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	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Neck Senior Care Community	20 Delfae Drive Warsaw, VA 22572

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41449 Based on staff interview and facility documentation review, the facility staff failed to report an allegation of abuse to Adult Protective Services for 1 of 2 allegations of abuse reviewed. The findings included: For two Residents involved in an altercation resulting in one of the Residents being slapped in the face, the facility staff failed to report the incident of abuse to adult protective services. On 8/1/23, the survey team reviewed facility records with regards to Resident allegations of abuse and/or neglect. During this review, it was noted that on 6/26/23, there was an incident involving two Residents which resulted in one of the Residents slapping the other in the face. The facility provided a form that was completed with regards to the incident and an excerpt from the document read, If applicable, date notification provided to: APS: N/A [adult protective services: not applicable]. On the afternoon of 8/1/23, an interview was conducted with the facility Administrator. The Administrator stated that all allegations of abuse are to be reported to adult protective services. When asked why this wasn't done in the instance on 6/26/23, the Administrator stated he wasn't employed at the facility at the time and couldn't answer why it was not done. The Administrator further acknowledged that it should have been reported. The facility policy titled, Abuse Investigating and Reporting was received and reviewed. This policy read, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies . An additional facility policy titled; Abuse was provided to the survey team. This policy read, . 5. Investigation: Designated staff will immediately review and investigate all allegations or observations of abuse. a. The results of all investigations are to be communicated to the administrator or his or her designated representative and to other officials in accordance with State law . On 8/15/23, during end of day meeting the facility Administrator and Director of Nursing were made aware of the findings. No further information was received.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 40026 Based on interview, clinical record review and facility documentation the facility staff failed to provide necessary services to maintain good nutrition, grooming, and personal and oral hygiene, for 1 Resident (#1) in a survey sample of 9 Residents. The findings included: For Resident #1 the facility failed to provide adequate hygiene and incontinent care. Resident #1 was a Resident at the facility from 3/22/23 until 4/20/23, she was at the facility for rehabilitation after a post fall fractured hip. Resident #1 had a BIMS (Brief Interview of Mental Status) score of 3 out of a possible 15 indicating severe cognitive impairment. A review of the Clinical record revealed that Resident #1 was incontinent of bowel and bladder. A review of the ADL (Activity of Daily Living) sheets in the POC (Point of Care) system revealed that Resident #1 was not charted or documented on by CNA's from 03/22/23 until 3/27/23. On 8/01/23 at 10 AM, an interview was conducted with the DON who was asked when a Resident is admitted how long is it before the care is documented in POC (Point of Care the CNA documentation system), the DON stated that it should not take more than the time it takes to get the admission completed . When asked would that be 24 hours? She stated that it would not even be that long. A review of the ADL sheets for March revealed the following: Personal Hygiene - 3/28/22 - 11 pm-7 am was marked N/A. On 3/29/23 - 3 pm -11 pm & 11 pm -7 am were marked N/A. For April 2023 - 3 pm -11 pm was marked N/A = 4 times and 11 pm -7 am shift was marked N/A =16 times On 8/1/23 at approximately 11:00 AM an interview was conducted with CNA B who stated that N/A would mean they didn't have to provide that type of care. When asked do you provide personal hygiene if a resident is incontinent has dementia and has a hip fracture CNA B stated that they would most probably need assistance if they had both of those issues. She further stated, Even if they don't need to be changed you still have to check on them so if you put N/A it's like saying didn't need to check them. On 8/1/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on interview clinical record review and facility documentation the facility staff failed to provide emergency dental services for 1 Resident (#1) in a survey sample of 9 Residents. The findings included For Resident #1 the facility failed to provide emergency dental services to replace denture lost at the facility, and subsequently changed her diet to chopped to accommodate the missing bottom denture. On 7/31/23, a review of the clinical record revealed that Resident #1 was admitted to the facility with a top and bottom denture in place. According to the Admission Assessment the Resident had upper and lower denture and wears all the time. Also, on an assessment dated [DATE] the diet was listed as, Regular diet, regular consistency, regular thin liquids. Swallowing problem? No. A review of the Physician orders revealed that on 3/24/23 at 5:57 PM the diet order was changed as follows: Regular diet, Mechanical Chopped texture, Regular/Thin consistency for family request; no denture The following is an excerpt from the nutritionist notes dated 3/29/23 at 7:43 AM.: Diet: Regular diet, Mechanical Chopped texture, Regular/Thin consistency, per family request d/t no denture. A review of the progress notes revealed the following excerpt from the nurse practitioner note on 3/31/23: Denture Use: Meats changed to minced to help with chewing due to loss of denture. On 7/31/23 at approximately 11:00 AM, an interview was conducted with the DON who stated she was unaware of the denture being missing until after the Resident was discharged and the family contacted the DON via email. When asked if the physician orders reflect the change in diet by the dietician due to not having the denture would that indicate that someone on staff knew the denture was missing, she stated it would. On 8/1/23 during the end of day meeting the Administrator was made aware of the findings and no further information was provided