2)	F 8	312		11/1/23	
	Continued From page 9/14/23 revealed, in p for fluids." On 10/16/23 at 3:50 p interviewed. She state supposed to be using since she saw it on th "I guess I just didn't retime." On 10/18/23 at 11:18 practical nurse) was in R34, his dietary order cup, appear at the top anything about him is medical record. She sip cup appears as a screen. On 10/18/23 at 12:27 staff member) #1, the director of nursing, AS administrator, and LP improvement nurse, w concerns. A review of the policy. Program," revealed in responsible for observed feeding needs and resin resident's plan of call. No further information Food Procurement, St. CFR(s): 483.60(i) Food safett	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 9/14/23 revealed, in part: "Provide slow sip cup for fluids." On 10/16/23 at 3:50 p.m., RN #2 was interviewed. She stated she "thought" R34 was supposed to be using the slow sip cup for fluids since she saw it on the overbed table. She stated: "I guess I just didn't realize what he needed at the time." On 10/18/23 at 11:18 a.m., LPN (licensed practical nurse) was interviewed. She stated for R34, his dietary orders, including the slow sip cup, appear at the top of his information when anything about him is accessed on the electronic medical record. She stated his order for a slow sip cup appears as a warning at the top of the screen. On 10/18/23 at 12:27 p.m., ASM (administrative staff member) #1, the executive director, #2, the director of nursing, ASM #3, the assisted living administrator, and LPN #1, the quality improvement nurse, were informed of these concerns. A review of the policy, "Adaptive Feeding Program," revealed in part: "Nursing staffwill be responsible for observing individualized resident feeding needs and response to any modifications in resident's plan of care." No further information was provided prior to exit. Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i) (1)(2) §483.60(i) Food safety requirements.	A BUILDII 495400 ROVIDER OR SUPPLIER PEPER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 9/14/23 revealed, in part: "Provide slow sip cup for fluids." On 10/16/23 at 3:50 p.m., RN #2 was interviewed. She stated she "thought" R34 was supposed to be using the slow sip cup for fluids since she saw it on the overbed table. She stated: "I guess I just didn't realize what he needed at the time." On 10/18/23 at 11:18 a.m., LPN (licensed practical nurse) was interviewed. She stated for R34, his dietary orders, including the slow sip cup, appear at the top of his information when anything about him is accessed on the electronic medical record. She stated his order for a slow sip cup appears as a warning at the top of the screen. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED	
		495400	B. WING		10/18/2023	
NAME OF PROVIDER OR SUPPLIER THE CULPEPER			STREET ADDRESS, CITY, STATE, ZIP CODE 12425 VILLAGE LOOP CULPEPER, VA 22701		10/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION	
F 812	Continued From pa	ge 24	F 81	2		
	approved or consid state or local author (i) This may include from local producer and local laws or re (ii) This provision do facilities from using gardens, subject to safe growing and for (iii) This provision do from consuming for serve food in accordance from consuming for this REQUIREMENT by: Based on observate documentation review from a store from two nourishments of two nourishments of two nourishments of two nourishments of two nourishments. The findings included the facility staff failly kitchen, and failed the kitchen and in the reconstruction of the main facility at 10.1 made of the main facility at 10.2 made of the main facility at	refood items obtained directly so, subject to applicable State gulations. Does not prohibit or prevent produce grown in facility compliance with applicable and-handling practices. Does not preclude residents and procured by the facility. Does not procured by the facility. Does n		1 a. Facility staff failed to prepare an store food in a sanitary manner in on two nourishment refrigerators, the rel to home unit refrigerator, and in one two facility kitchens, the main kitcher 1. b. Facility staff failed to maintain a clean main kitchen. All identified issues were immediately addressed upon discovery; the main kitchen oven and stove top were immediately deep cleaned on 10/16/2 and all items discovered not labeled/on 10/16/23 and 10/17/23 were immediately discarded. No residents determined to have been affected by deficient practice. 2. All residents have the potential to affected by the deficient practices of	e of hab of n. 23 dated were the	
	stove contained cod	oked-on grease, and a large and dark black debris. OSM		affected by the deficient practices of keeping an unclean kitchen and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495400	B. WING _			1	0/18/2023	
NAME OF P	ROVIDER OR SUPPLIER	1	_	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		0.10.2020	
				12	2425 VILLAGE LOOP			
THE CULF	PEPER			CI	ULPEPER, VA 22701			
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					DEFICIENCY)			
F 812	Continued From pa	nge 25	F 8	312				
	(other staff membe	r) #1, the director of dining			unlabeled/undated food items. All			
		all could use a good			equipment in Main Kitchen was evalu	ated		
		ed the oven and stove get a			and deep cleaned as needed on 10/1			
	_	kly, but should also be spot			All freezers and refrigerators were			
		use. In the walk in freezer, a			inspected, any additional			
	10" by 10" plastic c			undated/unlabeled food items were				
	rested on a shelf. T			discarded immediately on 10/16/23,				
	container to indicat			10/17/23, and 10/18/23.				
	red material was. C							
	the plastic containe			3. All dining staff will be re-educated of	n			
	and needed to be o			required cleaning procedures in the				
	in the walk-in freez			kitchen and required labeling/dating o	f all			
				food items in all refrigerators.				
	On 10/17/23 at 3:2:			Re-education will be completed by the				
	of the nourishment			Director of Dining Services or designed	e by			
	home unit. The refr			11/22/23.				
	1 *	potstickers and a small			All nursing staff will be re-educated or			
		Neither container was			proper labeling/dating of all food items			
		er contained a bag of chocolate			and food items that are appropriate to	be		
	covered conee bea	ns; the bag was not labeled.			kept in the refrigerators on the units. Re-education will be completed by the	_		
	On 10/18/23 at 0:3	7 a.m., OSM #1 stated the unit			D.O.N. or designee by 11/22/23.	;		
		erators were the responsibility			D.O.N. of designee by 11/22/25.			
		es staff. She stated the dining			Signage will be placed on all refrigera	tion		
	services staff are s			units, with the guidance for labeling &				
	refrigerators and fre			dating of food, by 11/10/23.				
	food to the units.	,						
					Daily "cleaning duties" checklist/sign	off		
	On 10/18/23 at 12:	27 p.m., ASM (administrative			will be posted, along with staff check	ist		
		he executive director, #2, the			for checking all food items for label/da			
	director of nursing,			in the refrigerators. These checklists/s	sign			
	administrator, and I			offs will begin after re-education is				
	#1, the quality impr	ovement nurse, were informed			provided, implementation 11/23/23.			
					Executive Chef or designee will condu	uct a		
	A review of the faci	lity policy, "Cleaning and			one time evaluation/audit of current	•		
		g and Food Service Areas,"			equipment cleaning products, to ensu	re		
		Γhe food and nutrition services			products are effectively cleaning			
	staff will maintain th			equipment upon use (such as oven a	nd			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495400	B. WING _			10	/18/2023
NAME OF PROVIDER OR SUPPLIER THE CULPEPER			•	12	REET ADDRESS, CITY, STATE, ZIP CODE 1425 VILLAGE LOOP ULPEPER, VA 22701	•	
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F 812	of the dining and food compliance with a wri cleaning scheduleS frequency of cleaning held accountable for on A review of the facility revealed, in part: "Froshould be covered, lawill be checked to assiby their use by dates	service areas through tten, comprehensive taff will be trained in the , as necessary Staff will be cleaning assignments." policy, "Food Storage," zen FoodsAll foods beled, and dated. All foods sure foods will be consumed	F8	312	stove top) and will provide findings to Director of Dining. This evaluation will completed by 11/10/23. 4. The Executive Chef or designee will audit the new "cleaning duties" checklists/sign off sheets and checklist/sign off sheets for labeling/da of all food items. Audit will be done dai x4 weeks, and then 3x/week for 4 wee and then twice weekly for 4 weeks. Au to begin week of 11/27/23. Any deficie findings will be addressed immediately. The Executive Chef or designee will all visually inspect the Kitchen equipment (oven, stove top) for cleanliness and inspect freezer and unit refrigerators for proper labeling and dating of food item. This will be done twice weekly x2 mon and then weekly x1 month. Audits to be week of 11/27/23. Any deficient finding will be addressed immediately. All Audit findings will be reported to the QAPI Committee for further review and oversight.	ating ly ks, dits nt / so or is. ths egin	
F 842 SS=D	CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (i) A facility may not re- resident-identifiable to (ii) The facility may re- resident-identifiable to accordance with a co-	483.70(i)(1)-(5) at-identifiable information. elease information that is the public. lease information that is	F 8	342	5. 12/1/23 and ongoing		11/1/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED	COMPLETED		
		495400	B. WING	·····	10/18/20)23	
NAME OF PROVIDER OR SUPPLIER THE CULPEPER				STREET ADDRESS, CITY, STATE, ZIP CODE 12425 VILLAGE LOOP CULPEPER, VA 22701		,	
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F 842	to do so. §483.70(i) Medical II §483.70(i)(1) In acc professional standa must maintain medi that are- (i) Complete; (ii) Accurately docur (iii) Readily accessil (iv) Systematically of §483.70(i)(2) The fa all information conta regardless of the for records, except whe (i) To the individual, representative wher (ii) Required by Law (iii) For treatment, p operations, as perm with 45 CFR 164.50 (iv) For public health neglect, or domestic activities, judicial an law enforcement pu purposes, research medical examiners, a serious threat to h by and in compliance §483.70(i)(3) The fa record information a unauthorized use.	the facility itself is permitted records. ordance with accepted rds and practices, the facility cal records on each resident mented; ole; and organized cility must keep confidential ained in the resident's records, or or storage method of the en release is- or their resident e permitted by applicable law; or; ayment, or health care itted by and in compliance	F 84	12			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 842	(ii) Five years from the there is no requirement (iii) For a minor, 3 years against age under State §483.70(i)(5) The ment (i) Sufficient information (ii) A record of the receive (iii) The comprehens provided; (iv) The results of an and resident review of determinations cond (v) Physician's, nurse professional's progrec (vi) Laboratory, radio services reports as mander that the services reports as mander to the services of the professional of the services and clinical mander that the services are professional of the services and clinical mander that the services are professional of the services and clinical mander that the services are professional of	e required by State law; or ne date of discharge when ent in State law; or ears after a resident reaches e law. Redical record must containtion to identify the resident; sident's assessments; ive plan of care and services By preadmission screening evaluations and ucted by the State; e's, and other licensed ess notes; and ology and other diagnostic equired under §483.50. To is not met as evidenced exiew, facility document ecord review, the facility staff complete and accurate clinical residents in the survey 1. The facility staff failed to istration of a bisacodyl grams- administer one one time a day as needed for in three days. R51's July on administration record)	F8	1. Facility staff failed to maintain a complete and accurate clinical reconne of 26 residents, by failing to document the administration of an needed bisacodyl suppository. The identified resident was found to not affected by the deficient practice. 2. All residents with a prn bisacody suppository order have the potential affected by the deficient practice. A residents with physician's order for as needed bisacodyl suppository we reviewed on 10/26/23, by Nurse Mand found to have been documented compliant with physician order. 3. All Licensed Nurses will be re-econnected to the requirement of documenting the compliant with physician order.	ord for as t be I al to be All (prn) //ere anager, ed and

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
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F 842	A review of a 24-hour revealed documentation administered a supporeview of R51's clinica 2023 MAR and nurse reveal documentation a suppository. On 10/18/23 at 11:18 conducted with LPN (LPN #3 stated that if a suppository, the nurse sign the medication of On 10/18/23 at 12:27 staff member) #1 (the ASM #2 (the director aware of the above control of the above control of the administration and Doministering a process of the administering approach to the administering a process of the administering approach to the administering a process of the administering approach to the administering appro	report sheet dated 7/7/23 on that R51 was sitory on that date. Further al record, including the July s' notes for 7/7/23, failed to that R51 was administered a.m., an interview was licensed practical nurse) #3. a nurse administers a e should write a note and ff on the MAR. p.m., ASM (administrative executive director) and of nursing) were made oncern. d, "Medication ocumentation" documented, rn (as needed) med, the	F8	accurately recording i medication administrate medications administrate order (including prn besuppositories). Re-ederovided by 11/22/23, designee. 4. D.O.N. or designeer residents with prn bowensure prn bowel regiment documented in the record. Will compare to resident's electronical administration record complete and accurate Audit will be complete and then monthly x2 redeficient findings will immediately. All audit reported to the QAPI continued review and 5. 12/1/23 and ongoin	ation record, all ered per physician isacodyl ucation will be by D.O.N. or exist will audit 50% of wel regimen to imen medications e electronic medical 24 hour report sheet comedication to ensure a seculinical record. End weekly x4 weeks months. Any be addressed findings will be Committee for oversight.		