STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495374	A. BUILDING _____ B. WING _____	04/29/2021

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MOUNTAIN VIEW REGIONAL MEDICAL CENTER	310 THIRD STREET, NE NORTON, VA 24273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification on 04/26/21 to 04/29/21. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 04/26/21 through 04/29/21 Survey Census: 25 Sample Size: 15 Supplemental Residents: 0	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 record review and staff interviews the facility failed to ensure Resident (R)23's assessment accurately reflected gradual dose reduction attempts for an antipsychotic. This failure affected one of five residents reviewed for unnecessary medications. Findings include:	F 641	1. Modification of Quarterly MDS assessment N0450 with ARD of 12/10/2020 to correctly report that no GDR was performed. Completed 06/09/2021 2. Modification of Annual MDS assessment with ARD of 6/11/2020 section N0450 to correctly report that no	6/9/21

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

Electronically Signed | 06/14/2021

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 Review of the diagnosis tab in the electronic medical record (EMR) revealed Resident (R) 23's diagnosis included Alzheimer's Disease, Unspecified Dementia with behavioral disturbance, anxiety disorder due to know physiological condition, restlessness and agitation, and repeated falls. Review of physician's orders under the "orders" tab in the EMR revealed R23 had an order for Seroquel Tablet 25 MG (an Antipsychotic) give 0.5 tablet by mouth in the morning related to unspecified dementia with behavioral disturbance and an order for Seroquel tablet 25 MG give 1 tablet by mouth at bedtime related to unspecified dementia with behavioral disturbance. Both orders had a start date of 04/22/19. Review of R23's Minimum Data set (MDS) assessments for the past year revealed each of the assessments was inaccurately coded at Section N0450 "Antipsychotic Medication Review" to indicate a gradual dose reduction had been attempted during that quarter and included an inaccurate GDR date. Review of the MDS assessments revealed the following: The Quarterly MDS Assessment with an assessment reference date of 12/10/20 was marked that a Gradual Dose Reduction (GDR) of Seroquel was attempted on 02/25/20. The EMR was reviewed in its entirety and was silent for a dose reduction on the date listed. The Quarterly MDS Assessment with an assessment reference date of 12/10/20 was marked that a GDR of Seroquel was attempted on 02/25/20. The EMR was reviewed in its entirety and was silent for a dose reduction on the	F 641	GDR was performed. Completed 06/09/2021 3. MDS Coordinator will obtain GPR spreadsheet from consulting pharmacist from Pharmacy Network Services on an ongoing monthly basis. 4. Director of Nursing(DON)will perform monthly review of 10% of submitted MDS for correct reporting of section N0450 for 3 months. Target compliance for reviews of all reporting in MDS section of N0450 will be 100%. 5. Findings of stated audits will be reported and discussed in Monthly Quality meeting for recommendations and further follow ups as indicated.	

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F 641	Continued From page 2 date listed. The Annual MDS assessment with an assessment reference date of 06/11/20 was marked that a GDR of the Seroquel was attempted on 02/18/20. The EMR was reviewed in its entirety and was silent for a dose reduction on the date listed. On 04/29/21 at 11:02 AM the above MDS assessments were reviewed with the MDS Coordinator. On 04/29/21 at 1:26 PM the MDS Coordinator stated she completed a thorough review of R23's record and the only GDR she could find was on 04/22/19. She verified the MDS assessments were inaccurate.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy/procedure review the facility failed to ensure a resident's Port-A-Cath (also known as an intravenous vascular access port -IVAP) was flushed with heparin by a Registered Nurse (RN) and not by a Licensed Practical Nurse (LPN). Per accepted standards of practice, these flushes are outside an LPN's scope of practice. The deficient	F 684	1. All nurses were re-educated on facility procedure "Implanted Venous Access Port: Flushing" that Registered Nurses are to be the only licensed nursing professional to perform tasks related to the usage and maintenance of IVAP. Completed 5/3/2021	5/3/21

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F 684	Continued From page 3 practice affected one sampled resident (R)21 and one unsampled resident R22; and had the potential for poor quality of care for all residents, if staff operated outside their accepted scope of practice. Findings include: Review of the facility procedure titled "Implanted Venous Access Port: Flushing," dated February 9, 2018, revealed RNs, physicians, nurse practitioners and physician assistants can flush IVAPs. RNs are generally responsible for monitoring the effects of injected medications or fluids for administering appropriate treatment for adverse effects. Tasks related to the use and maintenance of an IVAP cannot be delegated to assistive healthcare staff." 1.) Review of the "Face Sheet" in the Electronic Medical Record (EMR) revealed R21 was admitted to the facility on 05/11/16 and readmitted on 07/13/19. The resident had diagnoses that included Alzheimer's disease and chronic kidney disease - stage 4. Review of the "Orders" tab in the EMR for R21 revealed a physician order dated 10/23/20 : Heparin Lock Flush Solution 100 Unit/milliliter (ml). Use 5 ml intravenously every night shift starting on the 23rd and ending on the 23rd every month for management of a Port-A-Cath access port a cath and flush with 10 ml of normal saline flush and then flush with 5 ml of heparin. Review of the Medication Administration Record (MAR) from July 2020 to April 2021 revealed the flushing of the Port-A-Cath was performed by a LPN, seven times, on 07/22/20, 8/22/20,	F 684	2. Orders for maintenance of IVAP for R21 and R22 were modified to be performed during day shift when more RNs are present to perform tasks. Facility protocol for maintenance care of IVAP was changed to be performed on day shift by RN only. Completed 4/29/2021 3. Order modification for R21 and R22 included the following instructions "to be completed and signed off by RN only". Completed 4/29/2021 4. Director of Nursing(DON)to monitor 100% documentation on accessing and flushing for maintenance IVAP in Resident record for 3 months. Target compliance for RN performing procedure and documentation of procedure will be 100%. 5. Findings of the stated audits will be reported and discussed in monthly Quality Meetings for recommendations and further follow ups as indicated.	

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F 684	Continued From page 4 11/23/20, 12/23/20, 2/23/21 3/23/21, and 4/23/21. Review of the "Progress Notes" tab in the EMR dated 07/22/20, revealed LPN4 documented a comment in the Progress Notes on the e-MAR Administration Note addressing the heparin flush: "flushed per charge nurse". LPN4 was the charge nurse. 2.) Review of the "Face Sheet" in the EMR revealed R22 was admitted to the facility on 10/05/16 and readmitted on 10/12/18. The resident's diagnoses included Hodgkin's lymphoma. Review of the "Orders" tab in the EMR for R21 revealed a physician order dated 08/20/18: Heparin Lock Flush Solution 100 Unit/ml. Use 5 ml intravenously every night shift starting on the 15th and ending on the 15th every month for management of a Port-A-Cath access port a cath and flush with 10 ml of normal saline flush and then flush with 5 ml of heparin. Review of the MAR from July 2020 to April 2021 revealed the flushing of the Port-A-Cath was performed by a LPN, nine times, on 07/15/20, 8/15/20, 9/15/20, 10/15/20, 11/15/20, 12/15/20, 2/15/21 3/15/21, and 4/15/21. Review of the "Progress Notes" tab in the EMR dated 04/15/21, revealed LPN4 documented a comment in the Progress Notes for the e-MAR Administration Note for the heparin flush "no RN avail at this time". On 04/28/21 at 12:30 PM, the Director of Nursing (DON) verbalized "only RNs can do flushing of Port-a-Cath. LPNs are not to flush the ports." The	F 684		

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F 684	Continued From page 5 DON verbalized she was aware LPNs were doing the flush of the Port-a-Cath and it was not an acceptable practice and only RNs are to perform the heparin flush for R#21 and R#22. On 04/29/21 at 12:20 PM, LPN3 confirmed only RNs should do the heparin flush.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure the correct physician's order was followed for wound care for one of 12 sampled residents (Resident (R)11). The failure to follow current physician's orders for wound care could impede healing of the sacral pressure ulcer being treated, and increase the health risks associated with a wound, such as infection and sepsis. Findings include:	F 686	1. Incorrect dressing removed and correct dressing applied by LPN1 on 4/28/2021 @ 0745. Completed 4/28/2021 2. Education to all Registered Nurses and Licensed Practical Nurses on Professional Standard of Nursing: Following Physician Orders completed. Completed 5/3/2021 3. Director of Nursing(DON) to review all wound care documentation to ensure	5/3/21

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F 686	Continued From page 6 Review of the "Face Sheet" in the Electronic Medical Record (EMR) revealed R11 was admitted to the facility on 05/11/20 and readmitted on 11/26/20, with diagnoses including Alzheimer's Disease and chronic kidney disease, stage four. Review of the "Orders" tab in the EMR for R11, a new physician's order dated 04/18/21 revealed Wound Care-Sacrum: Clean with normal saline (NS), pat dry, cover with Allevyn daily and as needed (PRN). On 04/28/21 at 6:22 AM, in R11's room, the pressure ulcer dressing was changed by Licensed Practical Nurse (LPN)1. The resident was positioned on her side and the previous dressing of Allevyn and Aquacel AG was removed. Skin and wound were cleaned with normal saline and gauze. The Aquacel AG dressing needed to be cut to the size of the opening of the pressure ulcer. Once the Aquacel AG dressing was in place the Allevyn dressing was applied over the wound. Review of the Medication Administration Record (MAR) dated April 2021 for R11, revealed dressing changes were performed from 04/18/21 to 04/27/21 (10 days) with initials in the boxes for the order reading clean sacral wound with NS, pat dry, and cover with Allevyn daily and PRN. Review of the "Assessments" tab in the EMR the documents titled "My Wound Flowsheet-V2" revealed the description of the wound order of the dressing changes for R11 from 04/18/21 to 04/27/21 was clean sacral wound with NS, pat dry, apply Aquacel AG and cover with Allevyn daily and PRN. The application of the Aquacel AG was not included on the MAR order but was	F 686	correct orders are being followed for a period of 3 months. 4. Findings of the stated audits will be reported and discussed in monthly Quality Meeting for recommendations and further follow ups as indicated.	

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F 686	Continued From page 7 documented as applied on the "My Wound Flowsheet-V2." On 04/28/21 at 6:45 AM, LPN1 stated she did "not review the physician's order before performing the dressing change" and did not realize the Aquacel AG dressing was not ordered for the wound care for R11. On 04/28/21 at 8:36 AM, the Charge Nurse confirmed the physician's order was changed on 04/18/21 and Aquacel AG was no longer being applied to the wound during the dressing change. The Charge Nurse confirmed her expectation that staff would review the physician's orders prior to doing a dressing change and to follow the current physician's orders. Review of the facility policy titled "Wound Cleansing, Dressing and Irrigation - LTC - Ballad Health," revised 09/25/21, revealed "Residents will receive appropriate wound care and dressing changes per providers orders."	F 686		
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	F 758		4/29/21

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F 758	Continued From page 8 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 §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 record review and staff interview the facility failed to ensure residents who received antipsychotic medications had a gradual dose	F 758	1. Pharmacy Network Services(PNS) will create and maintain an ongoing monthly GDR Tracking spreadsheet to include all	

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F 758	Continued From page 9 reduction attempt at least annually. This failure affected 1 resident (R)esident 23) of 5 residents reviewed for unnecessary medications. Findings include: The diagnosis tab in the electronic medical record (EMR) revealed Resident (R) 23's diagnosis included Alzheimer's Disease, Unspecified Dementia with behavioral disturbance, restlessness and agitation, and repeated falls. Review of physician's orders under the "orders" tab in the EMR revealed R23 had an order for Seroquel Tablet 25 MG give 0.5 tablet by mouth in the morning related to unspecified dementia with behavioral disturbance and an order for Seroquel tablet 25 MG give 1 tablet by mouth at bedtime related to unspecified dementia with behavioral disturbance. Both orders had a start date of 04/22/19. Seroquel is an antipsychotic medication. Antipsychotics are a class of psychotropic medications primarily used to manage psychosis (including delusions hallucinations, or disordered thought), particularly in schizophrenia and bipolar disorder. Review of R23's care plan revealed she had a care plan focus area stating she receives psychotropic medications due to behavior management (agitation), general anxiety disorder, Depression and Disease process (dementia) and appetite stimulation. The care plan had a revision date of 03/15/21. The interventions included to "consult with the pharmacy, MD to consider dosage reduction when clinically appropriate but at least quarterly." There were no documented behaviors present in the record review for R23.	F 758	Residents who have ordered a medication that requires a GDR to be performed. Information on spreadsheet will include Resident name, medication and month(s) GDR was performed. Completed 4/29/2021 2. PNS will provide the Director of Nursing with the spreadsheet on a monthly basis. DON will monitor compliance with GDR being completed for a period of three months. 3. Findings of the stated audits will be reported and discussed in monthly Quality Meeting for recommendations and further follow ups as indicated.	

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F 758	Continued From page 10 The drug regimen reviews printed on forms titled "MV Pharmacy Drug Regimen Review" were reviewed. The pharmacist documented no recommendations or irregularities were noted on the drug regimen review forms dated 04/14/20, 06/15/20, 07/14/20, 08/18/20, 10/23/20, 11/16/20, 12/21/20, 1/19/21, 02/16/21, 03/16/21, and 04/20/21. On 04/28/21 at 1:00 PM an interview was conducted with the Director of Nursing (DON) related to dose reduction attempts for the Seroquel. She provided two Medication Regimen Review forms titled "Professional Networks Services" dated 04/15/19 and 11/18/19. Review of the Medication Review forms revealed the following: On 04/15/19 the pharmacist wrote R23 was receiving Seroquel 25mg two times a day since 10/21/18 and requested the physician consider reducing Seroquel to 25mg once a day. On the bottom of the form the physician wrote to reduce the Seroquel to 12.5mg in the morning and 25mg in the evening. He signed and dated the form 04/22/19. Review of the physician's orders under the "orders" tab in the EMR revealed the order was changed on 04/22/19. On 11/22/19 the pharmacist recommended reducing the Seroquel to 12.5mg twice a day. On the bottom of the form the physician checked the "Do not change" box and wrote, "Pt failed GDR repeatedly in the past." He did not include any additional information or include the dates Gradual Dose Reductions (GDR) had been attempted and failed. The paper chart and EMR were reviewed in its	F 758		

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F 758	Continued From page 11 entirety and were silent to any notes related to attempted dose reductions other than the reduction on 04/22/19. Review of the physician progress notes under the "miscellaneous" tab of the EMR revealed the physician wrote progress notes on 10/16/20, 12/04/20, 02/26/21, and 04/13/21 and each of the notes was silent to the use of the Seroquel for the resident. The facility policy titled "Medication Reconciliation/Drug Review" with a last reviewed date of 12/18/21 stated, "Gradual dose reductions will be completed at a minimum frequency of annually for any resident receiving psychotropic medications." On 04/29/21 at 11:02 AM the Director of Nursing and the MDS Coordinator were interviewed. The DON and the MDS Coordinator verified the physician failed to attempt gradual dose reductions quarterly and failed to document the attempted dose reductions. On 04/29/21 at 1:26 PM the MDS Coordinator stated she looked through all of R23's medical record in attempt to find physician documentation related to the reason for using the Seroquel and any gradual dose reduction attempts. She stated she could not find any progress notes addressing gradual dose reductions and the only notes she found related to why R23 was on Seroquel were dated 11/18/16 and 12/13/16. There were no more recent behaviors documented for R23.	F 758		
F 761 SS=D	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	F 761		6/1/21

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F 761	Continued From page 12 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: Based on observation, interview and facility policy review the facility failed to ensure expired medications were removed from the medication cart and the medication storage room. This deficient practice occurred in one of one med rooms and two of two med carts; and could potentially lead to administering ineffective, outdated medications to the residents. Findings include: On 04/29/21 at 12:12 PM, in the medication cart for resident rooms 4-11 and 29-32, two individual Tylenol 325 milligram (mg) packets were found	F 761	1. Reeducation on policy titled Storage of Medication completed with all Registered Nurses and Licensed Practical Nurses. Completed 5/3/2021 2. Medication Room and Medication Carts monthly checklist for expirations created. Completed 5/25/2021 3. Implementation of one team member being assigned each month on an ongoing basis to complete a check for expired medications in both medication room and medication carts. Completed	

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F 761	Continued From page 13 with an expiration date of 03/04/21. On 04/29/21 at 12:12 PM, Licensed Practical Nurse (LPN)3 verified the Tylenol packets were outdated and confirmed the medication should have been removed from the cart and not available for administration. On 04/29/21 at 12:43 PM, three 10 cubic centimeters (cc) heparin flush syringes were found in the medication storage room with an expiration date of 2/2021. On 04/29/21 at 12:43 PM, LPN2 verified the heparin syringes were outdated and confirmed the syringes should be sent back to the pharmacy and not available for resident use. On 04/29/21 at 12:46 PM, the Charge Nurse confirmed the syringes were outdated and should have been discarded. The Charge Nurse verified the pharmacy sent 30 cc and since there were three 10 cc syringes in the bag, concluded none of the expired heparin syringes were used for resident port flushes. Review of the facility policy titled "Storage of Medication - LTC - Ballad Health," dated 09/25/20, revealed, "No discontinued, outdated or deteriorated medications are available for use in the facility. All such medications are destroyed. Any unused, expired, damaged, returned, and/or contaminated medications are removed from medication cart."	F 761	6/1/2021 4. RN designee will complete random weekly checks to ensure no expired medications are present in either the medication room or the medication carts for 6 months. 5. Finds of the stated audit will be reported and discussed in monthly Quality Meetings for recommendations and further follow ups as indicated.	
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy.	F 803		6/9/21

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F 803	Continued From page 14 Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, menu review, and staff interview the facility failed to follow the menu selected for the residents. This affected three (Resident (R) 2, R20, R23) of 25 residents in the facility. Findings include: The lunch meal was observed in the kitchenette on the nursing unit on 04/28/21 continuously from 11:54 AM through 12:40 PM. At 12:36 PM the Cook ran out of spaghetti (pasta). As a result,	F 803	1. One on one reeducation with the cook on the importance of serving sizes, preparing a sufficient amount of food on the menu, appropriate substitutions, and procedure to obtain more food if insufficient amount prepared. Completed 4/28/2021 2. Education on Food Substitutions, Portion Control, and Utensil Usage completed with all dietary team members. Completed 6/9/2021	

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F 803	Continued From page 15 Resident (R) 2, R22, and R23 did not receive any pasta. The pasta was served as a side dish with chicken parmesan and the last three residents served were not offered or provided a substitiute of equal nutritive value when there was not enough spaghetti prepared. Review of the "orders" tab in each of the resident's electronic medical records revealed R2 had an order for a regular, dysphagia mechanically altered texture; R20 had an order for a Regular diet; and R23 an order for a Regular, dysphagia mechanically altered, regular consistency diet. Review of the menu revealed R20 was supposed to receive pasta and R2 and R23 mechanically altered diets were supposed to receive chopped pasta. Following the observations on 04/28/21 at 12:43 PM the Cook was interviewed. He stated he was the person who cooked the meal. He stated he did not cook enough pasta and he verified he did not give the last three residents he served pasta or a substitute for the pasta. The System Chef was present in the dining room on the nursing unit when the cook ran out of pasta. At 1:00 PM he confirmed the cook ran out of the pasta and should have cooked enough for all the residents.	F 803	3. CDM or designee will complete an audit of the substitution log on weekly basis for 8 weeks then monthly for 2 months to monitor for any issues with substitutions being provided due to insufficient amount of food preparations. 4. Findings of the audits will be reported and discussed in monthly Quality Meetings for recommendations and further follow ups as indicated.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		6/9/21

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F 812	Continued From page 16 §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 policy review the facility failed to ensure the sanitizing solution was maintained at an acceptable level to sanitize food contact surfaces; and failed to perform hand hygiene after contaminating their gloves and before touching resident food. This had the potential to affect 25 of 25 residents residing in the facility. Findings include: 1.On 04/26/21 at 11:07 AM one of two red containers of sanitizing solution used to sanitize food preparation surfaces and to hold wiping cloths measured at zero parts per million (ppm). The wiping container was located by the three-compartment sink. The Dietary Supervisor and the System Chef both verified the solution was not at the proper sanitizer level to sanitize the food contact surfaces. The Dietary Supervisor stated she made the solution about 8:00 AM that	F 812	1. Sanitizer in wiping container changed immediately and replaced with new sanitizer along with a review with the dietary team on the "Sanitizing Food Contact Surfaces" policy. Completed 4/26/2021 2. Reeducation on sanitation with review of policy and manufacturer's guidelines for Diversey sanitizing solution completed with all dietary team members. Completed 6/09/2021 3. Ongoing weekly sanitizer audit will be completed by CDM or designee where in random sanitizer bucket will be tested per sanitizer strip directions to ensure that sanitizer is within parameters of 200-400ppm. The audit will begin on 6/11/2021 and become a permanent part of ongoing dietary monitoring.	

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F 812	Continued From page 17 morning. The System Executive Chef tested the sanitizing solution with a test strip and verified it measured zero ppm. The facility policy titled "Sanitizing Food Contact Surfaces" with a revised date of 01/19 stated the J-512 sanitizer must be between 200 ppm and 400 ppm. The policy stated the sanitizer in the red buckets should be replaced every two hours or more frequently, if visibly dirty. The manufacture's information titled "Diversey Final Step J-512" stated the solution should be between 200 ppm and 400 ppm to sanitize food contact surfaces and equipment. 2. On 04/28/21 the noon meal service was observed continuously from 11:54 AM through 12:40 PM. At 11:56 AM a plastic bag containing hot dog buns dropped on the floor from the cart. The Cook picked the bag up with his gloved hands and placed it on a tray with clean soup bowls. Without first washing his hands or changing his gloves he removed bread from a bread bag and made a turkey and cheese sandwich and held the sandwich with the same gloved hands to cut it in half. He served two additional trays touching the handles of the serving utensils with the contaminated gloves and at 12:03 PM, with the same gloves on, he obtained a bowl off the tray and poured potato soup into it. He touched the handle of the ladle with the same gloves on. At 12:04 PM he removed his gloves, washed his hands, and put on clean gloves. During the same continuous observation of the cook on 04/28/21 at 12:25 PM he pushed his eyeglasses up with his gloved hands. At 12:27	F 812	4. Findings of audit will be reported and discussed in monthly Quality Meetings for recommendations and further follow ups as indicated. 5. One on one education with the cook on the importance of maintaining sanitary conditions by completing hand hygiene, appropriate changing of gloves, and procedures to follow if items are dropped in the floor. Completed 4/28/2021 6. Education reinforcing hand hygiene and disposable glove usage completed with all dietary team members. Completed 6/09/2021 7. Hand Hygiene monitoring team will perform weekly meal time observations for proper hand hygiene and glove usage for 3 months. 8. Findings of audit will be reported and discussed in monthly Quality Meetings for recommendations and further follow ups as indicated.	

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F 812	Continued From page 18 PM he stuck his hands in a quart size bag of parmesan cheese and obtained the cheese with his gloved hands without first changing his gloves. The Executive Chef was present in the kitchenette area and verbally prompted him to use a spoon to serve the parmesan cheese. At 12:29 PM the cook picked up the bag containing the hot dog buns that had been dropped on the floor touching the portion of the bag (bottom) that had landed on the floor. He removed two hot dog buns with the same gloves on. He put the hot dogs on the bun using tongues. At 12:32 PM he again obtained bread from the bread bag with the same gloves on. At that time, the Executive Chef was made aware of the situation and he prompted the cook to change his gloves and wash his hands and stated he was going to replace the resident's hot dogs. At 12:43 PM the Cook was interviewed. He verified that he did pick the bread up and verified he had not changed his gloves or washed his hands after picking it up off the floor and confirmed he touched the bag and served the hot dog buns that were in the bag. The facility policy titled "Hand Hygiene" with a revised date of 01/19 stated hands should be washed with soap and water after any activity that may contaminate the hands. The facility policy titled "Food Handling Guidelines" with a revised date of 01/19 stated gloves should be changed between task and hands should be washed after removing gloves.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		6/18/21

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F 880	Continued From page 19 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 20 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review the facility failed to ensure the scissors, used by the nurse, to cut dressings for a pressure ulcer were cleaned prior to use on the dressing for one of 12 sampled residents (Resident (R) 11). The failure to follow accepted standards of practice related to infection control with wound care could potentially introduce bacteria into the wound causing an infection. Findings include:	F 880	DPoC: See attached policies, RCA with interventions, outline of education, and post test for CDC Sparkling Surfaces Test. 1. Education video with pre and post test computer based learning(CBL) for all Healthcare Professionals titled Infection Control and following Standard Precautions. Completion date 6/18/2021	

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F 880	Continued From page 21 Review of the "Face Sheet" in the Electronic Medical Record (EMR) revealed R11 was admitted to the facility on 05/11/20 and readmitted on 11/26/20, with diagnoses including Alzheimer's Disease and chronic kidney disease, stage four. Review of the "Orders" tab in the EMR for R11, a physician's order dated 04/18/21 revealed Wound Care-Sacrum: Clean with normal saline (NS), pat dry, cover with Allevyn daily and as needed (PRN). On 04/28/21 at 6:22 AM, in R11's room, the pressure ulcer dressing was changed by Licensed Practical Nurse (LPN)1. The resident was positioned on her side, and the previous dressings were removed. R11's skin and wound were cleaned with normal saline and gauze. The dressing needed to be cut to the size of the opening of the pressure ulcer. LPN1 removed her scissors from the pocket of her uniform and, without cleaning the blades of the scissors, cut the dressing to the size of the opening of the pressure ulcer. Once the dressing was in place the Allevyn dressing was applied over the wound. On 04/28/21 at 6:45 AM, LPN1 acknowledged she knew to clean the scissors prior to cutting the dressing to the size of the pressure ulcer opening. She admitted that she did not bringing alcohol pads with her into the room for the dressing change, and so she did not clean the blades of the scissors prior to using them to cut the dressing. LPN1 explained by not cleaning the blades of the scissors, bacteria could potentially be introduced into the pressure ulcer creating an infection.	F 880	2. CDC Sparking Surfaces video and post test for all facility team members. Completion date 6/16/2021 3. Infection Prevention in Wound Care CBL for all Licensed Practical Nurses and Registered Nurse team members. Completion date 6/18/2021	

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F 880	Continued From page 22 Additionally, LPN1 stated she did "not review the physician's order before performing the dressing change" and did not realize the wound care order had changed for R11's dressings. On 04/28/21 at 8:46 AM, the Charge Nurse confirmed the importance of following infection control practices for dressing changes and the use of aseptic technique; and by not cleaning the scissor blades prior to cutting the dressing created an increased potential for infection in the pressure ulcer for R11. Review of the facility policy titled "Infection Control Program-Long Term Care-Ballad Health," revised January 21. 2021, revealed " There is consistent use of aseptic technique for dressing changes."	F 880		