STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 04/19/2022 through 04/21/2022. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The	E 037		5/18/22

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

Electronically Signed | 05/10/2022

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E 037	Continued From page 1	E 037		

hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF

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E 037	Continued From page 2	E 037		

must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The

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E 037	Continued From page 3 CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency	E 037		

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E 037	Continued From page 4 procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to provide documentation of the facility's annual emergency preparedness training offerings and documentation that facility staff have received annual emergency preparedness training. The findings include: On 04/20/2022 at approximately 2:00 p.m., the facility's emergency preparedness plan was reviewed. Review of the facility's emergency preparedness plan failed to evidence documentation of the facility's annual emergency preparedness training offerings and documentation that facility staff have received annual emergency preparedness training. At approximately 2:30 p.m., interview was conducted with OSM (other staff member) # 4,	E 037	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. E 037 1- The Emergency Preparedness Plan has been updated with completed education/ training	

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E 037	Continued From page 5 director of maintenance. When asked about the annual training regarding the facility's emergency preparedness OSM # 4 stated that emergency drills are conducted but the emergency plan is not reviewed with staff annually. On 04/20/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit.	E 037	2- Current residents in the center have the potential to be affected. 3- The Administrator/Maintenance Director will be educated by the VP Of Operations/designee on the requirements for updating the Emergency Preparedness Plan annually. 4- The VP of Operations/Designee will review the required education for the Emergency Preparedness Plan and Update education as needed 5- Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis. 6- Date of compliance. 5/18/22	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/19/2022 through 04/21/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 108 at the time of the survey. The survey sample consisted of 34 current resident reviews and three closed record reviews.	F 000		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal	F 567		5/18/22

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F 567	Continued From page 6 funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on resident interview, facility document review and clinical record review, the facility staff failed to allow one of 37 residents in the survey	F 567	F 567 1. Resident #99 has been made aware of her ability to receive greater than $20	

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F 567	Continued From page 7 sample to withdraw more than twenty dollars from their personal fund account at a time, Resident #99 (R99). The findings include: On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/1/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions. An interview was conducted with R99 on 4/19/2022 at approximately 12:30 p.m. R99 stated the facility keeps changing the rules about getting my money out. R99 stated the facility is only allowing the resident to take twenty dollars at one time. An interview was conducted with OSM (other staff member) #5, the receptionist, on 4/20/2022 at 3:24 p.m. When asked the process for residents to access their money in the personal fund account, OSM #5 stated the residents come to the front desk and ask for their money, the residents are given the money and a receipt is printed.. OSM #5 stated the residents can get $20 at a time. When asked why are they limited to $20, OSM #5 stated the facility only keeps so much on hand and has to replenish it. When asked if there was a new system put into place for the residents to obtain their money, OSM #5 stated a few months ago some changes were made. When asked how residents are notified of changes in the procedure for obtaining their money, OSM #5 stated residents are told verbally. OSM #5 stated a letter was sent to the	F 567	from her personal fund account. 2. Current residents with personal funds have the potential to be affected 3. The Business office manager or designee will be educated by the Administrator on current policy related to resident personal funds. 4. The Business office manager or designee will interview 5 residents weekly requesting funds from their personal account to ensure resident satisfaction . The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, review will be completed on a random basis 5. Date of compliance 5/18/22	

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responsible parties but the process for the residents is the same. When asked how long the $20 limit had been in effect, OSM #5 stated it was an old (former corporation name) operating system. When asked if a resident wants more than $20 how do they do that, OSM #5 stated larger amounts are given to the resident with a check that takes a few days to obtain. When asked, doesn't the resident have the right to their money, OSM #5 stated, absolutely. The resident can get $80 if it is approved by the administrator.

The facility policy, Patient Trust Fund, documented in part, Policy: Requests for cash from the Patient Trust Fun petty cash box will be disbursed in accordance with Medicare and Medicaid regulations. Procedure: 1. According to State Regulations request for less than $50.00 ($100.00 for a Medicare Part A patient) in cash must be honored on the same day; requests for $50.00 ($100.00 for a Medicare Part A patient) or more in cash must be honored within three banking days. 2. Upon request for $20.00 or less from a patient: Cash will be disbursed immediately to the patient and a withdrawal properly signed...3. Upon request for $21.00 to $49.00 ($100.00 for a Medicare Part A patient): a. The patient should be given $20.00 in cash immediately. b. A withdrawal is prepared for the total amount of the requested cash. c. The amount given in cash is entered on the CAS - personal use cash line of the withdrawal. d. The amount of the check written for the balance of the request is entered on the withdrawal on the CHK - personal use line. e. The patient initials the CAS line to indicate the cash was received. f. A check, made payable to the Center Administrator, is written for the balance of the requested cash. g. The check is taken to the Patient Trust Fund

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F 567	Continued From page 9 bank and cashed. h. The balance of the requested cash is disbursed to the patient before the next of the business day. i. The patient signs the withdrawal after the balance of the cash requested is received. 4. Upon request for $50.00 ($100.00 for Medicare Part A patient) or more: a. A check, made payable to the Center Administrator, is written for the amount of the cash request. b. The Center has three (3) business working days to cash the check and disburse the funds to the patient, but every effort should be made to secure the cash by the next business day. c. The Patient Fund Withdrawal is written when the check is written. d. The patient signs the Patient Fund Withdrawal ticket after the money has been received. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN (registered nurse) #1, the unit manager, were made aware of the above findings on 4/20/2022 at approximately 5:15 p.m. No further information was provided prior to exit.	F 567		
F 684 SS=E	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:	F 684		5/18/22

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F 684	Continued From page 10 Based on staff interview, facility document review and clinical record review, the facility staff failed to follow physician's orders for three of 37 residents in the survey sample, Resident # 93 (R93), Resident #15 (R15) and Resident #75 (R75). The facility staff failed to monitor a fluid restriction for R93; and failed to provide care and services for a central venous access (central line) for R15 and R75. The findings include: 1. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/31/2022, R93 scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section O - Special Treatments, Procedures and Programs, the resident was coded as receiving dialysis. The physician order dated 4/11/2022, documented, "Fluid Restriction (1200 ml [milliliters]) Give the following fluid volume with medication administration: 7-3 [7:00 a.m. to 3:00 p.m.] meds: (120 ml with morning meds and 120 ml afternoon meds) 3-11 [3:00 p.m. to 11:00 p.m.] meds: 120 ml (evening meds) 11-7 [11:00 p.m. to 7:00 a.m.] meds: 40 ml (night meds). Remainder 600 ml with daily meals (120 ml breakfast, 240 ml lunch, 240 ml dinner) every shift for Fluid Restriction." The MAR (medication administration record) documented the above order. The MAR documented two opportunities for indicating the amount of fluids taken, one for "days" and one for "nights." On 4/15/2022 the "days" documented	F 684	F 684 Cross ref 12VAC5 -371-220 (B) 1. Resident # 93 , Fluid restriction orders have been discontinued. Resident #15 Picc line has been discontinued. Resident #75 Picc line dressing change was completed 4/20/22, current documentation of Picc Line dressing change and measurement of external portion of Picc line is in place 2. Current residents with order for fluid restriction have potential to be affected .Current residents with PICC Line orders related to dressing change, external catheter measurements and those current residents with orders to discontinue a picc line have potential to be affected. 3. SDC or designee will educate all Licensed staff on documentation related to fluid restriction intake. Picc line dressing change, external Picc line catheter measurements, discontinuation of Picc line catheter upon order from Physician. 4. DON or designee will review 5 patients weekly to ensure accurate documentation of fluid restriction, will complete weekly review of Picc line orders to ensure documentation related to dressing change and measurement of external portion of picc line , and Physician orders to discontinue Picc line have been completed and documented. 5. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, review will be completed on a random basis	

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F 684	Continued From page 11 1340 ml, the "nights" documented 550 ml consumed, for a total of 1890 ml in a 24 hour period. On 4/19/2022, the "days" documented 960 ml and the "nights" documented 960 ml consumed, for a total of 1920 ml in a 24 hour period. Review of the nurse's notes dated 4/11/2022 through 4/19/2022, failed to evidence documentation regarding the fluid restriction. The comprehensive care plan dated, 7/2/2020 and revised on 4/19/2022, documented in part, "Focus: Nutrition Risk r/t (related to) ESRD (end stage renal disease) on HD (hemodialysis)... +1200 ml fluid restriction." LPN (licensed practical nurse) #3 was interviewed on 4/20/2022 at 4:16 p.m. When asked who is responsible for monitoring the physician ordered fluid restriction for a resident, LPN #3 stated she looks at the meal trays as they are handed out and then the CNA (certified nursing assistants) usually provides information on how much they are drinking. LPN #3 stated the residents have a certain amount of cups. When asked where the amount of fluids a resident consumes is documented, LPN #3 stated it is documented in the MAR. When asked who monitors the fluid restriction, LPN #3 stated each nurse on each shift monitors the amount for the shift. LPN #3 stated she monitors and records it for 3-11 shift. When asked if anyone is responsible for monitoring the totals for the day, LPN #3 stated, no, the nurse monitors it when she puts it in for her shift. When asked the purpose of a fluid restriction for R93, LPN #3 stated the resident is a dialysis patient and his	F 684	6. Date of Compliance 5/18/22	

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kidneys are not working properly. Again asked who is monitoring the exact amount the resident is taking, LPN #3 stated that was a good question. The MAR was reviewed with LPN #3.

On 4/20/2022 at 4:43 p.m., RN (registered nurse) #2, and RN #1, both unit managers, were interviewed. When asked the purpose of a fluid restriction for a resident on dialysis, RN #2 stated so the resident will not go into fluid overload between dialysis as they can't rid themselves of the fluid. When asked who monitors the fluid restriction, RN #2 stated the nursing staff. When asked who looks at it to see if the resident is over or under the physician ordered fluid restriction, RN #2 stated it should have a total for the day and the nurses should look at it at the end of their shift. Each nurse is responsible on their shift to monitor it. RN #1 stated, typically we, the nurses, go around to the residents on fluid restrictions and make sure there are no extra cups in the room, everything they drink is recorded. RN #1 stated the physician orders specify what the resident are supposed to get each shift. RN #1 stated each nurse is documenting what they gave. The above orders were reviewed with RN #1, when asked about documentation, RN #1 stated, the nurse signing off at 3:00 p.m. should tell the oncoming nurse how much they gave the resident and then the next nurse will document the total until 7:00 p.m. When asked what are the potential consequences for R93 to go over their fluid restriction, RN #2 stated, a lot could arise, congestive heart failure, fluid overload or edema.

The facility policy, "Fluid Management/Fluid Restriction" documented in part, "Policy: The nursing staff will assess and monitor adherence to fluid management for patients placed on fluid

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restriction...Procedure: 7. Document fluid intake."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN (registered nurse) #1, the unit manager, were made aware of the above findings on 4/20/2022 at approximately 5:15 p.m.

No further information was provided prior to exit.

2. On the most recent MDS, (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/18/22, R15 scored 12 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately cognitively impaired for making daily decisions.

On 4/19/22 at 4:05 p.m., R15 was sitting up in a wheelchair. During the interview, R15 stated concern about the central line used to administer IV antibiotics. R15 stated the antibiotic was complete, but the central line had remained. The resident was worried about getting an infection from the central line. The central line access was located on R15's right upper arm. The dressing was dated 4/4/22.

On 4/20/22 at 12:38 p.m., R15 was sitting up in bed, awake and alert. The dressing on R15's central line access on the right upper arm was unchanged from the previous day, and dated 4/4/22.

A review of R15's physician orders revealed the following: "Mid-line (type of central venous access) dressing change Q (every) Sunday and prn (as needed) every day shift every Sun (Sunday) for infection prevention...Midline flush -

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10 ml (milliliters) NS (normal saline) infuse medication, then 10 ml NS flush and follow with 5 ml 10 units/mlv heparin (2) one time a day." Both orders were dated 3/2/22 and were discontinued 4/12/22.

A review of R15's MARs (medication administration records) and TARs (Treatment Administration Records) for April 2022 revealed no evidence R15's central line dressing was changed after 4/4/22. R15's

MARs revealed the normal saline and heparin flushes were administered as ordered between 3/2/22 and 4/12/22. The clinical record contained no evidence R15's central line access was assessed or flushed between 4/12/22 and 4/20/22.

A review of R15's comprehensive care plan dated 5/25/20 and updated 3/2/22 revealed, in part: "(Central line) catheter...change dressing with a transparent dressing weekly or as needed...flush as ordered.""

On 4/20/22 at 12:54 p.m., LPN (licensed practical nurse) #2 was interviewed. When asked about specific interventions to care for a central line, she stated there should be orders in place to have the dressing changed weekly. She stated if a resident has completed treatment requiring use of the central line, the nurses should still be assessing the site and flushing it regularly to make sure no blood clots form within or around the line.

On 4/20/22 at 1:08 p.m., LPN #1 was interviewed. She stated the nursing staff should have orders to change the central line dressing once a week,

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and as needed. She stated sometimes a provider will want to leave a central line in place beyond completion of a round of IV medications in case additional laboratory tests reveal the necessity for additional IV medications. She stated a nurse needs an order to "do anything" with a central line, including flushing and dressing changes. She stated flushes should continue as part of routine central line care, whether or not the line is being used for medication administration. She stated it is important to change the central line dressing in order to prevent infection, and to allow a nurse to see the access site more clearly.

On 4/20/22 at 1:54 p.m., ASM (administrative staff member) #3, a nurse practitioner, was interviewed. She stated central line care should include flushes every shift to check for blood return and to clear the line, as well as dressing changes each week. She stated if the line is not flushed regularly, even if it is not in use, it could develop blood clots. She stated central line care should include dressing changes each week. She stated if a dressing is not changed regularly, there is a higher risk of bacteria getting into the central line and causing an infection. When asked if she knew why R15's central line was still in place, she stated R15 was cleared from isolation on 4/19/22, and should have the central line removed today.

On 4/20/22 at 5:09 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

3. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an

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assessment reference date of 3/18/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions.

On 4/19/2022 at approximately 11:20 a.m. R75 was observed resting in bed. A PICC line was observed on the resident's right arm just above the elbow. The dressing on the PICC line was dated 4/8/2022.

On 4/20/2022 at 8:30 a.m., a second observation was made of R75's PICC line dressing. The same dressing was in place dated 4/8/2022. R75 was asked if the staff has changed the dressing on the PICC line since they returned to the facility on 4/11/2022. R75 stated the dressing had not been changed since before they left the hospital. When asked if the nurses look at the dressing and measure it, R75 stated, not really. R75 stated they just do the flush before and after the antibiotic and infuse the antibiotic.

The physician order dated 4/12/2022 documented, "PICC line dressing change on admission, then Q (every) week on Sunday and PRN (as needed) every day shift every Sunday for infection Prevention."

A physician order dated 4/17/2022 documented, "PICC line - measure external portion of PICC line catheter weekly with dressing changes every night shift every Sunday." There were no orders to flush the PICC line.

The MAR (medication administration record) for April 2022 documented the above order for the PICC line dressing. The order of 4/17/2022 did

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not appear on the MAR. On 4/17/2022 a "9" was documented. The Chart Codes documented a 9 equal "Other/See Progress Note."

The nurse's note dated 4/17/2022 at 12:45 p.m. documented, "PICC line dressing change on admission, then Q week on Sunday and PRN every day shift every Sun for Infection Prevention - Being done on 3-11 p.m." There was no documentation that the dressing was completed on 3-11 p.m. shift on 4/17/2022.

The comprehensive care plan dated, 4/19/2022 documented in part, "PICC/Midline catheter Medication administration for Osteomyelitis to right foot." The "Interventions" documented in part, "Change dressing with a transparent dressing weekly or as need. Flush as ordered. Monitor insertion site for redness, drainage and pain."

An interview was conducted with LPN (licensed practical nurse) #1 on 4/20/2022 at 1:08 p.m. When asked how a nurse cares for a resident with a PICC line, LPN #1 stated there should be orders for the dressing changes, the resident may come with orders for laboratory tests and the SASH (Saline, antibiotic, saline, heparin) protocol. LPN #1 stated the dressing should be changed at least weekly and as needed. When asked if there should be orders for the flushes, LPN #1 stated yes. When asked where the flushes are documented, LPN #1 stated on the MAR or in a nurse's note. When asked if she had observed R75's PICC line this morning, LPN #1 stated she observed it once on rounds this morning. When asked if she noticed anything, LPN #1 stated it looked like it needed to be changed. When asked if she checked the date, LPN #1 stated she did

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not. When asked why the dressing is changed weekly, LPN #1 stated because of infection control; the nurse needs to observe the site, and when the dressing is changed, the nurse has to measure the amount of tubing is hanging out from the insertion site. When asked where this measurement is documented, LPN #1 stated it should be with the order for the dressing change.

An interview was conducted with ASM (administrative staff member) # 3, the nurse practitioner, on 4/20/2022 at 1:53 p.m. When asked what kind of care should central lines, PICC, Midline catheters receive from the staff, ASM #3 stated they should be flushed every shift, to make sure it's flushing and maintaining the integrity of the line. ASM #3 stated she was not sure of the facility protocol. When asked if the nurses need orders for the flushes and dressing changes, ASM #3 stated there is a plan of care in the electronic medical record system that should populate, but yes the nurses need orders for daily PICC care. When asked why should there be orders to flush the line, ASM #3 stated the PICC line can clot and that's why there should be orders for heparin flush or regular flush. When asked why there should be orders for a dressing change, ASM #3 stated if the dressing is loose then bacteria can get in and cause an infection.

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN (registered nurse) #1, the unit manager, were made aware of the above findings on 4/20/2022 at approximately 5:15 p.m. Policies regarding central line care were requested.

On 4/21/22 at 8:40 a.m., ASM #1 stated the facility did not have a policy related to central line

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F 684	Continued From page 19 care. No further information was provided prior to exit.	F 684		
F 695 SS=D	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, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to provide respiratory care and services for 2 of 37 residents in the survey sample, Residents #33 and #97. The facility staff failed to administer oxygen to Resident #33 (R33) per the physician prescribed rate of three liters per minute. The facility staff failed to store a nebulizer mask in a sanitary manner for Resident # 97 (R97). The findings include: 1. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 2/4/22, the resident scored 6 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely cognitively impaired for making daily decisions. A review of R33's clinical record revealed a	F 695	F 695 Cross ref 12VAC5-371-220 1. Resident # 33 oxygen order has been discontinued. Resident # 97 bedside nebulizer is stored in a sanitary manner. 2. Current residents with oxygen orders /bedside nebulizer have potential to be affected. 3. SDC or designee will educate Licensed staff on appropriate setting of oxygen delivery. Need for bedside nebulizer to be stored in sanitary manner. 4. The UM or designee will complete random weekly review of patients oxygen setting , and ensure bedside nebulizers are stored in sanitary manner . 5. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, review will be completed on a random	5/18/22

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comprehensive care plan dated 8/12/21 that documented, "The resident has altered respiratory status/difficulty breathing r/t (related to) pneumonia."

R33's April 2022 physician's order sheet documented a physician's order dated 3/28/22 for oxygen at three liters per minute as needed to keep the resident's oxygen saturation level above 90%.

On 4/19/22 at 10:55 a.m. and 1:54 p.m., R33 was observed in a wheelchair in the bedroom, receiving oxygen at three and a half liters per minute.

On 4/20/22 at 12:53 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated nurses are supposed to check residents' oxygen concentrator flow rate every shift. LPN #2 stated the middle of the ball in the oxygen concentrator flow meter should run through the three liter line if the physician's order is for three liters.

On 4/20/22 at approximately 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The oxygen concentrator manufacturer's instructions documented, "2. Check the flow meter to make sure that the flow meter ball is centered on the line next to the prescribed number of your flow rate."

The facility policy titled, "Respiratory/Oxygen Equipment" documented, "3. Set appropriate flow rate and place oxygen delivery device on the

basis
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patient."

No further information was presented prior to exit.
2. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/24/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions.

Observation was made on 4/19/2022 at approximately 11:15 a.m. of R97's room. A nebulizer machine was observed on the night stand. The nebulizer mask was sitting on the machine with no covering on it, open to air.

A second observation was made on 4/20/2022 at 9:02 a.m. of R97's room. The nebulizer mask was sitting on the nebulizer machine without any covering. An interview was conducted with R97 at that time. When asked if she uses the nebulizer machine and mask, R97 stated she uses it three to four times a day and had just used it early this morning.

The physician order dated, 1/24/2022, documented, "Formoterol Furmarate Nebulization Solution (used to control wheezing, shortness of breath, and chest tightness caused by chronic obstructive pulmonary disease) (1) 20 MCG/ML (micrograms per milliliter) - 2 ml inhale orally via nebulizer two times a day for COPD (chronic obstructive pulmonary disease)."

The comprehensive care plan dated, 12/8/2021, documented in part, "Focus: The resident has altered respiratory status/difficulty breathing r/t (related to) COPD." The "Interventions"

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F 695	Continued From page 22 documented in part, "Administer medications/puffers as ordered." An interview was conducted with LPN (licensed practical nurse) #2 on 4/20/2022 at 12:56 p.m. When asked how a nebulizer mask is stored when it is not in use, LPN #2 stated it should be in a bag. When asked why it is stored in a bag, LPN #2 stated they didn't know but that's what they were taught to do. The facility policy provided entitled, "Respiratory/Oxygen Equipment" documented in part, "Licensed staff will administer and maintain respiratory equipment, oxygen administration and oxygen equipment per physician's order and in accordance with standards of practice." The policy addresses the care of Non-heated/heated Aerosol Trach Collar/Mask but the facility staff highlighted, "Store mask/collar in storage bag when not in use." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN (registered nurse) #1, the unit manager, were made aware of the above findings on 4/20/2022 at approximately 5:15 p.m. No further information was provided prior to exit.	F 695		
F 727 SS=C	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	F 727		5/18/22

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F 727	Continued From page 23 §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to have an registered nurse (RN), other than the director of nursing, on duty on 4/2/2022. The findings include: The as-worked schedules for the past 30 days were reviewed. On 4/2/2022, there was no documentation of an RN on duty throughout the entire day. On 4/19/2020 at 4:08 p.m. ASM (administrative staff member) #2, the director of nursing, was asked to provide evidence that an RN was on duty on 4/2/2022. On 4/19/2022 at 4:17 p.m. ASM #2 presented timecard documentation for herself, that she was the RN on duty for the day. When asked if the census in the building was less than 60 residents on that day, ASM #2 stated, no. An interview was conducted with OSM (other staff member) #6, the staffing coordinator, on 4/20/2022 at 4:12 p.m. When asked how she ensures that there is an RN on duty every day, OSM #6 stated she usually has an RN each day. The schedule for 4/2/2022 was reviewed with	F 727	F 727 Cross ref 12VAC5 371-200 (D) 1. Facility has met the requirement related to Registered Nurse coverage in center . 2. Current residents in the center have the potential to be affected. 3. Administrator or designee will educate the Staff scheduler on requirement to have 8 hours of registered nurse coverage per day. 4. Administrator or designee will review weekly staffing to ensure registered nurse coverage 8 hours per day is maintained. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, review will be completed on a random basis 5. Date of compliance 5/18/22	

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	495297	A. BUILDING _____ B. WING _____	04/21/2022

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F 727	Continued From page 24 OSM #6. OSM #6 stated, that was the weekend that (name of director of nursing) came in to be the RN on duty. ASM #1, the administrator, ASM #2, and RN (registered nurse) #1, the unit manager, were made aware of the above findings on 4/20/2022 at approximately 5:15 p.m. On 4/21/2022 at 8:40 a.m. ASM #1 stated the facility did not have a policy on RN coverage. No further information was provided prior to exit.	F 727		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and employee record review, the facility staff failed to perform annual performance evaluations on two of five CNA (certified nursing assistant) record reviews. The findings include: On 4/20/2022 at 9:23 a.m. OSM (other staff member) #7, the human resources staff member, presented the documentation of annual performance evaluations for three of the five CNAs; CNA #5, CNA #1, CNA #7. OSM #7	F 730	F 730 Cross REF 12VAC5-371-210 (A.5) 1. Performance evaluation have been reviewed with CNA # 4 CNA # 6 2. Current employees have potential to be affected. 3. Administrator or Designee will educate Human resources director on policy related to annual CNA performance evaluation review . 4. Human resources director or designee will complete random monitor of CNA hire dates to ensure yearly performance evaluation completed.	5/18/22

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F 730	Continued From page 25 stated that CNA #4 and CNA #6 got an across the board raise so no performance evaluations were completed. The facility policy, "Merit Increase" documented in part, "Policy: (Initials of company) will evaluate employees annually and reward eligible employees for performance through annual merit increases...Procedure: 1. Employees may earn merit increases for performance...4. Generally, all employees will receive a performance appraisals annually." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN (registered nurse) #1, the unit manager, were made aware of the above findings on 4/20/2022 at approximately 5:15 p.m. No further information was provided prior to exit.	F 730	5. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, review will be completed on a random basis 6. Date of compliance 5/18/22	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. 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	F 803		5/18/22

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F 803	Continued From page 26 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, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to follow the menu for one of 37 residents in the survey sample, Resident #309; and for the dinner meal on 4/19/22. The findings include: 1. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/11/22, R309 scored 14 out of 15 on the BIMS (brief interview for mental status), indicating she is cognitively intact for making decisions. On 4/19/22 at 11:34 a.m., R309 was interviewed. R309 stated she had concerns about not getting the food that was on the meal ticket for each meal. R309 stated it was rare for them to receive "anything close" to what they had repeatedly told staff they were able to eat. On 4/19/22 at 1:37 p.m., R309 sat in a wheelchair at the overbed table. An open plate of food was on a tray on the overbed table. R309 was not	F 803	F 803 1. Resident # 309 has been discharged. 2. Current residents have potential to be affected 3. Dietary manager or designee will educate dietary staff on following daily menu 4. Dietary manager or designee will interview 5 resident weekly to ensure menu has been followed. 5. Results of the resident interviews will be presented to the QAPI Committee for review and recommendation, one the committee determines the problem no longer exits the interviews will be conducted on a random basis. 6. Date of Compliance 5/18/22	

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F 803	Continued From page 27	F 803		

eating. The meal ticket on R309's tray included the following items: shrimp and vegetable stir fry, orange twist, buttered white rice, roll, margarine, frosted carrot cake, 2% milk, hot coffee or hot tea. R309's meal tray contained the following items: steamed shrimp (unseasoned and without sauce per R309), steamed mixed vegetables (without any sauce), rice, cold tea, and yellow cake with chocolate icing. The tray did not contain hot coffee or tea, 2% milk, or an orange twist. R309 stated this was typical for her meal trays; the facility substituted other items without informing the resident, and the resident was unaware of an option to get any other items. CNA (certified nursing assistant) #3 entered the room. CNA #3 stated she was unaware of any substitutions made on the menu for that meal. CNA #3 stated the shrimp and vegetables were not stir fried, as the published menu stated. CNA #3 stated it might be possible for her to go to the kitchen to see if there was any other food for R309, but she had not had "very good luck" in doing so in "a really long time." She stated, "Sometimes they have something else and sometimes they don't." CNA #3 was not aware of any way to address the missing items from R309's tray.

On 4/20/22 at 9:32 a.m., R309 sat in a wheelchair at the overbed table. An open plate of food was on a tray on the overbed table. R309 was not eating. The meal ticket on R309's tray included the following items: Orange juice, scrambled egg substitute, orange twist, wheat toast, margarine, oatmeal, 2% milk, hot coffee or tea. R309's meal tray contained the following items: oatmeal, cooked egg products shaped in a square, orange sliver, and biscuit. The tray did not contain milk or wheat toast.

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On 4/20/22 at 9:53 a.m., OSM (other staff member) #1, the culinary service manager, entered the room and was interviewed. OSM #1 the daily menus are posted in the hallway across from the nurse station. OSM #1 stated only 2 main entrees are offered (a primary and an alternate), and each resident receives the primary entree at every meal. She stated if the resident wants something different, the CNA who served the meal is responsible for being knowledgeable about the alternates, going to the kitchen, and obtaining the alternate meal for the resident. When asked if the lunch meal on 4/19/22 contained any substitutions, OSM #1 stated she was not aware of any substitutions. When asked if carrot cake was served for lunch yesterday, OSM #1 stated, "I think so." When informed that R309 received yellow cake with chocolate icing, OSM #1 stated she suddenly remembered that she could not get carrot cake from her supplier, so she had to substitute a chocolate cake. When asked about the substitution of steamed shrimp and vegetables for the published menu item of shrimp and vegetable stir fry, she stated the facility never offers stir fry. When asked how the facility informs residents about menu substitutions/changes, she stated she changes the item on meal tickets and changes the posted menus. When asked how residents who cannot see the posted menu in the hallway or read the small print on the meal tickets are informed of substitutions, she did not answer. When shown the lunch meal ticket from the day before which listed carrot cake and shrimp and vegetable stir fry, OSM #1 stated she had not been at the facility very long, and she was still learning.

On 4/20/22 at 10:44 a.m., OSM #1 and OSM #2,

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the regional director of culinary services, were interviewed. OSM #1 stated the cooks should be utilizing a production sheet for each meal. The production sheet contains all the food items that should be cooked/prepared for each meal. She stated that the cook is responsible for making sure that what is cooked matches what is on the production sheet. When asked who checks to make sure the food items match the production sheet, she stated she guessed she does that. She stated she had been out on medical leave recently, and she was not sure who had checked the cooks on those days. When asked the process that is followed when a substitution needs to be made on the menu, OSM #2 stated the facility cooks in batches. He stated the facility orders pre-made cakes from the food distributor, and there has been a shortage of carrot cake. OSM #1 and OSM #2 were unaware that any residents had been informed of this substitution. When asked about the steamed shrimp and vegetables, OSM #2 stated that it is just the cooking method that did not match the menu item. He stated when the staff is cooking high volume, there is no way to stir fry or make meals to order. He stated: "Country fried steak is not made in the country." When asked if the shrimp or vegetables at lunch on 4/19/22 contained any sort of stir fry sauce, he stated he did not know.

A review of the facility's Menu Substitution Record revealed no information related to these specific concerns.

On 4/20/22 at 5:09 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

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A review of the facility policy, "Menu Planning," revealed, in part: "Menu substitutions shall be limited to preferences of the Center's patients and emergency situations...Menu substitutions refer to unavoidable situations or emergencies."

No further information was provided prior to exit.
2. Observation was made on 4/19/2022 at 4:59 p.m. of the dinner served. A test tray was requested. OSM (other staff member) #2, the regional director of culinary services, served a pureed diet tray and a regular diet tray.

The dinner menu documented, sliced baked ham, pineapple sauce, orange twist, home fried potatoes, steamed cabbage, corn bread and margarine.

The puree tray consisted of pureed beef, pureed California blend vegetables, and mashed potatoes and pureed bread. When asked why the pureed diet did not have the ham, OSM #2 stated he'd go check with the cook. OSM #2 returned and stated the cook said the beef was easier and made a better puree than the ham.

At 5:06 p.m. the menu was reviewed with OSM #2. When asked where the pineapple relish was on the test trays, OSM #2 stated there was an au jus on the ham. When asked if an au jus is the same as a relish, OSM #2 didn't answer. When asked where the orange twist was on the test tray, OSM #2 stated the orange twist is just a garnish. OSM #2 was asked why there wasn't cabbage on the trays, OSM #2 did not know the answer. OSM #1, the culinary services manager for the facility, was then asked about the cabbage. OSM #1 stated the cabbage did not come in with their delivery today so she made the

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F 803	Continued From page 31 decision to substitute with the California Blend. When asked how she informs the residents of a change in the menu, OSM #1 stated she went out and told a few residents. The facility policy, "Food Quality and Palatability" documented in part, "1. The Dining Services Director and Cook(s) are responsible for food preparation. Menu items are prepared according to the menu, production guidelines and standardized recipes." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN (registered nurse) #1, the unit manager, were made aware of the above findings on 4/20/2022 at approximately 5:15 p.m. No further information was provided prior to exit	F 803		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to honor a resident's preferences for one of 37 residents in	F 806	F 806 1. Resident # 309 has been discharged 2. Current residents have potential to be affected	5/18/22

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F 806	Continued From page 32 the survey sample, Resident #309 (R309). The findings include: 1. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/11/22, R309 scored 14 out of 15 on the BIMS (brief interview for mental status), indicating she is cognitively intact for making decisions. On 4/19/22 at 11:34 a.m., R309 was interviewed. R309 stated she had concerns about not getting the food that was the meal ticket for each meal. R309 stated it was rare for them to receive "anything close" to what they had repeatedly told staff they were able to eat. On 4/19/22 at 1:37 p.m., R309 sat in a wheelchair at the overbed table. An open plate of food was on a tray on the overbed table. R309 was not eating. The meal ticket on R309's tray included the following items: shrimp and vegetable stir fry, orange twist, buttered white rice, roll, margarine, frosted carrot cake, 2% milk, hot coffee or hot tea. R309's meal tray contained the following items: steamed shrimp (unseasoned and without sauce, per R309), steamed mixed vegetables (without any sauce), rice, cold tea, and yellow cake with chocolate icing. The tray did not contain hot coffee or tea, 2% milk, or an orange twist. R309 stated this was typical for her meal trays; the facility substituted other items without informing the resident, and the resident was unaware of an option to get any other items. R309 stated someone from the dietary staff met with the resident within a couple of days of admission. R309 told the staff of the preference for eggs and bacon for breakfast, milk on every	F 806	3. Dietary manager or designee will educate dietary staff on resident preferences. UM or designee will educate nursing staff on communication related to dietary preferences. 4. UM or designee will complete 5 resident interviews weekly to ensure preferences have been identified and communicated . 5. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, review will be completed on a random basis 6. Date of compliance 5/18/22	

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tray at every meal, and an extra sandwich at lunch. R309 stated she had trouble with nausea often, and the sandwich was something she felt she could always eat. R309 stated she rarely received bacon, and never received milk. R309 stated she had sometimes asked for an alternate or for additional food, but the staff usually told her that the kitchen was "all out."

CNA (certified nursing assistant) #3 entered the room. CNA #3 stated she was unaware of any substitutions made on the menu for that meal. CNA #3 stated the shrimp and vegetables were not stir fried, as the published menu stated. CNA #3 it might be possible for her to go to the kitchen to see if there was any other food for R309, but she had not had "very good luck" in doing so in "a really long time." She stated, "Sometimes they have something else and sometimes they don't." CNA #3 was not aware of any way to address the missing items from R309's tray.

On 4/20/22 at 9:32 a.m., R309 sat in a wheelchair at the overbed table. An open plate of food was on a tray on the overbed table. R309 was not eating. The meal ticket on R309's tray included the following items: Orange juice, scrambled egg substitute, orange twist, wheat toast, margarine, oatmeal, 2% milk, hot coffee or tea. R309's meal tray contained the following items: oatmeal, cooked egg products in a perfect square, orange sliver, and biscuit. The tray did not contain milk or wheat toast.

On 4/20/22 at 9:53 a.m., OSM (other staff member) #1, the culinary service manager, entered the room and was interviewed. OSM #1 stated the daily menus are posted in the hallway across from the nurse station. OSM #1 stated

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F 806	Continued From page 34	F 806		

only 2 main entrees are offered (a primary and an alternate), and each resident receives the primary entree at every meal. She stated if the resident wants something different, the CNA who served the meal is responsible for being knowledgeable about the alternates, going to the kitchen, and obtaining the alternate meal for the resident. OSM #1 stated she had not yet met with R309 to determine the resident's preferences because OSM #1 had been out of work for a period of time. OSM #1 stated another member of the culinary services staff had met with R309. OSM #1 was shown R309's breakfast tray, and was asked to compare the tray to the meal ticket. OSM #1 stated R309 had not received scrambled eggs, milk, or wheat toast. OSM #1 stated R309 had not received wheat toast. When asked if OSM #1 was aware that R309 had expressed a preference for eggs and bacon for breakfast, and milk at every meal, OSM #1 stated she was not. R309 told OSM #1 that she had requested the nurse to call the kitchen at 7:30 a.m. this morning to specifically ask for extra bacon. OSM #1 agreed there was no bacon at all on R309's tray.

A review of R309's Food Preferences Interview form dated 4/7/22 revealed, in part: Breakfast 2% milk; Lunch 2% milk; Dinner 2% milk...Breakfast: milk, scrambled eggs, toast, jelly, bacon; Lunch: milk, tuna sandwich extra; Dinner: milk."

On 4/20/22 at 10:44 a.m., OSM #1 and OSM #2, the regional director of culinary services, were interviewed. OSM #1 stated the tray line staff are responsible for making sure the food on the residents' trays match the meal tickets and the residents' stated food preferences. OSM #2 stated that when a staff member meets with a resident, the staff member is responsible for

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F 806	Continued From page 35 informing other members of the culinary services staff of the resident's preferences. The staff member should make changes as needed to each resident's meal tickets as an additional way of communicating a resident's preferences. OSM #1 stated several staff members have met with R309 during the resident's stay at the facility, and that R309 "has been one who will switch on you in a heartbeat." On 4/20/22 at 5:09 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. Policies regarding resident meal preferences were requested. On 4/21/22 at 8:40 a.m., ASM #1 stated the facility did not have a policy related to central line care. No further information was provided prior to exit.	F 806		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		5/18/22

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F 812	Continued From page 36 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility failed to store food in a sanitary manner in one of two refrigerators in the main kitchen. The findings include: The facility kitchen was observed on 4/19/2022 at 10:10 a.m. A container of sliced American cheese was observed in a refrigerator with and open date of 3/6/2022 and a use by date of 3/10/2022. A second container with shredded cheddar cheese did not have a date when opened, but had a use by date of 3/10/2022. When asked if these containers of cheese should be still available for use, OSM (other staff member) #1, the culinary services manager, stated the staff probably put the wrong dates on it. When asked if it should be available for use with the dates on it, OSM #1 stated, "No, I guess not." The facility policy, "Food Storage: Cold" documented in part, "The Dining Services Director/Cook(s) insures that all food items are stored properly in covered containers, labeled and dated." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN (registered nurse) #1, the unit manager, were made aware of the above findings on 4/20/2022 at approximately 5:15 p.m.	F 812	F 812 cross ref 12VAC5 -371-340 1.Out of date items in refrigerators have been discarded 2. Current residents have the potential to be affected 3. Dietary Regional consultant or designee will educate dietary managers on appropriate management, storage, and safe sanitary food procurement. 4. Regional dietary consultant or designee will complete random weekly audits of Kitchen refrigerators to ensure food items have not expired. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, review will be completed on a random basis. 5.Date of compliance 5/18/22	

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F 812	Continued From page 37 No further information was provided prior to exit.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to maintain one of one dumpsters in a sanitary manner. The findings include: On 4/19/2022 at approximately 10:35 a.m. the facility dumpster was observed with OSM (other staff member) # 1, the culinary services manager. There were 11 used gloves around the dumpster area. A 12th used glove was found just outside the door to go back into the building. When asked who was responsible for maintaining the dumpster area, OSM #1 stated it is between dietary and maintenance. When asked if the gloves should be on the ground, OSM #1 stated, no. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN (registered nurse) #1, the unit manager, were made aware of the above findings on 4/20/2022 at approximately 5:15 p.m. A request was made for the policy on maintaining the dumpster area on 4/20/2022 at 5:30 p.m. No further information was provided prior to exit.	F 814	F 814 1. Gloves were removed from dumpster area 4/19/22 , area is maintained in a sanitary manner 2. Center has the potential to be affected 3. Administrator or designee will educate Maintenance / Housekeeping staff on the need to maintain dumpster area in a sanitary manner. 4. Housekeeping / Maintenance director will monitor dumpster area 5x weekly to ensure area is maintained in a sanitary manner. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, review will be completed on a random basis 5. Date of Compliance.5/18/22	5/18/22
F 880	Infection Prevention & Control	F 880		5/18/22

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F 880 SS=D	Continued From page 38 CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

§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

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F 880	Continued From page 39 resident; including but not limited to: (A) The type and duration of the isolation, 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, staff interview, facility document review and clinical record review, the facility staff failed to implement infection control practices for one of nine residents during the medication administration observation, Resident #105. The facility staff failed to administer oral medication to Resident #105 (R105) in a sanitary manner. The findings include:	F 880	F 880 cross ref VAC5-371-180 1. Resident # 105 is receiving medications in a sanitary manner. 2. Current residents have potential to be affected. 3. SDC or designee will educate all Licensed staff on infection control practice related to medication administration. 4. SDC or designee will observe 3 nurses weekly to ensure infection control	

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F 880	Continued From page 40 On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/31/22, the resident scored 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely cognitively impaired for making daily decisions. On 4/20/22 at 7:55 a.m., an observation of LPN #1 preparing and administering medications was conducted. LPN #1 popped a pill out of a blister pack and the pill dropped on top of the medication cart. LPN #1 scooped the pill into the medication cup then administered the pill to R105. LPN #1 had not disinfected the cart prior to the medication pass or dropping the pill on the cart. On 4/20/22 at 1:14 p.m., an interview was conducted with LPN #1. LPN #1 stated a pill dropped on top of the medication cart should be thrown away for infection control reasons. LPN #1 stated she did not have a reason or excuse for scooping the dropped pill into the medication cup and administering the pill to R105. LPN #1 stated it was just her instinct. On 4/20/22 at approximately 5:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility pharmacy policy titled, "Oral Medication Administration" documented, "3. For solid medications: a. Pour or push the correct number of tablets or capsules into the soufflé cup, taking care to avoid touching the tablet or capsule unless wearing gloves." The policy did not include specific information regarding	F 880	practices are being followed during medication administration. 5. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, review will be completed on a random basis 6. Date of compliance 5/18/22	

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F 880	Continued From page 41 dropping a pill on the medication cart. No further information was presented prior to exit.	F 880		