STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0059	A. BUILDING: _____ B. WING _____	C 10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HEALTH & REHAB CENTER	2406 ATHERHOLT ROAD 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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted on 10/26/21. Corrections were required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this ninety-seven bed facility was 51 at the time of the survey. The survey sample consisted of six current resident reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12VAC5-371-220 A Based on staff interview and clinical record review, the facility staff failed to follow physician orders for one of six residents in the survey sample, Resident #3. Weight monitoring and notifications regarding weight changes were not implemented for Resident #3 as ordered by the physician. The findings include: Resident #3 was admitted to the facility on 3/10/21 with diagnoses that included pulmonary hypertension, mild protein-calorie malnutrition, congestive heart failure, COPD (chronic obstructive pulmonary disease), hypothyroidism, peripheral vascular disease, bipolar disorder, mania with psychotic features, dementia with behaviors, kyphosis, insomnia and osteoporosis.	F 001	Forest Health and Rehab is filing this plan of correction for the purpose of regulatory compliance. The facility is submitting this plan of correction to comply with the applicable law. The submission of this plan of correction does not represent an admission or statement of agreement with respect to the alleged deficiencies. F001— 12 VAC5-371-220 A The facility staff failed to follow physician orders A. Corrective action accomplished for the resident found to have been affected by the alleged deficient practice: a. Resident #3 was weighed on date of survey. Resident orders and weights reviewed by DON with facility PA and new orders obtained for weekly weights. B. Identify other residents who have the potential to be affected by the same	11/15/21

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

Electronically Signed | 11/08/21

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F 001	Continued From page 1 The minimum data set (MDS) dated 9/13/21 assessed Resident #3 as cognitively intact. Resident #3's clinical record included a physician's order dated 3/20/21 documenting, "Obtain daily weight. Alert MD if gain of >2 pounds in one day or >5 pounds in a week..." A new order was entered on 9/22/21 stating, "Obtain weight every Mon, Wed, Fri. Alert MD if gain of >2 pounds in 1 day or >5 pounds in a week..." Resident #3's clinical record documented no weights on 9/4/21, 9/5/21, 9/18/21 and 9/19/21. The record documented the resident weighed 124.3 lbs. (pounds) on 9/12/21 and weighed 132.4 lbs. on 9/13/21 indicating an 8 lb. weight gain. There was no notification to the physician of the weight change and no documented explanation for the weight shift. Resident #3's weight was documented on 9/14/21 as 132.6, on 9/15/21 as 132.9 and on 9/16/21 as 132.5. The resident's weight on 9/17/21 was listed as 122 lbs. Nursing notes made no mention or explanation of this 10.5 lbs. weight loss. Resident #3's clinical record documented no weights on 10/1/21, 10/4/21, 10/11/21, 10/13/21, 10/15/21, 10/18/21, 10/20/21 and 10/22/21. Nursing notes for October 2021 made no mention of the resident's weights. On 10/26/21 at 2:20 p.m., registered nurse (RN) #2, the former unit manager, was interviewed about Resident #3's order for weights and notifications. RN #2 stated she had the missing weights for October documented on a sticky note in her calendar. RN #2 stated the weights were not entered into the resident's clinical record. RN	F 001	deficient practice and what corrective action taken: a. All residents with daily/weekly weights have the potential to be affected by same deficient practice and what action taken: C. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: a. Maintain a list of all residents on daily or weekly weights. This list will be run from the Point Click Care orders. b. Tracking log will be maintained for residents on daily/weekly weights c. All weekly weights will be obtained on the same day each week d. Weight log will be reviewed weekly by DON or designee for compliance. e. Education provided to nursing staff on monitoring weights and following physicians orders for obtaining weights D. Monitoring of corrective action to ensure the deficient practice will not reoccur; a. Director of Nursing or designee will review weight log and documentation weekly b. Residents on weekly/daily weights will be reviewed weekly with IDT team c. Findings will be reported to NHA immediately when policy not adhered to d. Failure to adhere to facility policy will be considered a violation which will result in disciplinary action e. Findings will be reported to QAPI Committee monthly for 3 months to review need for continued intervention or amendment of plan	

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F 001	Continued From page 2 #2 stated she did not have an explanation for the 8 lb. weight gain on 9/13/21 or the weight loss of 10.5 lbs. on 9/17/21. RN #2 stated she was not sure if the weights were in error and usually the resident was re-weighed if there was a unexplained shift. On 10/26/21 at 2:30 p.m., the current unit manager, RN #1 was interviewed about the missing weights and notifications. RN #1 stated the weights were supposed to be obtained as ordered and notifications made to the physician per the parameters. RN #1 reviewed Resident #3's record and stated the weights "were not there." RN #1 stated notifications regarding weight changes were supposed to be documented in the clinical record. These findings were reviewed with the administrator and director of nursing on 10/26/21 at 4:00 p.m. 12VAC5-371-340 A Based on observation, facility document review and staff interview, the facility staff failed to store and prepare food in a sanitary manner from the kitchen. The findings include: On 10/26/21 at 10:10 a.m., accompanied by the cook (other staff #1), the kitchen and food storage areas were inspected. The floor in the walk-in freezer near the back, left corner was covered with a black/gray substance. Trash including plastic packaging tape was accumulated in the back corners of the freezer. Stored in the walk-in refrigerator were the	F 001	E. Date of Completion 11/15/2021 & ongoing 12VAC5-371-340 A The facility staff failed to store and prepare food in a sanitary manner from the kitchen A. Corrective action a. Kitchen refrigerators were inspected and out of date food and food not labeled properly was thrown out. B. Identify other residents that have the potential to be affected by this deficient practice a. All residents have the potential to be affected by this deficient practice. C. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur a. Kitchen staff were educated on the policy of food storage and labeling. D. Monitoring of corrective action to ensure the solutions are sustained a. The Administrator and/or designee will make weekly rounds in the kitchen to check refrigerators to ensure all foods are stored appropriately. b. All areas of concern will be addressed immediately. c. Findings will be reported to the QAPI Committee for 3 months for continued intervention, recommendation and/or	

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F 001	Continued From page 3 following: a plastic container of white gravy prepared on 10/17/21 with a use-by date of 10/20/21; a Ziploc bag (not original packaging) of shredded mozzarella cheese with no use-by date; a plastic container of ketchup (not in original packaging) with use by date of 10/24/21. In the kitchen prep area, a scoop was observed stored inside the bulk flour bin. The scoop was in the bottom of the bin with the handle partially covered with flour. On 10/26/21 at 10:30 a.m., the cook was interviewed about the freezer, out of date items and the scoop. The cook stated the freezer floor needed to be cleaned. The cook stated leftover foods were supposed to be labeled with a use-by date and discarded if beyond that date. The cook stated a clean scoop was supposed to be used each time to obtain flour from the bulk bin. There was no kitchen manager available for interview. The cook stated the dietary manager resigned last week and had not been replaced. The facility's policy titled Storage of Refrigerated Foods Policy (revised 2/19/19) documented, "...Refrigerated items must have a label showing the name of the food and the date it should be consumed, or discarded...Monitor daily for expiration dates or 'use by' dates and discard all outdated items immediately..." This finding was reviewed with the administrator and director of nursing on 10/26/21 at 4:00 p.m. 12VAC5-371-340 B Based on observation and staff interview, the facility staff failed to employ a qualified food	F 001	amendment of plan. E. Date of Completion 11/15/2021 & ongoing 12VAC5-371-340 B The facility failed to employ a qualified food services manager in the kitchen A. Corrective action a. The RD covered remotely and onsite between 10/22/21-10/27/21. b. The new DM started 10/27/21 and is ServSafe certified. B. Identify other residents that have the potential to be affected by this deficient practice a. All residents have the potential to be affected by this deficient practice C. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur a. On 10/31/21, the Administrator completed a course in Safe Food Handling b. 3 Dietary Cooks are enrolled in the Safe Food Handling Course. The course is to be completed by 1/1/22. D. Monitoring of corrective action to ensure the solutions are sustained a. HR will monitor the dietary department weekly to ensure that someone has a current ServSafe certificate. b. HR will report to QAPI monthly that a current dietary employee holds a ServSafe	

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F 001	Continued From page 4 services manager in the kitchen. The findings include: On 10/26/21 at 10:10 a.m., an initial tour of the kitchen was performed accompanied by the cook (other staff #1). Observed working in the kitchen were two dietary aides and the cook. When asked about the kitchen manager or anyone certified in food safety, the cook stated they currently did not have a dietary manager as he resigned "last Thursday or Friday." The cook stated no employees in the kitchen had any formal classes or certifications regarding food safety. On 10/26/21 at 10:45 a.m., the administrator was interviewed about a qualified dietary manager. The administrator stated, "We don't have one [kitchen manager]." The administrator stated the previous dietary manager "walked out" last Friday (10/22/21). This finding was reviewed with the administrator and director of nursing on 10/26/21 at 4:00 p.m.	F 001	certificate. c. All findings will reviewed by the QAPI committee for 3 months to further recommendations and follow up as needed. E. Date of Completion 11/15/21 & ongoing	