STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495077	A. BUILDING _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB (LYNCHBURG)	2200 LANDOVER PLACE LYNCHBURG, VA 24501

(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 from 11/15/21 through 11/18/21. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Survey Dates: 11/15/21 through 11/18/21 Survey Census: 90 Sample Size: 30 Supplemental Residents: 0 No deficiencies were cited related to Intake ID VA00052532. No deficiencies were cited related to Intake ID VA00050412. Deficiencies were cited related to Intake ID VA00051259.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review	F 644		12/18/21

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

Electronically Signed | 12/03/2021

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F 644	Continued From page 1 (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and interview, the facility failed to refer one resident of three residents (Resident (R) 40) reviewed for Preadmission Screening and Resident Review (PASARR) to the appropriate State-designated authority for a Level II PASARR evaluation and determination. Findings include: Review of the facility's policy titled, "Social Services Guidelines Documentation" dated August 2021 revealed, ". . .complete the new PASARR screen for patients if the PASARR received is incorrect. . .", and ". . .Social service staff are required to coordinate the PASARR assessment." Review of R40's electronic medical record (EMR), under tab "Clinical," revealed R40's initial admission date was 07/13/19.	F 644	F644 Corrective Action: The Social Worker and Admissions Director designee requested a Level II PASARR for Resident #40 on 12-2-2021. Identification of Like Residents: The Social Worker and Admissions Director designee completed an audit of all residents in the facility to ensure that all residents that require a Level II PASARR screening have a screening in place. Systemic Change: The Administrator re-educated the Social Worker and Admissions Director on the PASARR process for residents including the need to refer for a Level II screening when appropriate.	

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F 644	Continued From page 2 Review of R40's EMR under "Med Diag" (Medical Diagnoses) tab, revealed R40's diagnoses included a diagnosis of schizophrenia (mental disorder), dated 07/13/19. Review of R40's paper medical record, under the tab "Legal Documents," revealed a PASARR I dated 09/03/19, which documented R40 did not have a serious mental illness. Review of R40's paper medical record, under the tab, "Legal Documents," revealed there was not a PASARR II form. Review of R40's admission "Minimum Data Set (MDS)," with an assessment reference date (ARD) of 10/06/21, located in the resident's EMR under the "MDS" tab revealed the resident was assessed to have the active diagnosis of "schizophrenia," (a mental disorder). During an interview on 11/18/21 at 5:35 PM, the Director of Nursing (DON) verified neither R40's electronic nor paper medical record included a Level II PASARR. The DON confirmed R40 had a diagnosis of a serious mental illness, schizophrenia, at the time the Level I was completed. DON confirmed SW was responsible to refer R40 to the department of community health, for a Level II PASARR screening and determination.	F 644	Monitoring: The Administrator or designee will audit new admissions weekly times 8 weeks to validate that a PASAAR is completed and level II screening is requested if indicated. The Administrator will submit audit findings to the QAPI committee for review and further recommendations. Date of compliance: December 18, 2021	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		12/18/21

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F 656	Continued From page 3	F 656		

care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:

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F 656	Continued From page 4 Based on interview, medical record review, and facility policy review, the facility failed to ensure a comprehensive care plan was developed and implemented for two of 30 sampled residents (Resident (R) 32, R47, and R186). Specifically, the facility failed to develop a care plans for R32's and R47's oxygen therapy; and an incontinence care plan for R186. Findings include: Review of the facility's policy titled, "INTERDISPLINARY CARE PLANNING", updated March 2018 revealed, ". . .The facility must develop and implement a baseline person-centered care plan for each patient that includes the instructions needed to provide effective and person-centered care that meets professional standards of quality care. . ." 1. Review of R32's electronic medical record (EMR), under tab "Clinical," revealed R32's initial admission date was 08/05/13. Review of EMR under "Med Diag" (Medical Diagnoses) tab, revealed R32's diagnoses did not indicate a respiratory diagnosis (dated 08/05/13). Review of the EMR under the tab, "Care plans," revealed R32 did not have a care plan for oxygen treatment. Review of the EMR under the tab, "TAR" (treatment administration record), included ". . . O2 [oxygen] @ [at] 4 liters per minute via [by way of] NC [nasal canula] every shift for chronic O2 use. . ." dated November 2021. Review of the EMR under the tab, "Orders"	F 656	F656 Corrective Action: The care plan was updated on 11-30-2021 for Resident #32 and on 12-2-2021 for Resident #44 to include oxygen therapy. Resident #186 no longer resides in center as of 2/15/21. Identification of Like Residents: The Director of Nursing or designee will complete an audit of residents on oxygen to validate oxygen is reflected in the care plan. Systemic Change: The Director of Nursing or designee will re-educate licensed nurses on care plan development and implementation for residents on oxygen. Monitoring The Director of Nursing or designee will randomly audit 5 residents receiving oxygen weekly times 8 weeks to validate oxygen is reflected in the care plan . The Administrator will submit audit findings to the QAPI committee for review and recommendations. Date of Compliance: 12-18-2021	

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F 656	Continued From page 5	F 656		

revealed, ". . .O2 @ 4 liters per minute via NC every shift for chronic O2 use O2 check @ shift, notify MD [Medical Doctor] below 90%. . .," dated 09/23/21.

Review of R32's quarterly "Minimum Data Set (MDS)," with an assessment reference date (ARD) of 11/01/21 revealed the resident was assessed for respiratory diagnosis and no diagnosis was documented. Facility staff assessed the resident as using oxygen while at the facility.

An observation conducted on 11/15/21 at 3:46 PM, revealed R32 was receiving oxygen treatment with a flow rate of 5 liters via nasal cannula.

A second observation conducted on 11/16/21 at 9:39 AM, revealed R32 was receiving oxygen treatment with a flow rate of 5 liters via nasal cannula.

A third observation conducted on 11/17/21 at 8:32 AM, revealed R32 was receiving oxygen treatment with a flow rate of 5 liters via nasal cannula.

During an interview and observation conducted on 11/17/21 at 2:36 PM, the Unit Manager (UM) verified R32 was receiving oxygen with a flow rate of 5 liters via nasal cannula.

During an interview on 11/18/21 at 3:01 PM, the Director of Nursing (DON) confirmed R32's care plan should have included oxygen therapy.

2. Review of the admission "MDS" with an ARD of 10/12/21 indicated R47 was admitted to the

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F 656	Continued From page 6	F 656		

facility on 10/08/21 with diagnoses including cardiopulmonary disease (range of disorders affecting the heart and lungs), chronic obstructive pulmonary disease (COPD, a condition involving constriction of the airways and difficulty breathing), and viral pneumonia.

Review of the EMR under the "Care Plan" tab, the care plan dated 10/11/21 did not include a plan for the use of oxygen.

During observation on 11/16/21 at 9:44 AM, 11/17/21 at 8:40 AM, and 11/18/21 at 9:40 AM, R47 was in bed with oxygen being administered via nasal canula at 4 liters per minute (LPM).

During an observation and interview on 11/18/21 at 1:20 PM, Licensed Practical Nurse (LPN)1 verified that R47 was receiving oxygen per nasal canula and that it was set at a rate of 4 LPM. LPN1 also verified the resident did not have a care plan for the use of oxygen.

3. Review of the "MDS" dated 01/29/21 located in the EMR indicated R186 was admitted to the facility on 01/25/21 with a diagnosis of adult failure to thrive. The resident was also noted to be frequently incontinent of bowel and bladder.

Review of R186's "Care Plan" under the "Care Plan" tab dated 01/25/21 revealed no evidence of a care plan to address the resident's incontinence.

Review of the Kardex dated 01/25/21 revealed no evidence of incontinence care.

In an interview with LPN1 on 11/18/21 at 1:20 PM confirmed R186 did not have a care plan to

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F 656	Continued From page 7 address her incontinence.	F 656		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information	F 660		12/18/21

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F 660	Continued From page 8 regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by:	F 660		

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F 660	Continued From page 9 Based on interview, medical record review, and facility policy review, the facility failed to include one resident of 25 sampled residents (Resident (R) 25) in the discharge planning process. Findings include: Review of the facility's policy, titled "Social Services Guidelines," dated 8/21, revealed ". . . Discharge planning is a person-center interdisciplinary process driven by the patient . . . It is important that patients make informed choices in the course of discharge planning. . ." During an interview conducted on 11/15/21 at 12:45 PM, R25 indicated he would like a discharge plan from the facility and Social Worker (SW) would not help. Review of R25's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 08/15/21 revealed the facility assessed R25 to have a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15 which indicated R25 was cognitively intact. Review of R25's electronic medical record (EMR), under the "Profile" tab, revealed a facility initial admission date of 03/04/21 with multiple medical diagnoses. Review of R25's EMR, under the tab, "Progress Note", a note dated 11/01/21, revealed a note documented by the Social Worker (SW). The note further revealed, the SW informed R25 his option for discharge was Against Medical Advice (AMA) per the Interdisciplinary Team (IDT) meeting's decision.	F 660	F660 Corrective Action: The Social Worker completed an interdisciplinary discharge planning update with R25 on 11-18-2021. Identification of Like Residents: The Administrator or designee will complete an audit of facility residents to validate discharge planning is in place. Systemic Change: The Administrator re-educated the Social Worker on the development and updating of each resident□s discharge planning during their stay. Monitoring: The Administrator or designee will review 5 residents weekly times 8 weeks to validate that a discharge plan is present and accurate. The Administrator will submit audit findings to the QAPI committee for review and further recommendations. Date of Compliance: 12-18-2021	

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F 660	Continued From page 10 An interview conducted with Medical Doctor on 11/18/21 at 4:35 PM, revealed AMA was not R25's only discharge option. An interview conducted with the SW on 11/18/21 at 5:05 PM, revealed R25 was not included in his discharge plan. The SW stated R25 was not part of the IDT meeting. The SW stated because the IDT decided the discharge was AMA, she was unable to assist R25 with discharge options. The SW confirmed including R25 in his discharge plan and IDT meeting would be beneficial. During an interview on 11/18/21 at 5:26 PM, the Director of Nursing (DON) stated the facility should begin discharge planning, with the resident, on the day of the resident's admission.	F 660		
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, policy review and record review, the facility failed to ensure	F 686	F686	12/18/21

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F 686	Continued From page 11 professional standards of practice were maintained for the treatment of pressure ulcers, for one of one resident (Resident (R) 47) observed for pressure ulcer treatments. Staff failed to perform hand hygiene and ensure a clean environment prior to performing wound treatments. Findings include: Review of the admission "Minimum Data Set (MDS)" found in the electronic medical record (EMR) revealed R47 was admitted to the facility on 10/08/21 and had a "Brief Interview for Mental Status (BIMS)" of 15 which indicated that resident was cognitively intact. The assessment revealed that R47 had a Stage 3 Sacral wound, a surgical wound to her right lower quadrant and a peri-stoma. Review of R47's EMR under, the "Orders" tab and Treatment Administration Record, (TAR) dated 11/11/21 revealed, R47 had three wounds with three different treatments. An abdominal right lower quadrant (RLQ) peristomal wound, a RLQ (boil) and a Sacral Stage 3 wound. Observation on 11/16/21 at 4:15 PM revealed Nursing Supervisor Registered Nurse (NSRN) was completing wound care to R47's three wounds. NSRN did not clean and disinfect or drape the area for clean supplies and did not perform hand hygiene after doffing and prior to donning gloves in between treatments to the resident's three wounds. During an interview on 11/18/21 at 4:15 PM, NSRN verified that she did not clean the table, did not put down a barrier and did not perform hand	F 686	Corrective Action: The Nurse assigned to Resident 47 on 11/16/21 was re-educated by the Director of Nursing on 12-1-2021 regarding hand hygiene and ensuring a clean environment prior to performing wound treatments. Identification of Like Residents: The Director of Nursing reviewed all residents in the center with wounds on 12-2-2021. Systemic Change: The Director of Nursing or designee will re-educate licensed nurses on the non sterile dressing change process to include hand hygiene and maintaining a clean environment during dressing change. Monitoring: The Director of Nursing or designee will randomly observe 5 non sterile dressing changes weekly times 8 weeks. The Administrator will submit audit findings to the QAPI committee for further recommendations. Date of Compliance: 12-18-21	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 12 hygiene between dirty to clean glove changes during the wound care performed on 11/16/21. Review of the facilities policy titled, "Dressing change: nonsterile (clean)", dated 12/09 indicated, " ...disinfect over bed table using an EPA (environmental protective agent) approved disinfectant ...Place a clean barrier on the over bed table ...Perform hand hygiene when going from clean to dirty."	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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, interview, record review, and review of facility policies, the facility failed to provide assistive devices to prevent accidents for one of five (Resident (R) 23) residents reviewed for accidents out of 30 sample residents. Findings include: Review of R23's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR) revealed he was admitted to the facility on 02/17/20. Review of R23's diagnoses, located under the "Diagnosis" tab of his EMR revealed unspecified	F 689	F689 Corrective Action: The Administrator validated that Resident #23 currently has elevated leg rests on his wheelchair. Identification of Like Residents: The Director of Rehab reviewed all facility residents for the need of wheelchair leg rests. Systemic Change: The Director of Nursing or designee will re-educate licensed nurses and nurse	12/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495077	A. BUILDING _____ B. WING _____	C 11/18/2021

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F 689	Continued From page 13	F 689		

dementia without behavioral disturbance, type 2 Diabetes mellitus with diabetic neuropathy (Weakness, numbness, and pain from nerve damage, usually in the hands and feet), and cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it).

Review of R23's quarterly "Minimum Data Set (MDS)" with an assessment reference date (ARD) of 09/13/21, revealed a Brief Interview of Mental Status (BIMS) score of 13 out of 15, indicting intact cognition. R23 was assessed as being total dependent on two persons for transfers with mechanical lift.

Review of R23's care plan located in the EMR under the "Care Plan" tab, dated 02/18/20 revealed a "Focus" area of risk for falls. Review of the "Interventions" revealed the facility planned to keep his bed in the low position; encourage to transfer and change positions slowly; have commonly used articles within easy reach; and staff education.

Further review of R23's care plan revealed an additional intervention for therapy evaluation on his wheelchair beginning 09/20/21.

Review of a "Falls" report provided by the facility revealed R23 had a fall on 09/20/21 at 1:12 PM. R23 had an outside appointment and was transported by a transport company arranged by the facility. Upon return to the facility and while still inside of the transport van, R23 slid out of his wheelchair to the floor of the transport vehicle. R23 had no visible injuries noted at that time.

Review of a "Witness Statement" report provided

aides on the facility process to provide assistive devices, to include leg rests, for residents.

Monitoring:
The Administrator or designee will randomly review 5 residents with elevated leg rests weekly times 8 weeks to validate compliance. The Administrator will submit audit findings to the QAPI committee for further review and recommendation as needed.

Date of compliance: 12-18-2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495077	A. BUILDING _____ B. WING _____	C 11/18/2021

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F 689	Continued From page 14	F 689		

by the facility, dated 09/20/21 at 1:30 PM, revealed the van driver stated R23 was properly secured when leaving the dental appointment. When the driver turned around and realized the resident was sliding out of his wheelchair, he pulled over to a safe area to reposition the resident. He could not reposition the resident successfully and returned to the facility that was five minutes away. By that time, the resident had slid all the way to the floor.

The driver of the transport van was not available for interview.

Interview on 11/17/21 at 3:22 PM with R23 revealed that the resident did not remember having a fall during transport.

Observation of R23's room on 11/17/21 at 3:22 PM revealed the resident's wheelchair folded between the wall and the bed. Leg/footrest were not on the wheelchair.

Interview on 11/17/21 at 3:25 PM with Nurse Aide (NA) 2 revealed that the footrest was usually taken off the wheelchair and stored when not in use. NA2 stated the footrest kept the resident from sliding out of his chair.

On 11/17/21 at 2:09 PM, interview with the Director of Nursing (DON) revealed that R23 did not self-propel, and his wheelchair should have leg/footrests. DON stated footrests should have been in place on R23's wheelchair when he left for his appointment. At the time of the incident, his wheelchair did not have that assistive device. The DON stated the resident's wheelchair was used for transport and was strapped into the van. No other facility staff assisted the resident during

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	495077	A. BUILDING _____ B. WING _____	C 11/18/2021

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F 689	Continued From page 15	F 689		

transportation.

At 2:13 PM on 11/17/21, an interview with the Corporate Quality Assurance Consultant-RN (CQAC-RN) stated "that the root cause of the fall incident was due to R23 not having a leg/footrest on his wheelchair and that was the contributing factor for him sliding out of his wheelchair.

On 11/17/21 at 3:29 PM an interview with the Administrator revealed that she went out to the transport van as soon as the facility was notified of the incident. R23 was on the floor of the van and his wheelchair did not have leg/footrests attached to the chair. The Administrator believed they were taken off to help the resident and stated that the leg rest were on the floor of the van.

Review of the "Rehabilitation Screening" for R23 on 9/20/21 revealed that the R23 stated "that the wheelchair did not have leg rests on at the time of his fall." Rehabilitation services documented that the resident has no issues sitting in his chair when leg rests were used. Staff documented the resident reported he did not have his leg rests when he left the facility.

Review of the facility "Falls Practice Guide" dated 12/11, indicated that this is what the facility provided as the "Fall Policy." The CQAC-RN stated that this is the "Fall Policy." This Practice Guide indicated ... that this booklet is considered a practice guide ... this guide is intended to support clinical practice ...the purpose is to describe the process steps for identification of patient fall risk factors and interventions and systems that may be used to manage falls ...the information included within this guide does not

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F 689	Continued From page 16 relieve a business unit ore center of the obligation to comply with all applicable HCR ManorCare policies as well as federal and state regulations.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the resident receiving enteral feeding received appropriate care and services to prevent complications for one of one resident (Resident (R)17) reviewed for tube feeding cares. Findings include:	F 693	F693 Corrective Action: The nurse assigned to Resident #17 on 11/18/21 was re-educated by the Director of Nursing on (insert date) related to the facility procedure for Enteral Feeding	12/18/21

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	495077	A. BUILDING _____ B. WING _____	C 11/18/2021

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F 693	Continued From page 17 Review of R17's face sheet located under the "Admissions Record tab" in the electronic medical record (EMR) revealed R17 was admitted to the facility on 06/02/21 following a cerebral vascular accident (CVA, loss of blood flow to the brain resulting in damage to brain tissue). R17's physician's orders found under the "Orders" tab of the EMR revealed R17 had an enteral feeding tube in place for nutrition and administration of medications. During an observation on 11/17/21 at 12:50 PM, Licensed Practical Nurse (LPN) 2 administered one medication to R17 by way of (via) the enteral tube. LPN2 did not place a barrier down on the overbed table or the bed prior to placing her supplies on it. LPN2 aspirated for residual volume from the feeding tube without opening the clamp proximal to R17's body. LPN2 placed the syringe on the bed while she was getting her supplies ready. LPN2 flushed to tube with 30 cubic centimeters (cc) of water, gave the crushed medication with 15 cc of water and then flushed the tube with 30 cc of water. LPN2 used the plunger on the syringe to push the fluids in as opposed to attempting a gravity feed. During an interview on 11/18/21 at 9:05AM, the Family Nurse Practitioner (FNP), referring to how medications were to be given via enteral tube stated, "Always gravity-that is how we were taught to do it-always." During an interview on 11/18/21 at 9:17AM, the Medical Director, referring to how medications were to be given via an enteral tube stated, "Always gravity is the preferred method."	F 693	Identification of Like Residents: The Director of Nursing or designee will review current Residents that receive Enteral Feedings in the facility. Systemic Change The Director of Nursing or designee will re-educate licensed nurses on the Enteral Feeding Nursing Procedure to include using a barrier for supplies, opening clamp for residual checks and to gravity feed. Monitoring The Director of Nursing or designee will audit 5 random Enteral Feed Observations weekly times 8 weeks to validate compliance. The Administrator will submit audit findings to the QAPI committee for review and further recommendations. Date of Compliance: 12-18-2021	

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F 693	Continued From page 18 During an interview on 11/18/21 at 1:54 PM, LPN 2 stated she was not sure why she did it (used the plunger, opposed to allowing to gravity feed) that way on that day. LPN 2 stated she was aware of the need to use a barrier and to do attempt a gravity feed prior to using the syringe plunger. During an interview on 11/18/21 at 6:50 PM, when asked how the nurse would know to give medications by gravity feed, the Director of Nursing (DON) stated there was a procedure manual on each nurses' station for the nurses to review. The DON added that their policy did not indicate to give medication by gravity feed but acknowledged it was a Standard of Practice and should be done by gravity feed.	F 693		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and facility policy review, the facility failed to ensure physician orders were verified and followed for oxygen therapy flow rate for four of four residents (Resident (R) 40, R32, R44, and R47) reviewed for respiratory care.	F 695	F695 Corrective Action The Director of Nursing validated correct O2 settings for Resident 40, 32,44, and 47 on 12-1-2021 and 12-2-2021.	12/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495077	A. BUILDING _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 19 Findings include: Review of the facility's policy, titled " OXYGEN ADMINISTRATION," updated 07/17, revealed ". . .Verify Physician's order. . ." 1. Review of R40's electronic medical record (EMR), under tab "Clinical," revealed R40's initial admission date was 07/13/19. Review of the EMR under "Med Diag" (Medical Diagnoses) tab, revealed R40's diagnoses included COPD (chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breath)), dated 07/13/19. Review of the EMR under the tab "Care plans" under the column "Focus," created date of 07/13/19, revealed ". . .Has respiratory impairment related to COPD," Under the column titled, "Interventions/Tasks," revealed ". . .Administer medications/treatments per physician, orders. . ." Review of the EMR under the tab, "TAR" (treatment administration record), included ". . .O2 [oxygen] @ [at] 2 liters per minute via [by way of] NC [nasal cannula]. . ." dated 11/21. Review of the EMR under the tab "Orders" revealed, ". . .O2 @ 2 liters per minute via NC. . .," dated 10/21/21. Review of R40's quarterly, "Minimum Data Set (MDS)," with an assessment reference date (ARD) of 10/06/21, revealed the resident was assessed for respiratory diagnosis and COPD or chronic lung disease was included with multiple	F 695	Identification of Like Residents: The Director of Nursing or designee will audit all residents receiving oxygen for correct settings. Systemic Change The Director of Nursing or designee will re-educate licensed nurses on Oxygen administration process to include verification of oxygen flow rates as stated in the Provider order. Monitoring The Director of Nursing or designee will randomly audit 5 residents receiving oxygen weekly times 8 weeks to validate the oxygen flow rate is per the Provider order. The Administrator will submit audit findings to the QAPI committee for review and further recommendations. Date of Compliance: 12-18-2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495077	A. BUILDING _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 20	F 695		

other diagnoses. The MDS revealed the facility answered yes to the question regarding use of oxygen while a resident at the facility.

An observation conducted on 11/16/21 at 9:42 AM, revealed R40 had oxygen being administered at a flow rate of 5 liters per minute.

A second observation conducted on 11/17/21 on 8:36 AM, revealed oxygen was not being administered to R40.

A third observation conducted on 11/18/21 at 9:53 AM, revealed R40 had oxygen being administered at a flow rate of 5 liters per minute.

During an interview on 11/18/21 at 3:01 PM, the Director of Nursing (DON) confirmed physician orders should be followed for administration of oxygen's flow rate.

During an interview on 11/18/21 at 2:24 PM, the Medical Doctor confirmed the oxygen flow rate should be the same as the physician's order for the resident.

2. Review of R32's EMR, under tab "Clinical", revealed R32's initial admission date was 08/05/13.

Review of EMR under "Med Diag" tab, revealed R32's diagnoses did not indicate a respiratory diagnosis, (dated 08/05/13).

Review of the EMR under the tab, "Care plans," revealed R32 did not have a care plan for oxygen treatment.

Review of the EMR under the tab, "TAR,"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495077	A. BUILDING _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB (LYNCHBURG)	2200 LANDOVER PLACE LYNCHBURG, VA 24501

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F 695	Continued From page 21	F 695		

included ". . . O2 @ 4 liters per minute via NC every shift for chronic O2 use. . ." dated November 2021.

Review of the EMR under the tab, "Orders" revealed, ". . .O2 @ 4 liters per minute via NC every shift for chronic O2 use O2 check @ shift, notify MD [Medical Doctor] below 90%. . .," dated 09/23/21.

Review of R32's quarterly "MDS," with an ARD of 11/01/21 revealed the resident was assessed for respiratory diagnosis and no diagnosis was documented. Facility staff assessed the resident as using oxygen while at the facility.

An observation conducted on 11/15/21 at 3:46 PM, revealed R32 was receiving oxygen treatment with a flow rate of 5 liters via nasal cannula.

A second observation conducted on 11/16/21 at 9:39 AM, revealed R32 was receiving oxygen treatment with a flow rate of 5 liters via nasal cannula.

A third observation conducted on 11/17/21 at 8:32 AM, revealed R32 was receiving oxygen treatment with a flow rate of 5 liters via nasal cannula.

During an interview and observation conducted on 11/17/21 at 2:36 PM, the Unit Manager (UM) verified R32 was receiving oxygen with a flow rate of 5 liters, administered by nasal cannula.

During an interview on 11/18/21 at 3:01 PM, the DON confirmed physician orders should be followed for administration of oxygen's flow rate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 22	F 695		

3. During an observation on 11/15/21 at 1:10 PM, R44 was in his room with oxygen flowing at a rate of 4 liters per minute via nasal cannula.

During subsequent observations on 11/15/21 at 1:20 PM and 4:58 PM, R44 was sleeping, and his oxygen continued at 4 liters per minute via nasal cannula.

Review of R44's EMR, under tab "Admission Record", revealed R44 was admitted to the facility on 09/21/21.

Review of the EMR under "Med Diag" tab, revealed R40's had a diagnosis of congestive heart failure and coronary artery disease.

Review of R44's EMR under the "Orders" tab revealed, R44 did not have orders for oxygen.

Review of R44's EMR under the "Care Plan" tab revealed R44 was not care planned for care for oxygen therapy.

A review of R44's most recent MDS with an ARD of 11/05/21, documented he did not receive oxygen therapy.

During an interview on 11/16/21 at 2:34 PM, Licensed Practical Nurse (LPN) 2 confirmed she could not locate an order for R44's oxygen in the EMR orders. LPN2 checked R44's Medication Administration Record (MAR) and TAR in the EMR and was unable to find an oxygen order. LPN2 stated when she went into R44's room to give meds, she checked his oxygen to make sure tubing was dated, water bottle was full, and oxygen was running. When asked how she knew

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495077	A. BUILDING _____ B. WING _____	C 11/18/2021

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F 695	Continued From page 23 what rate the oxygen was to be running, LPN2 stated she would look at the order. LPN 2 admitted she did not have an order for R 44's oxygen and should not have administered it without an order. LPN 2 stated she did not know how the order was missed but she would call the doctor right away to get the order. LPN2 stated nurses could administer oxygen at 2 liters per minute per nursing judgement and then get the order. LPN2 agreed this was not the case since R44 had been getting oxygen at 4 liters per minute. During an interview on 11/18/21 at 2:24 PM, the Medical Doctor confirmed oxygen should not be administered without a physician order. 4. Review of the admission "MDS" with an ARD of 10/12/21indicated that (R)47 was admitted to the facility on 10/08/21 with diagnoses including cardiopulmonary disease, chronic obstructive pulmonary disease (COPD) and viral pneumonia. During observation on 11/16/21 at 9:44 AM, 11/17/21 at 8:40 AM, and 11/18/21 at 9:40 AM revealed R47 was in bed, with oxygen being administered at a rate of 4 LPM via nasal canula. During an observation and interview on 11/18/21 at 1:20 PM LPN1 verified R47 was receiving oxygen per nasal canula at a rate of LPM. LPN1 verified R47 did not have a current order for the use of oxygen.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who	F 698		12/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495077	A. BUILDING _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 698	Continued From page 24 require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and facility policy review, the facility failed to ensure there was a physician order for dialysis treatment for one resident of two residents (Resident (R) 25) reviewed for dialysis out of 30 sampled residents. Findings include: Review of the facility's policy, titled "Agreement for Outpatient Dialysis," dated 07/01/16, revealed ". . .G. Prescription for treatment by any other physician. . ." Review of R25's electronic medical record (EMR), under the "Profile" tab, revealed a facility initial admission date of 03/04/21 with multiple medical diagnoses including chronic kidney disease, Stage 3 unspecified, under "Med diag" tab. Review of R25's quarterly "Minimum Data Set (MDS)" with an assessment reference date (ARD) of 08/15/21 revealed the facility assessed R25 to have a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15 which indicated R25 was cognitively intact. The facility assessed R25 for "Active Diagnosis," and confirmed R25's diagnoses of renal insufficiency (decreased kidney function), renal failure (a condition where the kidneys stop working and are not able to remove waste), and end stage renal disease (ESRD, reduced kidney function requiring dialysis treatment).	F 698	F698 Corrective Action The Director of Nursing obtained a physician order for dialysis on Resident 25 on 11/18/21. Identification of Like Residents The Director of Nursing or designee will review all residents at the facility that receive Dialysis to ensure a current Provider order Systemic Change The Director of Nursing or designee will re-educate licensed nurses on obtaining provider orders for residents requiring dialysis. Monitoring The Director of Nursing or designee will randomly audit residents that receive Dialysis weekly times 8 weeks to validate provider orders. The Administrator will submit audit findings to the QAPI committee for review and further recommendations. Date of Compliance: 12-18-2021	

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F 698	Continued From page 25 Review of R25's EMR, under the "Orders" tab, revealed there was not a physician's order for dialysis treatment. Review of R25's paper chart, under "Physician Orders" tab, revealed there was not a physician's order for dialysis treatment. Review of R25's EMR under the "Care Plan" tab, under the column "Focus," created date of 08/04/21, revealed ". . .resident needs dialysis hemo. . ." During an interview on 11/18/21 at 10:26 AM, the Unit Manager (UM) verified and confirmed no physician order was included on R25's EMR for dialysis treatment. UM confirmed the facility should include a physician order for R25's dialysis treatment. During an interview on 11/18/21 at 2:50 PM, the Director of Nursing (DON) verified and confirmed R25's EMR did not include a physician's order for dialysis treatment. DON confirmed R25 was transported to dialysis outpatient treatment center on 11/16/21 without physician orders on the R25's EMR or paper chart. During an interview on 11/18/21 at 2:24 PM, the Medical Doctor (MD) confirmed R25's paper chart did not include a physician's order for dialysis treatment. MD confirmed a physician's order was required for hemodialysis treatment for facility's residents.	F 698		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		12/18/21

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F 761	Continued From page 26 §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: Based on observation, interview, and review of the facility's policy, the facility failed to remove expired medication from their medication room. This failure to remove expired medication had the potential to place the resident at an increased risk of receiving expired medications. Findings include: During an observation of the Third Floor Medication Room on 11/18/21 at 10:50 AM, the following items were found to be expired: one	F 761	F761 Corrective Action: The Director of Nursing removed the expired medications on 11/18/21. Identification of Like Residents: The Director of Nursing audited all medication storage areas on 12-2-2021 for expired medications or supplies. Systemic Change:	

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F 761	Continued From page 27 opened stock vial of TUBERSOL, Tuberculin Purified Protein Derivative (Mantoux) solution dated as opened on 10/11/21 and 30 packets of stock ProSource with manufacturer expiration dates of 04/03/21 and 06/02/21. Licensed Practical Nurse (LPN) 2 verified the items in question had expired at the time of the observation. Interview with the Director of Nursing (DON) on 11/18/21 at 6:30PM, revealed the medication rooms were to be checked weekly by the central supply staff for expired medications. The DON did not have a reason for the medications to have remained in the medication room and agreed they should have been removed. Review of the facility policy titled Disposal/Destruction of Expired or Discontinued Medication dated 12/01/07 revealed ". . . 4. Facility should place all discontinued or out-dated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction."	F 761	The Administrator re-educated the central supply clerk on the re-stocking process and removal of expired items. The Director of Nursing re-educated licensed nurses on the removal of expired items from medication areas. Monitoring: The Director of Nursing or designee will randomly audit medication storage areas for expired medications or supplies weekly times 8 weeks to validate compliance . The Administrator will submit audit findings to the QAPI committee for review and further recommendations. Date of Compliance: 12-18-2021	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced	F 804		12/18/21

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F 804	Continued From page 28 by: Based on observation, resident interview, staff interview, and review of the facility policy, the facility failed to serve food that was palatable for three of 30 sample. Specifically, pureed food was unpalatable, pasta overcooked, and meat was tough. Findings include: Review of the facility's menu for 11/18/21 indicated the facility was served country fried steak with gravy, mashed potatoes, squash casserole, Texas toast, and strawberry rhubarb pie. The alternate choices were baked fish, orzo pilaf, and broccoli. Pureed foods included beef, mashed potatoes, the orzo, broccoli, squash casserole, bread, and pudding. Review of the facility's policy titled, "Consistency Modified Foods-Level 4 Pureed," dated 11/2020, documented " ...pureed Level 4 diet requires foods that have a smooth texture with no lumps and are not sticky ...". 1. During an interview on 11/15/21 at 10:30 AM, R45 stated he did not like the food. 2. During an interview on 11/15/21 at 10:50 AM, R337 stated he did not like the food. 3. During an interview on 11/15/21 at 11:20 AM, R84 stated that a "pig wouldn't eat the food." 4. During an observation and interview on 11/18/21 at 10:45 AM, the Dietary Cook (DC), Food Service Director (FSD), and the surveyor tasted the pureed orzo which was served as the alternative item on the menu. The DC gagged	F 804	F804 Corrective Action: The Administrator re-educated the Food Service Director on the use of the facility recipe guide that includes times and temperatures that should be used in food preparation. Identification of Like Residents: The Food Service Director validated the food preparation process for the facility. Systemic Change: The Food Service Director re-educated cooks on the food preparation and serving process and removed the orzo from the menu. Monitoring: The Administrator or designee will randomly audit food items on steam table for palatability weekly times 8 weeks. The Administrator will submit audit findings to the QAPI committee for review and further recommendations. Date of Compliance: 12-18-2021	

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F 804	Continued From page 29 and stated, "this tastes like pure paste." The FSD stated "the pureed orzo was terrible, and he was taking it off the tray line so it would not be served." Both the DC and FSD stated they did not taste the prepared pureed foods. During observations on 11/18/21 from 12:43 PM to 1:11PM, five residents were served pureed trays on the second-floor units. These residents were not interviewable and were not able to answer questions regarding their meals. 5. On 11/18/21 at 12:59 PM, a test tray was tasted by the FSD and the surveyor. The FSD stated, "the country fried steak was hard, dry, and the coating did not stay on the steak. It was extremely hard to chew, and I would not serve it again." The FSD stated the orzo was gummy and overcooked. The FSD stated the food texture was correct for the residents on the first floor served. However, for the last floor and unit served, the food was overcooked due to being on the steam table for so long. The FSD said he did not know how to prevent this. Observations on 11/18/21 at 1:23 PM of trays going back to the kitchen after being served to residents, revealed 14 trays with the country fried steak not eaten.	F 804		
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.	F 812		12/18/21

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F 812	Continued From page 30 (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 review of facility policy, the facility failed to ensure foods stored in the kitchen were labeled, dated when opened, and sealed closed. Also, pots and pans were not properly sanitized after washing and cups were not allowed to air dry before lids were reattached. These failures had the potential to affect all 90 residents in the facility who ate food from the kitchen. Findings include: Review of the facility's policy titled, "Labeling Food and Date Marking," dated November 2020, documented ". . .foods are labeled following preparation or opening to identify the item and to provide date, and time information ...Use-by date is the last date recommended for the use of the product while at peak quality." Review of the facility's policy titled, "Storage of Food," dated November 2020, documented " ... label opened foods as to contents and date."	F 812	F812 Corrective Action The Administrator re-educated the Food Service Director on the labeling and dating of food, sanitizing process for pots and pans, and the process for drying items prior to use. Maybe add something to say that he checked all food storage in the kitchen to ensure properly labeled, dated when opened and sealed close, ensured that all pots and pans were properly sanitized and that all cups were air dried prior to replacing the lids. Identification of Like Residents: The Food Service Director reviewed the facility process for labeling and dating of food, sanitation process for pots and pans, and the process for drying items prior to use.	

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F 812	Continued From page 31 Review of the facility's policy titled, "Food Storage and Date Marking," dated 2018, documented " ... Plastic containers with tight-fitting covers must be used for storing cereals, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must be legible and accurately labeled ..." 1. On 11/15/21 at 9:20 AM, the following observations were made with and verified by the Food Service Director (FSD). The dry storage room contained one bag of breadcrumbs, one bag of coconut flakes, one bag of cherry gelatin powder, and one bag of almonds that were opened and had not been labeled with a use by date. One bag of cherry gelatin powder that was open to air and not sealed closed. A plastic container of a powder food thickener was not labeled as to the contents of the container, nor did it have a use by date. The FSD confirmed open foods should be labeled with a use by date. 2. On 11/15/21 at 9:20 AM, four cups with lids on trays ready to go to the units that were still wet on the inside were observed with the FSD. The FSD stated the cups were still wet and could not air dry because the lids were on them. The FSD stated, "there would be a potential for bacteria since the cups were closed and wet." 3. On 11/17/21 at 10:45 AM, an observation revealed there were no sanitizing buckets in the kitchen to wipe off workstations. The FSD located two sanitizing buckets in the dish washroom that did not contain sanitizer and one bucket had broken glass in it. The FSD stated they did not use spray disinfectants in the kitchen. The FSD stated, "the buckets were being washed and they should have one in the kitchen to be used at all	F 812	Systemic Change: The Administrator or designee re-educated the cooks and dietary aides on the labeling and dating of food, sanitation process for pots and pans, and drying items prior to use. Monitoring: The Administrator or designee will audit the kitchen weekly times 8 weeks to validate items are labeled, dated when opened and sealed close, pots and pans are sanitized properly, and cups are air dried prior to replacing lids. The Administrator will submit findings to the QAPI committee for review and further recommendations as needed. Date of compliance: 12-18-2021	

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F 812	Continued From page 32 times." 4. On 11/17/21 at 11:14 AM, the wash, rinse, and sanitizer sinks were cold and contained food products. The sanitizer was tested by the FSD and did not register any sanitizer. All three sinks were emptied and refilled, and the sanitizer level was then adequate per manufacturer recommendation.	F 812		