STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. BUILDING _____ B. WING _____	C 01/09/2020

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BERRY HILL NURSING HOME	621 BERRY HILL ROAD SOUTH BOSTON, VA 24592

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/7/2020 through 1/9/2020. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/7/2020 through 1/9/2020. 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 (VA00046388) was investigated during the survey. Complaint allegations were unsubstantiated with two unrelated deficiencies cited. The census in this 120 certified bed facility was 81 at the time of the survey. The survey sample consisted of 18 current resident reviews and two closed record reviews.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate minimum data set (MDS) for one of 20 residents in the survey sample. Resident #73's significant change MDS dated	F 641	F641 – Accuracy of Assessments On 1/23/2020, the Activity Director completed the supplemental assessment for section F on paper for resident #73. On 1/27/2020, the minimum data set (MDS) Coordinator completed a 100% audit of the most recent MDS assessment section "F" for all residents to ensure all MDS's assessments were completed accurately regarding preferences for customary routines and activities. The Activity Director will address any identified areas of concern during the audit.	2/11/2020

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

Allegra Bale — 2.4.2020

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

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F 641	Continued From page 1 12/12/19 included no assessment regarding preferences for customary routines and activities. The findings include: Resident #73 was admitted to the facility on 10/16/19 with diagnoses that included metastatic prostate cancer, anemia, anxiety, high blood pressure, arthritis and history of pathological rib fractures. The MDS dated 12/12/19 assessed Resident #73 with severely impaired cognitive skills. Resident #73's clinical record documented a MDS assessment for a significant change in status dated 12/12/19. All categories in section F for assessment of the resident's preferred routines and activities were incomplete. The resident interview questions were marked with dashes and the staff assessment (section F0700) was blank. On 1/8/20 at 1:25 p.m., the registered nurse MDS coordinator (RN #3) was interviewed about the incomplete assessment for Resident #73. RN #3 stated the section was not completed within the 7-day look back period. RN #3 stated the activities director was responsible for completing section F. On 1/8/20 at 1:30 p.m., the activities director (other staff #1) was interviewed about Resident #73's incomplete assessment. The activities director stated she was not made aware a significant change assessment was initiated and she failed to assess the resident during the look-back period. The activities director stated significant changes were usually communicated during their morning meetings. The activities	F 641	On 1/27/2020, an in-service was completed by the Administrator with the MDS coordinator and the activities director in regards to *MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual* with emphasis on completing assessment accurately and completely. Beginning on 2/4/2020, 10% audit of all resident's most recent MDS assessments will be completed by the Staff Development Coordinator utilizing the *MDS Accuracy Audit Tool*. This audit will be completed weekly for four (4) weeks then monthly for one (1) month to ensure accurate and complete coding of the MDS assessment to include section "F". The Staff Development Coordinator will address all areas of concern during the audit to include retraining of the MDS nurse and/or Activities Director and completing necessary assessment of the resident. The DON will review and initial the *MDS Accuracy Audit Tool* weekly for four (4) weeks and then monthly for one (1) month to ensure any areas of concerns were addressed. The DON will forward the results of *MDS Accuracy Audit Tool* to the Quality Assurance Performance Improvement Committee (QAPI) monthly for two (2) months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 641	Continued From page 2 director stated when she became aware of the significant change MDS, it was too late to perform the assessment. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual documents on page F-2 regarding completion of section F., "...Code 0, no: if the interview should not be conducted with the resident. This option should be selected for residents who are rarely/never understood, who need an interpreter but one was not available, and who do not have a family member or significant other available for interview. Skip to F0800, (Staff Assessment of Daily and Activity Preferences)...Code 1, yes: if the resident interview should be conducted. This option should be selected for residents who are able to be understood, for whom an interpreter is not needed or is present, or who have a family member or significant other available for interview. Continue to F0400 (Interview for Daily Preferences) and F0500 (Interview for Activity Preferences)..." (1) This finding was reviewed with the administrator and director of nursing during a meeting on 1/8/20 at 4:00 p.m. (1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, Centers for Medicare & Medicaid Services, Revised October 2019.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.	F 645	F645 – PASRR Resident #87 no longer resides in facility.	2/11/2020

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F 645	Continued From page 3 §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under	F 645	On 1/27/2020, the Administrator completed an audit of all new admissions from the last 30 days to ensure that all residents had an accurate and complete preadmission screening and record review (PASARR) on admission and that all diagnoses of serious mental illness were included. The Social Worker will address any identified areas of concern during the audit. On 1/27/2020, the administrator completed an in-service with the Admissions Director and Social Worker on *PASARRs*. Beginning 2/4/2020, the Admissions Director and/or designee will audit 100% of admissions utilizing the PASARR *Audit Tool* to ensure that PASARRs are present and complete on admission and include all diagnoses of serious mental illness. The *PASARR Audit Tool* will be completed weekly for four (4) weeks and monthly for one (1) month. The Social Worker will address all areas of concern. The Administrator will review and initial the *PASARR Audit Tool* weekly for four (4) weeks and monthly for one (1) month to ensure that concerns have been addressed. The Administrator will forward the results of *PASARR Audit Tool* to the Quality Assurance Performance Improvement Committee (QAPI) monthly for two (2) months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 645	Continued From page 4 paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and complaint investigation, the facility staff inaccurately completed a preadmission screening and resident review (PASARR) after admission for one of twenty residents in the survey sample. Resident #87's PASARR was completed five days after his admission and failed to include a diagnosis of a serious mental illness (schizophrenia). The findings include: Resident #87 was admitted to the facility on 3/6/19 and discharged from the facility on 6/5/19.	F 645		

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F 645	Continued From page 5 Diagnoses for Resident #87 included cerebral palsy, schizophrenia, anxiety disorder, intellectual disabilities, autistic disorder and dysphagia. The minimum data set (MDS) dated 3/14/19 assessed Resident #87 as non-verbal with short and long-term memory problems and severely impaired cognitive skills. Resident #87's clinical record documented admission records indicating diagnoses of schizophrenia, anxiety disorder, intellectual disabilities and autism. These diagnoses were documented on the resident's face sheet and initial MDS assessment dated 3/14/19. The clinical record documented a form titled Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions. The facility's social worker completed the form five days after the resident's admission, on 3/11/19. Section 2 of the form indicated the resident had no serious mental illness (including schizophrenia and severe anxiety disorder) and documented the resident had no functional limitation in major life activities in past 3 to 6 months due to his condition. On 1/9/20 at 9:00 a.m., the facility's social worker (other staff #2) was interviewed about the accuracy and timing of Resident #87's PASARR. The social worker stated the PASARR was not completed correctly, as he had limited paperwork when he completed the form. The social worker stated the administrator at the time asked him to complete the PASARR after the resident was admitted. The social worker stated he was "new" and was not familiar or knowledgeable about completing the PASARR. The social worker stated that he should have indicated the	F 645		

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F 645	Continued From page 6 schizophrenia and functional limitations on the form in section 2 and that would have initiated an additional level II assessment. The social worker stated the PASARR "was not done correctly." The administrator at the time of Resident #87's stay was not available for interview, as she no longer worked at the facility. This finding was reviewed with the administrator on 1/9/20 at 10:45 a.m.	F 645		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to provide nail care for one of 20 residents in the survey sample. Resident #73 was observed with long, dirty, jagged finger and toenails. The findings include: Resident #73 was admitted to the facility on 10/16/19 with diagnoses that included metastatic prostate cancer, anemia, anxiety, high blood pressure, arthritis and history of pathological rib fractures. The MDS dated 12/12/19 assessed Resident #73 with severely impaired cognitive skills. This MDS documented the resident was totally dependent upon one person for hygiene.	F 677	F677 – ADL Care Provided for Dependent Residents On 1/8/2020, Resident #73's nails were cleaned and trimmed by the assigned certified nursing assistant (CNA). On 1/27/2020, a 100% audit was completed by the Unit Managers on all residents to ensure that fingernails and toenails were not long, dirty or jagged per resident preference. Any issues identified were corrected immediately by the Unit Managers. On 1/27/2020, the Staff Development Coordinator initiated an in-service with CNAs and licensed nurses regarding *Providing Nail Care*. The in-service will be completed by 2/4/2020.	2/11/2020

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F 677	Continued From page 7 On 1/7/20 at 2:30 p.m., Resident #73 was observed in bed with his feet elevated on a pillow. The resident's fingernails were long and jagged. The left thumbnail had a "V" shaped cut in the center of the nail. A black substance was under the nails on the left hand. The resident's toenails were long and rough, extending beyond the end of his toes. On 1/8/20 at 9:00 a.m., Resident #73's finger and toe nails were observed again as long, rough and dirty. Resident #73 was interviewed about his nails at this time. Resident #73 stated his nails were long and needed cutting. Resident #73 stated, "I just haven't gotten to cutting them." On 1/8/20 at 9:15 a.m., the certified nurses' aide (CNA #1) caring for Resident #73 was interviewed about the long dirty nails. CNA #1 stated she usually cut finger and toenails during baths or showers. CNA #1 looked at Resident #73's nails and stated, "I see they need cleaning." Resident #73's plan of care (revised 12/24/19) documented the resident required assistance for personal care and activities of daily living. The plan goals documented, "Activities of Daily Living/Personal Care will be completed with staff support as appropriate to maintain or achieve highest practical level of functioning..." and listed one person was required for assistance with hygiene and personal care needs. This finding was reviewed with the administrator and director of nursing during a meeting on 1/8/20 at 4:00 p.m.	F 677	Beginning on 2/4/2020, 10 residents will be observed by the Activities Director utilizing the *ADL Monitoring Tool* to ensure that nails are clean and trimmed per resident preference weekly for four (4) weeks, then monthly for one (1) month. Any areas of identified concern will be immediately addressed by the Unit Managers and/or assigned hall nurse. The Director of Nursing (DON) will review and initial the *ADL Monitoring Tool* weekly for four (4) weeks and then monthly for one (1) month to ensure all areas of concern are addressed. The DON will forward the results of the *ADL Monitoring Tool* to the Quality Assurance Performance Improvement Committee (QAPI) monthly for two (2) months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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F 689	Continued From page 8 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to ensure a safe bed environment for one of 20 residents in the sample (Resident #87) and failed to ensure two resident accessible restrooms had a call system for safety. The findings include: 1. Resident #87 was admitted to the facility on 3/6/19 and discharged from the facility on 6/5/19. Diagnoses for Resident #87 included cerebral palsy, schizophrenia, anxiety disorder, intellectual disabilities, autistic disorder and dysphagia. The minimum data set (MDS) dated 3/14/19 assessed Resident #87 as non-verbal with short and long-term memory problems and severely impaired cognitive skills. A facility reported incident form dated 6/4/19 documented, "Resident's sister + guardian reported on 6/3/19 that when she visited the resident on 6/1/19, she found him with a belt around torso, close to his neck. She also found belt around his legs. Resident was in bed at the time."	F 689	F689 – Free of Accident Hazards/Supervision/Devices Resident #87 no longer resides in facility. On 1/8/2020, the two visitor restrooms were fitted with locks to ensure visitor restrooms were not a safety concern for residents. On 1/9/2020, an in-service was initiated by the Staff Development Coordinator and Therapy Director with CNAs on *Gait Belts*. The in-service will be completed by 2/4/2020. On 1/10/2020, an in-service was completed by the administrator with the maintenance department on the importance of ensuring all resident accessible areas have a call bell system for safety and if not, ensuring that the areas are not resident accessible. Beginning on 2/4/2020, 10 CNAs will be observed the unit managers and/or designee utilizing the *Resident Care Audit – Gait Belt* to ensure that gait belt is applied properly and removed following activity. The *Resident Care Audit – Gait Belt* will be completed weekly for four (4) weeks and then monthly for one (1) month. The Unit Managers and/or designee will immediately address any concerns noted during the audit. The Administrator will review and initial the *Resident Care Audit – Gait Belt* weekly for four (4) weeks and monthly for one (1) month to ensure all areas of concern have been addressed.	2/11/2020

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F 689	Continued From page 9 The facility's investigation dated 6/7/19 documented Resident #87 was non-verbal and walked independently "all over the facility all day long until he is ready to lie down." This report documented the resident was dependent on staff for all activities of daily living and that feeding the resident and providing hygiene was difficult as "he was constantly on the move." The investigation documented after falls on 5/9/19 and 5/15/19, the resident was placed on one to one supervision around the clock and staff were assigned to walk with him, using a gait belt. The investigation documented the certified nurses' aide (CNA #2) assigned to Resident #87 on 6/1/19 was in the room when the sister arrived. This investigation documented, "...When the sister pulled the covers back they saw that the gait belt that was used when ambulating him earlier had moved up and was loosely looped around his neck. Another belt had also slid down to his legs. [CNA #2] stated he used two gait belts when he ambulated [Resident #87] so he can stabilize him better when he start leaning back. He [CNA #2] admitted that he forgot to remove them [belts] before putting him in bed. He [CNA #2] stated he has not used a gait belt in two years and he had forgotten how to secure it so he had knotted them after applying them around the resident's waist. Apparently, due to [Resident #87's] constant motion and gyrations, both had loosened and one slid upwards and the other downwards..." Resident #87's clinical record made no mention of the incident with the gait belts. A physician's order was documented on 5/16/19 for one to one supervision "as needed" for safety. Resident #87's care plan (initiated 3/7/19) documented the resident was totally dependent	F 689	Beginning on 2/4/2020, the Administrator and/or designees will monitor visitor restrooms utilizing the *Visitor Restroom Audit Tool* to ensure that the restrooms remain locked and do not present a safety concern for residents. The *Visitor Restroom Audit Tool* will be completed weekly for four (4) weeks and then monthly for one (1) month. The Maintenance Director will address all areas of concern identified during the audit. The Administrator will review and initial the *Visitor Restroom Audit Tool* weekly for four (4) weeks and then monthly for one (1) month to ensure that all areas of concern have been addressed. The Administrator will forward the results of *The Resident Care Audit – Gait Belt* and the *Visitor Restroom Audit Tool* to the Quality Assurance Performance Improvement Committee (QAPI) monthly for two (2) months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 689	Continued From page 10	F 689		

on staff for activities of daily living, wandered constantly, had poor safety awareness and severe intellectual disability with impaired communication skills. Interventions for safety and fall prevention included one to one supervision as needed.

On 1/9/20 at 9:00 a.m., the registered nurse unit manager (RN #2) and the administrator were interviewed about Resident #87's incident with the gait belts. RN #2 stated the resident was in "constant motion" and that one to one supervision was provided after the resident had two falls with lacerations. RN #2 stated she was not working that weekend but understood that the sister observed the resident with the gait belts near his neck and around his legs and reported the observation the following week. The administrator stated she was not working in the facility at the time of the incident but the investigation by the previous administrator documented the gait belts were improperly applied and the CNA involved admitted to leaving the belts on the resident when in bed. The administrator stated the investigation concluded the belts moved up/down on the resident and presented a safety risk due to the resident's constant motion.

The facility's education sheet titled "Application and Use of Gait Belt" dated 6/3/19 documented steps for applying the gait. This education sheet documented, "How to apply a gait belt - end needs to slide through buckle; make sure it's not too tight or too loose...How to secure a gait belt - scalloped edge or 'teeth' keeps the canvas from sliding out. Make sure this edge is against the belt material...Use gait belt only when ambulating or transferring patient. It should be removed

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F 689	Continued From page 11	F 689		

once transfer or ambulation is completed...NEVER, NEVER LEAVE BELT ON PATIENT WHILE IN BED AS BELT COULD SLIDE UP RESULTING IN POTENTIAL RISK FOR STRANGULATION. OR IT COULD SLIDE DOWN THEREBY RESTRAINING RESIDENT'S LOWER LIMBS."

This finding was reviewed with the administrator, director of nursing and corporate consultant during a meeting on 1/8/20 at 4:00 p.m.

2. On 1/8/20 at 8:45 a.m., two bathrooms located on the hallway near the front entrance to the building were inspected. The restrooms were unlocked and accessible to residents, staff and visitors. There was no call bell system in either restroom in case of an emergency and/or fall. Multiple residents were observed on each day of the survey in the hallway in the area of the unlocked restrooms.

On 1/9/20 at 10:20 a.m., the administrator was interviewed about the unlocked restrooms without a safety call system. The administrator stated the restrooms were unlocked and she was aware there was no call system in either restroom. The administrator stated they discouraged residents from using these restrooms but she had seen residents using them on occasion. On 1/9/20 at 10:30 a.m., the administrator stated she investigated the unlocked restrooms and stated the doors at one time were locked with key access available with the receptionist. The administrator stated the previous administrator told staff that the restrooms were for visitors and to keep them unlocked. The administrator stated the restroom doors had been unlocked at least since August 2019 when she was hired as an

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F 689	Continued From page 12 interim administrator.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758	F758 – Free from Unnecessary Psychotropic Medications/PRN Use On 1/9/2020, resident #33's PRN Ativan was discontinued. On 1/8/2020, resident #83's PRN Ativan was discontinued. On 1/27/2020, the Unit Managers and/or hall nurses completed a 100% audit of all as needed (PRN) psychotropic medication to ensure that PRN psychotropic medications did not exceed 14 days and included a specified stop date. All PRN psychotropic medications found without a stop order were clarified with the physician or discontinued. On 1/27/2020, the staff development coordinator initiated an in-service with nurses on *PRN Psychotropic Medications*. The in-service will be completed by 2/4/2020. Beginning 2/4/2020, the MDS nurse and/or designee will audit 10 residents with current orders for PRN psychotropic medications utilizing the *PRN Psychotropic Medication Audit Tool* to ensure that all PRN psychotropic medication orders include a 14-day stop date. The *PRN Psychotropic Medication Audit Tool* will be completed weekly for four (4) weeks and monthly for one (1) month. The Unit Managers and/or assigned hall nurse will address all areas of concern during the audit. The DON will review and initial the *PRN Psychotropic Medication Audit Tool* weekly for four (4) weeks then monthly for one (1) month to ensure all areas of concern were addressed	2/11/2020

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F 758	Continued From page 13 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed for two of 20 residents in the survey sample, Residents # 33 and 83, to ensure the residents did not have a PRN (as needed) psychotropic medication ordered for greater then 14 days, and without a stop date specified. Both Resident # 33 and 83 had a PRN order for Ativan that did not have a stop date. The findings include: 1. Resident # 33 in the survey sample was admitted to the facility on 4/16/09 with diagnoses that included renal insufficiency, gastroesophageal reflux disease, hypertension, diabetes mellitus, hyperlipidemia, cerebrovascular accident, anxiety disorder, depression, bipolar disorder, and schizophrenia. According to the most recent Minimum Data Set (MDS), an Annual with an Assessment Reference Date (ARD) of 11/5/19, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 14 out of 15.	F 758	The DON will forward the results of the *PRN Psychotropic Medication Audit Tool* to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The QAPI Committee will meet monthly for two (2) months and review the *PRN Psychotropic Medication Audit Tool* to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 758	Continued From page 14 Resident # 33 had a medication order, dated 11/20/19, for Ativan Injectable (Lorazepam Inj) 2mg/ml (milligrams per mililter). Inject 0.5ml = 1mg intramuscular every 4 hours as needed for pain. There was no stop date for the Ativan order. NOTE: Ativan (Lorazepam) is a short acting Benzodiazepine used to treat anxiety, and irritability with psychiatric or organic disorders. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 788. At 2:55 p.m. on 1/8/2020, the Director of Nursing (DON) was interviewed regarding the PRN orders for Ativan (Lorazepam) for Residents # 33 and 83. "The doctor was not too particular," the DON said. The DON went on to say that, "...the nurses are pretty good about catching that. " The findings were discussed during an end of day meeting at 4:00 p.m. on 1/8/2020 that included the Administrator, DON, Corporate Nurse Consultant, and the survey team. 2. Resident # 83 in the survey sample was admitted to the facility on 12/12/19 with diagnoses that included coronary artery disease, congestive heart failure, hypertension, gastroesophageal reflux disease, renal insufficiency, diabetes mellitus, cerebrovascular accident, anxiety disorder, and depression. According to an Admission MDS with an ARD of 12/20/19, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 06 out of 15. Resident # 83 had a medication order, dated 12/12/19, for Lorazepam (Ativan) 2mg/ml give	F 758		

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F 758	Continued From page 15 0.25ml every 4 hours PRN for anxiety/shortness of breath. There was no stop date for the Lorazepam order. The findings were discussed during an end of day meeting at 4:00 p.m. on 1/8/2020 that included the Administrator, DON, Corporate Nurse Consultant, and the survey team.	F 758		
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 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761	F761 – Label/Store Drugs and Biologicals On 1/7/2020, the Unit Manager removed two bottles of expired medications from both medication carts on unit two. On 1/27/2020, a 100% audit of all medication carts was completed by the Unit Managers. Findings are to be corrected immediately by the Unit Managers. On 1/8/2020, the Staff Development Coordinator initiated an in-service with nurses on *Expired Medications*. The in-service will be completed by 2/4/2020. Beginning 2/4/2020, Unit Managers and/or designee will monitor all medication carts utilizing the *Medication Cart Audit* Tool to ensure that no expired medications are stored on medication carts. The *Medication Cart Audit Tool* will be completed weekly for four (4) weeks and then monthly for one (1) month. The Unit Managers and/or designee will address any areas of concern found during the audit. The DON will review and initial the *Medication Cart Audit Tool* weekly for four (4) weeks and monthly for one (1) month to ensure that all concerns have been addressed.	2/11/2020

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F 761	Continued From page 16 Based on observation, staff interview, and facility documentation, the facility staff failed to ensure expired medications were not readily available for distribution on 2 medication carts on unit two. Two bottles of Major Aspirin EC (enteric coated) - Analgesic, 325 (milligrams), 100 tablets had an expiration date of 12/18 (December 2018). Findings include: On 01/07/2020 at 4:00 p.m., an inspection of the medication carts was conducted with the registered nurse (RN #1) on unit two. Two bottles of Major Aspirin EC- Analgesic, 325 mg, 100 tablets were observed with an expiration date of 12/18 (December 2018). RN #1 was interviewed regarding who was responsible for checking dates on the medication carts. RN #1 stated all nurses who worked the medication carts were responsible for checking the dates. On 01/07/2020 at 4:09 p.m., the director of nursing (DON) was asked for a policy on medication storage and expiration of medications. The DON stated the expectation was for each nurse who worked the medication cart to check the expiration dates. A review of the policy "Medication Expiration Dates (revised 11/1/17)" documented the following: "Manufacturer's expiration dates shall be observed when provided, for any and all medications .... All house stock medications (opened and unopened) provided in the original manufacturer's original package shall be considered expired when the manufacturer's expiration date has been reached ...." On 01/08/2020 at 4:00 p.m., the above findings	F 761	The DON will forward the results of the *Medication Cart Audit Tool* to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The QAPI Committee will meet monthly for two (2) months and review the *Medication Cart Audit Tool* to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 761	Continued From page 17 were discussed with the administrator, the DON and the nurse consultant during a meeting. No additional information was received by the survey team prior to exit on 01/09/2020 at 11:15 a.m.	F 761		
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual	F 801	F801 – Qualified Dietary Staff On 1/10/2020, Administrator informed Dietary Manager that to continue in this position, regulatory qualifications will have to be met. On 1/10/2020, Administrator in-serviced Dietary Manager on regulations regarding qualified dietary staff. On 1/15/2020, Dietary Manager inquired about Food Protection Manager Certification class. On 1/31/2020, an ad was placed on Indeed for a Certified Dietary Manager. Beginning 2/3/2020 to 2/7/2020, the Corporate Dietary Consultant, BS, CDM, CFPP, will provide the Dietary Manager with education on company policy relating to food handling and safety. Beginning 2/3/2020, the Corporate Dietary Consultant, BS, CDM, CFPP, will stay until Dietary Manager meets regulatory requirements. Beginning on 2/11/2020, the RD will increase the number of visits from monthly to weekly until the Dietary Manager becomes qualified. Prior to 2/22/2020, the Dietary Manager will sit for the Food Protection Manager Certification Exam.	2/11/2020

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F 801	Continued From page 18 will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.	F 801	Beginning 2/4/2020, the Dietary Manager will have to report to Administrator weekly on the progress of certification. The Administrator will document the progress on *The Dietary Manager Progress Tool.* The Administrator will forward the results of the *Dietary Manager Progress Tool* to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The QAPI Committee will meet monthly for two (2) months and review the *Dietary Manager Progress Tool* to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 801	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to employee a qualified dietary manager. The dietary manager working since 2017 without a full-time registered dietitian, had no education and/or certifications for safe food service management. The findings include: As part of the kitchen inspection tasks, the qualifications of the facility's dietary manager were requested from the administrator on 1/8/20. On 1/8/20 at 1:55 p.m., the administrator stated the dietary manager was not certified. The administrator stated the dietary manager was hired as the kitchen manager on 10/23/17 and took the class for dietary certification and a food safety class but did not pass either class. The administrator stated she started work at the facility permanently in October 2019 and the dietary manager was taking the certification class at that time. The administrator stated she did not realize the manager did not pass and had no certifications about food safety. On 1/8/20 at 2:10 p.m., the administrator was interviewed again about any further qualifications of the dietary manager and supervision by the registered dietitian. The administrator stated the facility's registered dietitian was not a full-time employee and was contracted to come once per month or as needed. The administrator stated again that the dietary manager had no nutrition education, current certifications or safe food service qualifications. The facility's Food Service Manager job	F 801		

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F 801	Continued From page 20 description (dated 7/1/16) documented qualifications for the dietary manager included, "...as a minimum, a high school diploma or G.E.D...Be a certified food protection manager...Be a graduate or be enrolled in an accredited course in dietetic training approved by the American Dietetic Association..." This finding was reviewed with the administrator and director of nursing during a meeting on 1/8/20 at 4:00 p.m.	F 801		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to store and distribute food in a sanitary manner. The	F 812	F812 – Food Procurement, Store/Prepare/Serve – Sanitary On 1/7/2020, no pureed beef was served from container on steam table after temperature identified. On 1/10/2020, the Maintenance Director inspected the dishwasher. No problems with temperature noted. On 1/10/2020, Spartan Chemical came to facility to calibrate sanitizer concentration to ensure it was within recommended concentration range. On 1/8/2020, the staff development coordinator initiated an in-service with dietary staff on Food Temperatures to include, but not limited to the safe temperature of pureed beef stored/served on the kitchen's steam table. The in-service will be completed by 2/4/2020. On 1/13/2020, the Administrator initiated an in-service to all dietary staff on the Dishwasher Operation to include, but not limited to recommended range of wash/rinse temperatures and sanitizer concentration. The in-service will be completed by 2/4/2020.	2/11/2020

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F 812	Continued From page 21 temperature of pureed beef stored/served from the kitchen's steam table was held at an unsafe temperature. The dishwasher was operated with wash/rinse temperatures below the manufacturer's recommended and/or minimum temperature and the sanitizer concentration above the recommended range. The findings include: a) On 1/7/20 at 12:00 p.m., the meal service from the main kitchen's steam table was observed, accompanied by the dietary manager (other staff #3). The dietary manager checked the temperature of each hot food item on the steam table. The temperature of the pureed beef was measured at 120 degrees (F). The dietary manager stated the temperature was low but did not remove the pureed beef from the steam table. On 1/7/20 at 12:30 p.m., the dietary manager was interviewed about the pureed beef held on the steam table at 120 degrees. The dietary manager stated she did not think there was enough left in the container so she did not remove the food item from the table. The dietary manager stated if the temperature was not adequate, the food was supposed to be discarded and would "put out some more." The dietary manager stated she did not think the pureed beef was used after she checked the temperature. When asked about the required food temperatures on the steam table, the dietary manager stated from 145 to 160 degrees. The facility's policy titled Food Temperature (revised 2/9/16) documented, "...The Food Service Manager and/or Cooks are responsible for taking food temperatures prior to service of all	F 812	Beginning on 2/4/2020, the cook on shift will monitor temperatures of pureed beef stored/served from the kitchen's steam table at breakfast, lunch, and dinner utilizing the *Food Temperature Audit Tool*. The Food Temperature Audit Tool will be completed daily for four (4) weeks and then monthly for one (1) month. The Dietary Manager and/or designee will address any areas of concern immediately. The Administrator will review and initial the Food Temperature Audit Tool weekly for four weeks and then monthly for one (1) month. Beginning on 2/4/2020, dishwasher temperatures and sanitizer concentration will be checked daily by the dietary aide utilizing the *Dishwasher Audit Tool* to ensure that wash/rinse temperatures and sanitizer concentration are within recommended range. The Dishwasher Audit Tool will be completed daily for four (4) weeks and then monthly for one (1) month. The Dietary Manager will address any areas of concern. The Administrator will review and initial the Dishwasher Audit Tool weekly for four (4) weeks and then monthly for one (1) month to ensure that areas of concern have been addressed. The Administrator will forward the results of the *Food Temperature Audit Tool* and the *Dishwasher Audit Tool* to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The QAPI Committee will meet monthly for two (2) months and review the *Food Temperature Audit Tool* and the *Dishwasher Audit Tool* to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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	495318	A. BUILDING _____ B. WING _____	C 01/09/2020

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F 812	Continued From page 22 foods prepared...Hot foods will be maintained at 135 [degrees] or above in the kitchen (or on steam table) prior to service..." b) On 1/7/20 at 12:33 p.m., accompanied by the dietary manager, the chemical/low temperature dishwasher was observed for two wash/rinse cycles. The outer surfaces of the dishwasher were covered with heavy, white, scaly residue. The temperature gauge on the first run was observed at 104 degrees (F) and the second run was at 118 degrees (F). The dietary manager was interviewed at this time about the expected temperatures and stated the wash/rinse was supposed to be 140 degrees. The dietary manager also tested the chlorine sanitizer concentration with a test strip. The test strip was dark purple indicating 200 parts per million (ppm). The dietary manager stated the temperature gauge "hardly moves" when they wash dishes. The dietary manager stated their dishwasher vendor service was looking for a new gauge. When asked about the manufacturer's recommended settings for the dishwasher, the dietary manager stated she did not have a manual but was told the recommended temperature was 140 degrees and 50 ppm for the sanitizer concentration. On 1/8/20 at 12:40 p.m., the dietary manager was interviewed again about the dishwasher. The dietary manager stated the sanitizer was automatically dispensed into the wash/rinse water and was supposed to be between 50 ppm and 90 ppm. The dietary manager stated she did not know why the concentration was reading high. The facility's policy titled Cleaning Procedures - Warewashing (revised 2/9/16) documented the	F 812		

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F 812	Continued From page 23 wash water temperature using chemical sanitizing dishwasher was from 120 to 130 degrees (F) and the chlorine sanitizer concentration was 50 to 90 ppm. This policy documented, "In the event the dish machine does not maintain proper temperature or sanitizing solution, the kitchen supervisor and/or maintenance supervisor will be notified and the facility will use paper products for meal services..." The dishwasher manufacturer's manual was located online by the administrator. The manual documented recommended wash/rinse temperatures of 140 degrees and minimum of 120 degrees (F). There was no reference in the manual about the concentration of the sanitizer solution. These findings were reviewed with the administrator and director of nursing during a meeting on 1/8/20 at 4:00 p.m.	F 812		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to ensure proper operation of the facility's only dishwasher. The dishwasher wash/rinse temperatures were below the recommended range and the sanitizer concentration was higher than recommended. The findings include:	F 908	F908 – Essential Equipment, Safe Operating Condition On 1/10/2020, the Maintenance Director inspected the dishwasher. No problems with temperature noted. On 1/10/2020, Spartan Chemical came to facility to calibrate sanitizer concentration to ensure it was within recommended concentration range. On 1/13/2020, the Administrator initiated an in-service to all dietary staff on the Dishwasher Operation to include, but not limited to recommended range of wash/rinse temperatures and sanitizer concentration. The in-service will be completed by 2/4/2020.	2/11/2020

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F 908	Continued From page 24 On 1/7/20 at 12:33 p.m., accompanied by the dietary manager, the chemical low temperature dishwasher was observed for two wash/rinse cycles. The outer surfaces of the dishwasher were covered with heavy, white, scaly residue. The temperature gauge on the first run was observed at 104 degrees (F) and the second run was at 118 degrees (F). The dietary manager was interviewed at this time about the expected temperatures and stated the wash/rinse was supposed to be 140 degrees. The dietary manager also tested the chlorine sanitizer concentration with a test strip. The test strip was dark purple indicating 200 parts per million (ppm). The dietary manager stated the temperature gauge "hardly moves" when they wash dishes. The dietary manager stated their dishwasher vendor service was looking for a new gauge. When asked about the manufacturer's recommended settings for the dishwasher, the dietary manager stated she did not have a manual but was told the recommended temperature was 140 degrees and 50 ppm for the sanitizer concentration. On 1/8/20 at 12:40 p.m., the dietary manager was interviewed again about the dishwasher. The dietary manager stated the sanitizer was automatically dispensed into the wash/rinse water and was supposed to be between 50 ppm and 90 ppm. The dietary manager stated she did not know why the concentration was high. The facility's policy titled Cleaning Procedures - Warewashing (revised 2/9/16) documented the wash water temperature using chemical sanitizing dishwasher was from 120 to 130 degrees (F) and the chlorine sanitizer concentration was 50 to 90 ppm. This policy documented, "In the event the	F 908	Beginning on 2/4/2020, temperatures and sanitizer concentration will be checked daily by the dietary aide utilizing the *Dishwasher Audit Tool* to ensure that wash/rinse temperatures and sanitizer concentration are within recommended range. The Dishwasher Audit Tool will be completed daily for four (4) weeks and then monthly for one (1) month. The Administrator will review and initial the Dishwasher Audit Tool weekly for four (4) weeks and then monthly for one (1) month to ensure that areas of concern have been addressed. The Administrator will forward the results of the *Dishwasher Audit Tool* to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The QAPI Committee will meet monthly for two (2) months and review the *Dishwasher Audit Tool* to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 908	Continued From page 25 dish machine does not maintain proper temperature or sanitizing solution, the kitchen supervisor and/or maintenance supervisor will be notified and the facility will use paper products for meal services..." The dishwasher manufacturer's manual was located online by the administrator. This manual documented recommended wash/rinse temperatures of 140 degrees and minimum of 120 degrees (F). These findings were reviewed with the administrator and director of nursing during a meeting on 1/8/20 at 4:00 p.m.	F 908		