STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495220	A. BUILDING _____ B. WING _____	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS NURSING CENTER	167 SPRING STREET HOT SPRINGS, VA 24445

(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 An unannounced Emergency Preparedness survey was conducted 8/9/2022 through 8/10/2022. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced (Medicare/Medicaid) standard survey was conducted 08/09/22 through 08/10/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey: (1). VA00053780 - substantiated [with deficient practice at F-563] The census in this 60 certified bed facility was 58 at the time of the survey. The survey sample consisted of 15 current Resident reviews and three closed record reviews.	F 000	1. Due to the nature of this deficiency, no corrective action is possible. 2. Visitation is always open for all residents in the facility currently in compliance with F 563 Right to receive visitors. 3. The current procedure for allowing visitors was reviewed and no changes are warranted at this time. Facility staff were educated on the resident's right to always receive visitors 8/20-8/24/22. 4. The Administrator is responsible for compliance. The Administrator/designee will monitor complaint and grievances to ensure that the resident's right to receive visitors of his or her choosing is observed one time per week. Any findings will be corrected immediately, and trends will be discussed at the facilities monthly QAPI committee to ensure compliance is sustained. 5. All corrective action was completed on 8/24/22.	
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the	F 563		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Crystal Larson LNHA | TITLE: Chief Admin Officer | (X6) DATE: 8/26/22

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

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F 563	Continued From page 1 consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on complaint investigation, clinical record review, staff interview, and family interview, the facility staff failed for one of 18 residents in the survey sample, Resident # 58, to offer compassionate care visits. The family of Resident # 58 was not offered compassionate care visits while visitation in the facility was restricted. The findings were: Resident # 58 was admitted with diagnosed that included chronic systolic congestive heart failure, hypertension, chronic atrial fibrillation, dysphagia, moderate protein-calorie malnutrition, hypothyroidism, chronic respiratory failure with hypoxia, pneumonia, and generalized muscle weakness. The resident was in the facility for five days and left before completion of the Admission Minimum Data Set.	F 563		

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F 563	Continued From page 2 According to a complaint narrative written by the resident's daughter-in-law, the resident was married for 67 years and was upset that, due to COVID, was only able to visit his wife through a window. The daughter-in-law also wrote that during telephone conversation, the resident said, "I just want to go ahead and die," and was begging to see his wife and hold her hand. Review of the Progress Notes in the resident's Electronic Health Record revealed the following Social Services note: 9/2/2022 - 10:34 a.m. Social Services - "...(Name of Resident) stated, 'I am ready to die, I am suffering.' Social Services reported the information to the DON (Director of Nursing) and ADON (Assistant Director of Nursing)...." At 2:20 p.m. on 8/9/2022, LPN # 2 (Licensed Practical Nurse), who serves as a Unit Manager, and who was familiar with the resident, was interviewed regarding Resident # 58 and visitation. According to LPN # 1, the resident was placed on isolation upon admission, consistent with COVID practices at that time, even though the resident had a rapid COVID test on the day of admission that was negative. Asked about visitation, LPN # 1 confirmed that the family had window visits with the resident. When asked about compassionate care visits, LPN # 1 said, "We did not offer compassionate care visits because he was not on comfort care." LPN # 1 provided the date the resident was placed on comfort care, which was the fourth day of the resident's stay.	F 563		

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F 563	Continued From page 3 At 9:10 a.m. on 8/10/2022, the resident's daughter-in-law was interviewed by telephone. Asked if the facility offered the family compassionate care visitation, the daughter-in-law said, "No. We could only do a window visit. They (the staff) would wheel him to a window and we would talk through a screen. We couldn't even touch him." On 8/10/2022 at 2:45 p.m., the facility's Operations Manager was interviewed regarding family visitation. According to the Operations Manager, the resident's daughter and daughter-in-law were allowed in the facility to do a room visit. However, the Operations Manager said he did a search of visitation logs and could find no documentation of visits made by the family. On 8/11/2022, four opportunities were made to contact the former facility Administrator for further information regarding the family's visitation and compassionate care visits. All four calls were not returned. QSO-20-39-NH Revised 3/30/21 includes the following about Compassionate Care Visits: "While end of life situations have been used as examples of compassionate care situations, the term 'compassionate care situations' does not exclusively refer to end of life situations. Examples of other types of compassionate care situations include, but are not limited to: A resident, who was living with their family before recently being admitted to a nursing home, is struggling with the change in environment and lack of family support." The findings were discussed during a meeting at	F 563		

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F 563	Continued From page 4 4:00 p.m. on 8/9/2022 that included the Administrator, Director of Nursing, and the survey team. COMPLAINT DEFICIENCY	F 563		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to ensure an accurate MDS (minimum data set) assessment for one of 18 resident's in the survey sample. Resident #59's discharge MDS assessment was coded as being discharged to the hospital instead of home. The Findings Include: Diagnoses for Resident #59 included: Compression fracture, dementia, adult failure to thrive, and dehydration. The most current MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 3/17/22. Resident #59's cognitive score was a 11 indicating moderately cognitively intact. During a closed record review, Resident #59 was added to the sample as a hospital discharge review. On 8/10/22 Resident #59's clinical record was reviewed. Section "A2100" of Resident #59's discharge MDS (dated 5/26/22) documented Resident #59 had been discharged to "Acute	F 641	1. The MDS assessment for resident #59 was corrected on 8/10/22 to reflect discharge to home with hospice and resubmitted. 2. All discharge MDS assessments in the last 30 days was audited on 8/12/22 and no other issues were noted. 3. The MDS coordinator was re-educated on the requirement for correct coding of discharge disposition on the MDS on 8/12/22. 4. The Director of Nursing (DON) is responsible for compliance. The DON/designee will audit all new discharge MDS assessments once per week to ensure compliance. Any findings will be corrected immediately, and trends will be reviewed at the facilities monthly QAPI committee to ensure compliance is sustained. 5. All corrective action was completed on 8/12/22.	

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F 641	Continued From page 5 Hospital." Review of Resident #59's progress notes dated 5/26/22 read in part "Resident being discharged to home today." On 08/10/22 at 2:15 PM, during a meeting with the director of nursing, administrator, and unit manager (license practical nurse, LPN #1) the above finding was presented. LPN #1 reviewed the documentation and verbalized that Resident #59 was discharged home and an error had been made on the discharge MDS assessment. No other information was presented prior to exit conference on 8/10/22.	F 641		
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 (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.	F 644		

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F 644	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure one of 18 residents (Resident #32) had a targeted resident review coordinated with the appropriate state designated authority according to the Level II PASARR (pre-admission screening and resident review). Findings include: Resident #32's diagnoses included, but were not limited to: major depressive disorder, severe recurrent psychotic symptoms, dependent personality disorder, and bipolar disorder. The resident's most recent MDS (minimum data set) was an annual assessment dated 06/24/22. This MDS assessed the resident with a cognitive score of 15 indicating the resident was intact for daily decision making skills. This MDS also assessed the resident with major depressive disorder, recurrent, severe with psych symptoms in Section I. (I0020B. Primary Medical Condition ICD). Resident #32 triggered in the LTCSP system for 'No PASARR with diagnoses'. The resident's clinical records were reviewed and no level II could be located. On 08/10/22 at approximately 12:45 PM, the SW (social worker) was asked for the information. The SW presented the information. The resident's level II dated 06/11/2021 documented that the resident would receive services of lesser intensity at the nursing facility, but also	F 644	1. The Level 2 PASSR for resident #32 was referred to Ascend for review on 8/12/22. 2. The medical records of all residents with Level 2 PASSAR were reviewed and updates were sent to Ascend on 8/15/22. 3. The Social Worker was educated on the process for tracking and ensuring residents with Level 2 PASSAR are sent to ascend for review on 8/12/22. A tracking tool was implemented to ensure compliance with this requirement is maintained on 8/12/22. 4. The Administrator is responsible for compliance. The Administrator/designee will audit the medical records of residents with Level 2 PASSAR once per month to ensure Level 2 PASSAR are sent to Ascend for review per the date on recommendations from Ascend. Any findings will be corrected immediately, and trends will be reviewed at the facilities monthly QAPI meeting. 5. Corrective action was completed on 8/15/22.	

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F 644	Continued From page 7 documented the following: "...A targeted resident review is scheduled in 120 days to further assess [name of resident] status in the nursing facility and his potential to transition to a community setting with appropriate support services..." The SW was asked if that review had been completed. The SW stated that she was not in that role at that time and would check, but did not have anything regarding the targeted review. A policy was requested on pre-admission screening and resident review (PASARR) At approximately 1:00 PM, the administrator stated that they can't find where that review had been completed or had taken place for this resident. The policy was presented and documented, "...incorporating the recommendations from the PASARR level II determination and evaluation report into the resident's assessment, care planning and transitions of care..." No further information and/or documentation was presented prior to the exit conference on 08/10/22.	F 644		
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 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	F 656		

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F 656	Continued From page 8 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: Based on staff interview and clinical record review, the facility failed to develop care plans for two of 18 resident's in the survey sample. Resident #7 did not have a care plan for antidepressant medication and mood. Resident	F 656	1. The Care plan for resident #7 was updated to include a care plan for antidepressant medication and mood and resident # 27 was updated to include a care plan for gastrostomy tube/tube feeding care and management. 2. Residents who have gastrostomy tube feeding and antidepressant medication/depressed mood were at risk. The Care plans for residents who have Gastrostomy tube feeding and antidepressant medication/depressed mood were audited, and no other issues were noted. On 8/12/22. 3. The MDS coordinator was re-educated on the regulatory requirement for development of person-centered care plans on 8/12/22. 4. The Director of Nursing (DON) is responsible for compliance. The DON/designee will audit 10 care plans per week to ensure residents with new orders for gastrostomy tube feeding and antidepressant medication/depressed mood have care plans that address these issues. Any findings will be corrected immediately, and trends will be reviewed at the	

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F 656	Continued From page 9 #27 did not have a complete care plan for tube feeding care and management. The Findings Include: 1. Diagnoses for Resident #7 included: Respiratory failure, chronic obstructive pulmonary disease, anxiety, and depression. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 6/5/22. Resident #7's cognitive score was a 15 indicating cognitively intact. Section "D0200 (B) documented Resident #7 had felt "down, depressed, or hopeless" 7 to 11 days of the 14 day look back period. On 8/10/22 Resident #7's physician orders were reviewed and documented Sertraline 200 MG (milligrams) and Trazadone 100 MG (antidepressants) were ordered daily for depression and anxiety. Resident #7's care plan was then reviewed and did not evidence a care plan for mood, psychosocial or antidepressant medication. On 8/10/22 at 1:24 PM the MDS coordinator (license practical nurse, LPN #2) was interviewed. LPN #2 reviewed Resident #7's care plan and verbalized the care plans for mood and antidepressants were over-looked and would be corrected. On 08/10/22 at 2:15 PM the above information was presented to the director of nursing and administrator, during an end of day meeting. No other information was presented prior to exit conference on 8/10/22.	F 656	facilities monthly QAPI committee to ensure compliance is sustained. 5. All corrective action was completed on 8/12/22.	

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F 656	Continued From page 10	F 656		

2. The facility failed to develop a comprehensive care plan for Resident #27 for gastrostomy tube/tube feeding care and management.

Resident #27's diagnoses included, but were not limited to: history of cerebral infarct (stroke) due to occlusion/stenosis, moderate intellectual disability, contractures, chronic respiratory failure, chronic pain syndrome, epilepsy, GERD (gastroesophageal reflux disease), persistent vegetative state, abdominal distention, dysphasia and presence of gastronomy (peg) tube.

The resident's most current MDS (minimum data set) was a quarterly assessment dated 06/15/22. This MDS assessed the resident's cognitive status as '00', indicating the resident had severe impairment in daily decision making skills. The resident was also assessed as requiring total assistance from two or three staff for all ADSL's (activities of daily living). This MDS also assessed the resident in Section B0600. Speech Clarity as having no speech. In Section B0700. Makes Self Understood and Section B0800. Ability To Understand Others it documented the resident as, Rarely/never understands. This MDS also assessed the resident as having a abdominal (PEG) tube and receiving 51% or more of total calories through tube feeding and as receiving 501 cc/day or more per day of fluid intake.

On 08/09/22 Resident #27 was observed multiple

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F 656	Continued From page 11 times throughout the day without a peg tube dressing to the resident's peg tube site. On 08/09/22 Resident #27 was observed with the resident's HOB (head of bed) at a 25 degree angle during tube feeding administration. The resident's physician's orders were observed. The resident had an order for, "Peg care q [every] shift and prn [as needed]..." There were no specific orders for care and treatment for Resident #27 regarding the peg tube/peg tube site and/or enteral feeding guidelines. The resident's CCP (comprehensive care plan) was reviewed and documented, "...requires feeding by gastrostomy tube secondary to dysphasia secondary to anoxic brain injury...check placement...crush meds...flushes per order, G tube feeding per MD order, HOB elevated during feeding per order...NPO (nothing by mouth)...observe or aspiration...treatment to g tube insertion site as ordered..." The resident had no physician's order regarding keeping HOB elevation and/or treatment to the resident's peg tube site. On 08/10/22 at 10:13 AM, LPN #2 (MDS/Careplan) was interviewed regarding Resident #27's care plan. The LPN was asked if the resident should have something specific on the care plan regarding a dressing changes, having the HOB (head of bed) elevated, and monitoring fluid intake since the resident is on tube feeding. The LPN stated, "Yes Ma'am" as far as the dressing change and HOB. The LPN stated that as far as monitoring fluid intake she would check with the regional nurse. The LPN	F 656		

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F 693	Continued From page 13 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, staff interview, clinical record review and facility document review, the facility staff failed to ensure specific physician's orders and interventions were in place for the the care, treatment and management of a gastrostomy tube for one of 18 residents in the survey sample, Resident #27. Findings include: Resident #27's diagnoses included, but were not limited to: history of cerebral infarct (stroke) due to occlusion/stenosis, moderate intellectual disability, contractures, chronic respiratory failure, chronic pain syndrome, epilepsy, GERD (gastroesophageal reflux disease), persistent vegetative state, abdominal distention, dysphagia and presence of gastronomy (peg) tube. The resident's most current MDS (minimum data set) was a quarterly assessment dated 06/15/22. This MDS assessed the resident's cognitive status as '00', indicating the resident had severe impairment in daily decision making skills. The resident was also assessed as requiring total assistance from two or three staff for all ADL's (activities of daily living). This MDS also assessed	F 693		

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F 656	Continued From page 12 was made aware that she had included on the resident's careplan for treatment to the peg site per the physician's orders and the HOB elevated per order, but the interventions were not specific and there were no physician's orders for those items. The LPN stated that for HOB the bed should be at 30 degrees or higher for a resident with tube feeding. At approximately 10:30 AM, the LPN returned and stated that the regional nurse stated that fluid intake information did not need to be on the care plan. On 08/10/22 at 2:30 PM, the administrator, DON (director of nursing), ADON, and corporate consultant were made aware that the resident's comprehensive care plan (CCP) was not developed with specific, specialized care and treatment interventions for this particular resident. No further information and/or documentation was presented prior to the exit summary on 08/10/22.	F 656		
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	F 693		

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F 693	Continued From page 14 the resident in Section B0600. Speech Clarity as having no speech. In Section B0700. Makes Self Understood and Section B0800. Ability To Understand Others it documented the resident as, Rarely/never understands. This MDS also assessed the resident as having a abdominal (PEG) tube and receiving 51% or more of total calories through tube feeding and as receiving 501 cc/day or more per day of fluid intake. On 08/09/22 at 9:21 AM, Resident #27 was observed in bed without a shirt on, covered with a sheet from the navel down to the feet. The resident's peg tube was exposed. There was no dressing in place to the peg tube site. The tube feeding machine was sounding/beeping and observed, along with the TF (tube feeding) bottle and water flush bag. The bottle was dated 08/08/22 and timed 9:00 PM, documented 95ml/hr (milliliters per hour). The flush bag was dated the same and documented, 240 ml every 4 hours. LPN (Licensed Practical Nurse) #2 came into the room to address the machine beeping, the LPN turned the machine off and stated that she would tell LPN #4 (the resident's nurse for the day) that the resident was done. LPN #2 exited the room. At approximately 9:28 AM on 08/09/22, LPN #1 (also known as the UM/unit manager) entered the room and stated, "Is it beeping." The UM was made aware that LPN #2 had just come in an shut the machine off due to it beeping and stated that the resident was done. The UM stated that the resident was not done and restarted the machine. The UM was asked about the feeding machine readings, the UM stated that the resident gets 95ml/hr of feeding and 280 every 4	F 693	1. The head of bed for resident #27 was immediately adjusted to 30 degrees on 8/10/22 by the Unit manager. LPN #2 was educated on the requirement to keep head of bed at 30 degrees while tube feeding is being administered on 8/10/22. The Unit manager contacted the Nurse practitioner (NP) on 8/9/22 and made her aware of the machine being cleared and total intake is unknown and received a verbal order to do a one-time manual flush of free water. The Unit Manager also corrected the flush and infusion rate per physician order. On 8/10/22 resident #27 physician orders and treatment records were updated by the Unit Manager per verbal order from the NP to include a treatment to the peg site and total calculation of intake. 2. There are no other residents with tube feedings in the facility. 3. The policy "Enteral Feeding Guidelines" was reviewed on 8/10/22 and no changes are warranted at this time. Licensed nurses were provided re-education on this policy including head of bed at 30 degrees while tube feeding is being administered, obtaining, and following physician orders for	

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F 693	Continued From page 15 hours of flush. The bottle of TF hanging had approximately 1100 cc left in bottle (approx 1500cc bottle) and the water bag flush had approximately 700 cc remaining in bag (approx 1000cc bag). On 08/09/22 at 11:26 AM, the resident was again observed. There was no dressing in place to the peg tube site. The resident's tube feeding was again observed and again was sounding/beeping. The rate on the machine was set for 95ml/hr and the flush on the machine was reading, 'flush 240 ml every 0 hours, amount infused (for flush) is 0' this is what was showing on the machine. The flush bags again has approximately 700cc remaining in the bag, as observed earlier. On 08/09/22 at 1:43 PM, the UM was again asked about the resident's tube feeding. The UM stated that it should be getting ready to come down. The UM was asked if I&O (intake and output) records (specifically intake records) are kept on this resident and the UM stated, "No." The UM was asked about the resident's physician's orders and were asked to pull them up. The UM pulled the resident's orders up and stated that the TF is to start at 9PM and come down at 2PM the next day. The UM was asked if when the pump was shut down earlier by LPN #2 does the machine clear it's settings. The UM stated that the setting are not cleared, they have to cleared manually. The UM stated that an error had read on the machine earlier and that she had cleared the TF setting, but not the flush setting. The UM was asked to go to the resident's room and check the settings/volume infused. The resident was again observed without a dressing to the peg tube site. The UM observed the machine settings of 0 (amount infused) for flush	F 693	treatment of the peg site and the process for documenting adequate intake and flushes through the tube feeding 8/21-8/25/22. 4. The Director of Nursing (DON) is responsible for compliance. The DON/designee will audit the medical record of the resident with a gastrostomy tube feeding to ensure appropriate documentation of treatments, flushes and intake monitoring one time per week. Additionally, the DON/designee will observe resident three times per week to ensure that peg tube dressing is applied per the physician order, the settings on the pump are correct per physician orders and the head of bed is at 30 degrees. Any findings will be corrected immediately, and trends will be reviewed at the facilities monthly QAPI committee to ensure compliance is sustained. 5. All corrective action was completed on 8/12/22.	

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F 693	Continued From page 16	F 693		

and that it was set to infuse every 0 hour. The UM was made aware that this didn't make sense and was very confusing as the orders and the machine readings did not match. The UM stated that she would notify the NP (nurse practitioner) to see what she wants to do. The UM was asked how do you know what the resident is actually getting and what is actually infused, if there is no intake records. The UM stated that it's the volume is included on the physician's orders to be infused. The UM was asked or a policy and procedure on TF/peg tube care/maintenance/feeding and flush.

On 08/09/22 at 1:58 PM, The UM stated that the NP ordered to do a one time manual flush and stated that she did not know how much the resident had actually received due to the machine readings and tube feeding equipment.

The resident's physician's orders were reviewed and documented, "...[Name of TF formula] 1.2 @ 95ml/h for total of 1615 ml total kcal [kilocalories] 1398 in 24 hours Stop at 1400, Free water flush via pump of 280ml q4 hours Minimum volume to infuse is 1445, please notify MD/FNP if minimum volume not met..."

The resident's CCP (comprehensive care plan) was reviewed and documented, "...requires feeding by gastrostomy tube secondary to dysphagia secondary to anoxic brain injury...check placement...crush meds...flushes per order, G tube feeding per MD order, HOB elevated during feeding per order...NPO (nothing by mouth)...observe or aspiration...treatment to g tube insertion site as ordered..."

The policy was presented and reviewed. The

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F 693	Continued From page 17 policy titled, "Enteral Feeding Guidelines" documented, "...providing residents with the highest level of care...provide safe administration of enteral feedings...administration bottles and/or bags and tubing are to be marked with the resident's name and date...feeding bottles and tubing are to be changed per manufacturer's guidelines...verify the resident's physician's orders...position resident...keep the head of bed at a minimum of 30 degrees...utilize feeding tubes in accordance with current clinical standards of practice...the resident's plan of care will address the use of feeding tube, including strategies to prevent complications...examination and cleaning of the insertion site in order to identify, lessen, or resolve possible skin irritation and local infection...frequency of and volume used for flushing...and what to do when a prescriber's order does not specify...direction for staff regarding the conditions and circumstances under which a tube is to be changed will be provided...when to replace and/or change a feeding tube ...as ordered/scheduled by the physician...when a long term feeding tube comes out unexpectedly, or when the tube is worn or clogged...documentation of all nutritional formulas and flush amounts in the electronic health record...direction for staff regarding how to manage and monitor the rate of flow...use of pump...The resident's plan of care will direct staff regarding proper positioning of the resident consistent with the individual needs...notify and involve physician...of any complications..." On 08/10/22 at 9:18 AM, the resident was again observed. The resident's bed was set at a 25 degrees, tube feeing infusing. The resident's feeding pump was set to 95 ml/hr and the flush	F 693		

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F 693	Continued From page 18 set at 280 ml/every 4 hours. According to the TF pump, the feed volume infused read 766 ml at this time. The water flush, amount infused on the pump read 1400 ml. The bottle documented the time of 9PM [start] to 2 PM [finish] and was dated 08/10/22. The water flush bag had the date written 8/9 with a start time of 2100. The TF bottle had approximately 3/4 of feeding remaining in the bottle. The water bag flush was approximately 1/2 full. On 08/10/22 at 9:30 AM, the UM entered the room and asked if the machine was beeping again. The UM looked at the machine and then looked at the resident's bed and adjusted the head of bed higher for the resident. The UM was made aware that the bed height had been set at 25 degrees prior to that change. The UM was made aware that the volume infused shown on the pump and the amount remaining hanging and the amount ordered by the physician did not add up or make sense and was again asked if intake records are kept for this resident regarding the amount of TF and water flushes the resident is taking in each shift. The UM again stated that they do not keep intake records on this resident. The UM was made aware that Resident #27 did not have a dressing to the gastrostomy site during multiple observations on 08/09/22. The UM asked if the resident had a dressing in place now and pulled the resident's sheet down exposing the resident's peg tube and there was now a dressing in place. The UM was made aware that the resident's orders were reviewed and there was no evidence of an order for a dressing to the resident's peg tube site and there was no documentation on the resident's MARs/TARs (medication/treatment administration records) regarding a dressing to the site.	F 693		

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F 693	Continued From page 19 The UM stated that she would call the night shift nurse and try to get information and/or explanation regarding the TF machine reading and the amounts observed and see if something had happened. The UM stated that she didn't know unless a new bottle was hung. The UM stated that it doesn't make sense or add up. The UM stated that there is not a specific time documented on the bottle that was hung and that time should be documented when it is actually started. The UM was made aware that nothing was documented in the nursing notes regarding anything unusual pertaining to Resident #27 or the resident's peg tube, feeding and/or flushes. On 08/10/22 at 10:36 AM, the UM stated that she had spoke the NP, and she stated that the resident's weight has been stable and that they are going to adjust and extend the order to get the total volume ordered and then just resume the regular order at 8 pm tonight. On 08/10/22 at 2:14 PM, the administrator, DON (director of nursing), ADON, corporate consultant were made aware of concerns regarding the lack of specific physician's orders for the care and treatment of the Resident #27's peg tube/tube feeding/flushes and the lack of interventions to assess and monitor a resident with a gastrostomy tube. No further information and/or documentation was presented prior to the exit conference.	F 693		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		

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F 812	Continued From page 20 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility documents, the facility failed to ensure food was stored in a manner to ensure food safety, and kitchen staff failed follow proper handwashing procedures. The findings were: 1. At approximately 9:30 a.m. on 8/9/2022, during a tour of the Kitchen, the following was observed in the reach-in cooler: An open package of lunch meat in a zip-lock bag was undated. Asked about the lunch meat, the Dietary Manager said, "That's sliced ham." An open package of grated cheese, identified by the Dietary Manager as Mozzarella, wrapped in	F 812	1. The sliced ham, mozzarella cheese, parmesan cheese, sliced turkey and cheddar cheese and 2 pitchers of drinks were immediately discarded on 8/9/22. The dietary aide observed was re-educated on hand washing and demonstrated return demonstration on 8/10/22. 2. The kitchen was audited by the dietary manager on 8/9/22 to identify other open food items that were not labeled and dated, and no other items were found. Also, on 8/9/22 and 8/10/22 handwashing competencies were completed on all dietary staff and no deficient practices were noted. 3. Dietary staff were re-educated on the process for label and dating all food items that are open with item name, date opened and date use by on 8/12/22. Dietary staff were observed for competency in handwashing on 8/9/22 and 8/10/22. 4. The dietary manager is responsible for compliance. The dietary manager/designee will complete an audit 3 x per week to ensure all food items that are open are appropriately labeled and dated. Any items not	

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F 812	Continued From page 21 saran wrap was undated. An open package of grated cheese, identified by the Dietary Manager as Parmesan, wrapped in saran wrap was undated. An open package of lunch meat, identified by the Dietary Manger as sliced turkey, wrapped in saran wrap was undated. A pitcher, approximately one-quarter full of what appeared to be orange drink, was not labeled or dated. A pitcher full of what appeared to be fruit drink was not labeled or dated. The Dietary Manager acknowledged the food items were not dated or labeled. Review of the facility's Dietary and Food Handling revealed the following in the section titled Proper Food Handling: "Leftovers must be dated, labeled, covered, cooled and stored (within 1/2 hour) in a refrigerator, not at room temperature. Foods must be labeled with the date when opened and discarded, if not used, within 72 hours." 2. At 11:30 a.m. on 8/9/2022, during observation of preparation for the lunch meal, a staff member engaged in placing food on the steam table went to the handwashing sink. The staff member wet her hands, lathered with soap, and then rinsed her hands. After rinsing her hands, the staff member turned off the water and then obtained paper towels to dry her hands. Review of the facility's Dietary and Food Handling revealed the following in the section titled Personal Hygiene: "Handwashing procedure: a) Wet hand thoroughly.	F 812	labeled and dated will be discarded immediately. The dietary manager/designee will also complete handwashing observations on dietary staff 3 times per week to ensure proper handwashing is being observed and provide on the spot education as needed and trends will be reviewed at the facilities monthly QAPI committee to ensure compliance is sustained. 5. All corrective action was completed on 8/12/22.	

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F 812	Continued From page 22 b) Lather with soap to wrists and use friction. c) Rinse, clean nails. d) Lather second time. e) Rinse with water running from wrist down f) Dry on paper towel g) Turn faucet off with paper towel This findings were discussed during a meeting at 4:00 p.m. on 8/9/2022 that included the Administrator, Director of Nursing, and the survey team.	F 812		