STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495400	A. BUILDING _____ B. WING _____	04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CULPEPER	12425 VILLAGE LOOP CULPEPER, VA 22701

(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 4/5/22 through 4/7/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/5/22 through 4/7/22. 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 47 certified bed facility was 41 the time of the survey. The survey sample consisted of 19 current record reviews and 2 closed record reviews.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		4/22/22

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

Electronically Signed | 04/22/2022

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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paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal

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hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

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F 623	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to notify the ombudsman for a transfer to the emergency room for one of 21 residents in the survey sample, Resident #8 (R8). The findings include: On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/13/2022, the resident scored a four out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is severely cognitively impaired for making daily decisions. The nurse's note dated, 3/27/2022 at 9:39 p.m. documented in part, "@ (at) 2100 (9:00 p.m.) this writer heard yelling from resident's room. Upon entering, resident was observed laying on his right side on bathroom floor. Stated, 'he fell while transferring from toilet back to wheelchair.' Denies hitting his head but c/o (complained of) left leg pain. Resident remained on floor with pillows cushioning his head and right arm. Rescue Squad called for further assessment and resident was transferred to[name of hospital] ED (emergency department) for evaluation @ 2200 (10:00 p.m.) Care plan goals sent and written notice of transfer initiated." A request was made on 4/6/2022 at 1:17 a.m. to ASM (administrative staff member) #1, the interim administrator, for the notification to the ombudsman of the transfer to the hospital for R8. An email, documenting the residents that were	F 623	1. Facility staff failed to notify the ombudsman for a transfer to the emergency room for one of 21 residents. The identified resident was found not to be affected by the deficient practice. 2. All residents who transferred to the ER and returned to the facility without proper notification to the ombudsman, have the potential to be affected by the deficient practice. 3. Social Worker responsible for notifying the ombudsman of transfers to the ER was re-educated immediately by Surveyor on site 4/6/22; to include on the ombudsman notice all residents who go to ER, regardless if they return without hospital admission. 4. DON/Designee will audit 100% of all resident transfers/discharges for proper ombudsman notification monthly x 2 months. All findings will be reported to the QAPI committee for continued review and oversight. 5. 5/9/22 and ongoing	

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F 623	Continued From page 4 transferred out of the facility for the month of March 2022, was presented. R8's name was not on the list. An interview was conducted with OSM (other staff member) #2, the social worker, on 4/6/2022 at 3:39 p.m. When asked the process for notifying the ombudsman of transfers out of the facility, OSM #2 stated she completes a form monthly and sends it to the state ombudsman. When asked what type of transfers, OSM #2 stated residents that are transferred out fo the hospital and admitted, if the resident goes to the emergency room and comes back then she never does them. The facility policy, "Facility Initiated Transfer and Discharge" documented in part, "The facility will send a copy of the notice to a representative of the Office of the State Long-Term Ombudsman...Copies of notices for emergency transfers will be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis." ASM #1, ASM #2, the director of nursing, and ASM #3, the quality assurance/staff development/infection preventionist nurse were made aware of the above findings on 4/6/2022 at 5:19 p.m. No further information was provided prior to exit.	F 623		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658		4/22/22

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F 658	Continued From page 5 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to clarify two physician orders for the treatment of pain for one of 21 residents in the survey smaple, Resident # 194 (R194). The findings include: On the Initial Nursing Assessment, dated, 3/30/2022, R194 was documented as being alert but not oriented. The physician order dated 3/30/2022, documented, "Acetaminophen (Tylenol - used to treat mild to moderate pain) (1) 500 mg (milligrams) tablet 1 tab (tablet) by mouth every 6 hours as needed for pain. A second order dated, 3/30/2022, documented, "Celebrex (used to relieve pain, tenderness, swelling and stiffness caused by osteoarthritis, rheumatoid arthritis and to relieve other types of short-term pain including pain caused by injuries, surgery and other medical or dental procedures, or medical conditions that last for a limited time.) (2) 200 mg capsule - 200 mg by mouth twice a day as needed for pain." The April 2022 MAR (medication administration record) documented the above orders. The Tylenol was administered once on 4/2/2022 at 7:25 p.m. and the Celebrex was administered on 4/3/2022 at 3:41 p.m. The comprehensive care plan dated, 3/30/2022, documented in part, "Problem: Alteration in	F 658	1. Facility staff failed to clarify two physician orders for the treatment of pain for one of 21 residents. The identified resident was found not to be affected by the deficient practice. 2. All residents with physician orders for more than one pain medication have the potential to be affected by the deficient practice. An audit has been completed on 100% of all current residents who have more than one prn pain medication order, to ensure clarity of the orders for proper pain management. This audit has been completed as of 4/22/22. 3. All Licensed Staff will be re-educated on the requirement of clarifying pain management orders to ensure an effective pain management program for residents. 4. DON/Designee will audit 50% of residents who have more than one pain medication order, to ensure orders have been clarified for appropriate use of each pain medication. Audits will be completed weekly x 4 weeks, then monthly x2 months. All findings will be reported to the QAPI committee for continued review and oversight. 5. 5/20/22 and ongoing	

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comfort/pain related to compression deformities at T4 - T 6 (thoracic level 4 - 6), back pain, post fall and hx (history of) repeated falls." The "Approach" documented in part, "Administer pain meds (medications) per MD (medical doctor) order. Evaluate effectiveness of pain management prn (as needed)."

An interview was conducted with LPN (licensed practical nurse) #1 on 4/6/2022 at 4:53 p.m. The two medication orders were reviewed with LPN #1. When asked how she knows which one to give, LPN #1 stated she had only worked with R194 twice. LPN #1 stated there is no pain scale so I'm not sure which to give for what. When asked if those orders should be clarified, LPN #1 stated, yes.

A request for the facility policy on clarifying physician orders was requested on 4/7/2022 at approximately 10:00 a.m. At 10:50 a.m. ASM (administrative staff member) #2, the director of nursing, stated the facility does not have a policy on clarifying physician orders. When asked the standard of practice the facility follows, ASM #2 stated the facility follows their policies.

According to Potter and Perry's, Fundamentals of Nursing, 7th edition, page 268 documents the following statements: "Clarifying an order is competent nursing practice, and it protects the client and members of the health care team. When you carry out an incorrect or inappropriate intervention, it is as much your error as the person who wrote or transcribed the original order."

ASM #1, ASM #2, the director of nursing, and ASM #3, the quality assurance/staff

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F 658	Continued From page 7 development/infection preventionist nurse were made aware of the above findings on 4/6/2022 at 5:19 p.m. No further information was provided prior to exit. (1). This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a699022.html.	F 658		
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, staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to store respiratory equipment in a sanitary manner for two of 21 residents in the survey sample, Residents # 193 (R193) and # 194 (R194). The findings include:	F 695	1. Facility staff failed to store respiratory equipment in a sanitary manner for 2 of 21 residents. The identified residents were found not to be affected by the deficient practice. Immediate action was taken by facility staff on 4/6/22 to correct these issues. 2. All residents with respiratory equipment have the potential to be affected by the	4/22/22

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F 695	Continued From page 8 1. For R193, the facility staff failed to store his CPAP (continuous positive airway pressure prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems.) (1), in a sanitary manner. On the most recent MDS (minimum data set) assessment, a Medicare assessment, with an ARD (assessment reference date) of 3/25/2022, 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 of R193's room on 4/5/2022 at approximately 1:15 p.m. A CPAP machine was sitting on the night stand. The tubing for the CPAP machine was hanging over the machine with no covering over it. When asked if the staff had given him a bag or something to store the tubing for his CPAP machine when it wasn't in use, R193 stated the staff had not provided anything like that. A second observation was made on 4/6/2022 at 8:15 a.m. and 8:50 a.m. the CPAP machine tubing was again noted hanging over the CPAP machine on the night stand. The comprehensive care plan dated, 4/7/2022, failed to evidence the storage of the CPAP mask/tubing when not in use. An interview was conducted on 4/6/2022 at 4:53 p.m. with LPN (licenses practical nurse) #1. When asked how a CPAP mask/tubing should be stored when it is not in use by the resident, LPN #1 stated it should be stored in a dated Ziploc	F 695	deficient practice. 100% of residents with respiratory equipment were audited on 4/8/22 for proper storage of respiratory equipment, all found to be compliant. 3. All Licensed Staff will be re-educated on proper sanitary storage of respiratory equipment. 4. DON/Designee will audit 100% of residents with respiratory equipment, to ensure compliance with storage; audit will be completed weekly x4 weeks, then monthly x 2 months. Any incorrect findings will be corrected immediately. All audit findings will be reported to the QAPI Committee for continued review and oversight. 5. 5/20/22 and ongoing	

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bag. When asked the purpose of keeping the tubing in the plastic bag, LPN #1 stated it was to keep the germs off of it.

The physician order dated, 4/7/2022, documented, "CPAP mask and tubing to be stored in dated Ziploc bag when not in use. 11-7 (11:00 p.m. to 7:00 a.m.) shift to initiate new Ziploc bag each week. Date when changed."

The facility policy, "Use and Maintenance of BI-PAP/CPAP Machine" failed to evidence documentation of how the tubing/mask is to be stored when not in use. The policy, documented in part, "1. 7-3 (7:00 a.m. to 3:00 p.m. shift) daily - wash BI-PAP/CPAP mask and humidifier chamber daily with soapy water, then rinse and let air dry."

ASM #1, ASM #2, the director of nursing, and ASM #3, the quality assurance/staff development/infection preventionist nurse were made aware of the above findings on 4/6/2022 at 5:19 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/ency/article/001916.htm

2. For R194, the facility staff failed to store a CPAP mask/tubing in a sanitary manner.

On the Initial Nursing Assessment, dated, 3/30/2022, R194 was documented as being alert but not oriented.

Observation was made of R 194's room on

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4/5/2022 at approximately 1:30 p.m. The CPAP machine was observed sitting on the night stand. The tubing/mask were hanging over the machine, not store in any manner.

A second observation was made on 4/6/2022 at 2:18 p.m. The resident was in their wheelchair watching TV. The CPAP tubing/mask were hanging over the headboard of the bed. Not in any type of covering.

The physician order dated, 4/1/2022, documented, "BI-CPAP Use: 1. fill chamber to fill line with distilled water only. 2. To attach the water chamber to device, open top of machine, place chamber in device, chose top and secure. 3. Attach tubing to back of device and other end of the tube to the mask. Switch on device by pressing on/off button at bedtime."

The comprehensive care plan dated, 4/3/2022, failed to evidence documentation related to the storage of a CPAP machine.

An interview was conducted on 4/6/2022 at 4:53 p.m. with LPN (licenses practical nurse) #1. When asked how a CPAP mask/tubing should be stored when it is not in use by the resident, LPN #1 stated it should be stored in a dated Ziploc bag. When asked the purpose of keeping the tubing in the plastic bag, LPN #1 stated it was to keep the germs off of it.

ASM #1, ASM #2, the director of nursing, and ASM #3, the quality assurance/staff development/infection preventionist nurse were made aware of the above findings on 4/6/2022 at 5:19 p.m.

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F 695	Continued From page 11 No further information was provided prior to exit.	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to have a complete pain management program for one of 21 residents in the survey sample, Resident # 24 (R24). The facility staff failed to clarify the physician orders, document the location of pain and document the level of pain for R24. The findings include: On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 2/24/2022, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions. In Section J - Health Conditions - R24 was coded as having frequent pain, the limited her day-to-day activities because of pain. The resident rated the pain as a "6" on a pain scale of 0 to 10, 10 being the worse pain ever felt and zero being no pain. The physician orders dated, 3/11/2022, documented, "Acetaminophen (Tylenol - used to	F 697	1. Facility Staff failed to have a complete pain management program for one of 21 residents; by failing to clarify physician orders, failing to document the location of pain, and failing to document the level of pain. The identified resident was found not to be affected by the deficient practice. 2. All residents with a need for pain management program have the potential to be affected by the deficient practice. 100% audit completed on all residents with a pain management program to ensure completeness of deficient components. Audit completed as of 4/22/22. 3. All Licensed Staff will be re-educated on the requirement of having a complete pain management program, to include order clarity and proper documentation of location of pain and pain level. 4. DON/Designee will audit 50% of resident's Medication Administration Records (MARS) to ensure proper order	4/22/22

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	495400	A. BUILDING _____ B. WING _____	04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CULPEPER	12425 VILLAGE LOOP CULPEPER, VA 22701

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F 697	Continued From page 12 treat mild to moderate pain) (1)325 mg (milligrams) tablet, 2 tabs (tablets) by mouth every 6 hours as needed for pain." The physician order dated, 3/11/2022, documented, "Hydromorphone (Dilaudid) (used to relieve moderate to severe pain) (2) 2 mg tablet, 4 mg every 4 hours as needed for pain." The March 2022 MAR (medication administration record) documented the above medication orders: The Tylenol was administered on the following dates: time and with a pain scale" 3/19/2022 at 4:44 a.m. - pain scale of 3, no location documented 3/21/2022 at 7:29 p.m. - no pain scale documented, resident complained of "body aches." The March 2022 MAR documented the above medication orders. The Hydromorphone was administered on the following dates, time with a pain scale: 3/14/2022 at 5:00 p.m. -pain scale of 4 - no location documented. 3/19/2022 at 9:15 p.m. - pain level of 6 - no location documented. 3/20/2022 at 4:18 p.m. - pain level of 5 - no location documented. 3/21/2022 at 8:52 p.m. - pain level of 0 - location right hip and knee pain. 3/26/2022 at 3:06 p.m. - pain level of 0 - location right knee. 3/28/2022 at 3:08 p.m. - pain level of 5 - no location documented. Review of the nurse's notes for March failed to document the location or pain scales above. The April 2022 MAR documented the above medication orders. The Hydromorphone was	F 697	clarifications and complete documentation (including pain location and pain level); audit will be completed weekly x 4 weeks and then monthly x2 months. All findings will be reported to the QAPI Committee for continued review and oversight. 5. 5/20/22 and ongoing	

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F 697	Continued From page 13	F 697		

administered on the following dates, time with a pain scale:
4/1/2022 at 2:03 p.m. - pain scale of 6, no location documented.
4/3/2022 at 4:28 p.m. - pain scale of 3, no location documented.
4/4/2022 at 7:45 p.m. - pain scale of 5, no location documented.
4/6/2022 at 7:47 a.m. - pain scale of 4, no location documented.
Review of the nurse's notes for April 2022 failed to evidence documentation of the location of the pain when the medication was administered.

The comprehensive care plan dated, 12/21/2021, documented in part, "Problem: Alteration in comfort/pain related to...joint pain and right sided pain from falls PTS (prior to admission) that lead to R (right) hip fracture currently NWB (non - weight bearing) on RLE (right lower extremity)." The "Approaches" documented in part, "Complete pain assessment upon admission, quarterly and PRN (as needed) and when intensity/location of pain changes. Utilize pain scale to assess for intensity of pain."

An interview was conducted with LPN (licensed practical nurse) #1, on 4/6/2022 at 4:53 p.m. When asked the process for giving a pain medication, LPN #1 stated the nurse should assess the resident if in pain, try to do non-pharmacological interventions, offer repositioning, ice or heat packs. LPN #1 stated, skilled residents are alert and oriented and many times refuse non- pharmacological interventions. The above two medication orders were reviewed with LPN #1. LPN #1 stated she knew [R24] didn't have a scale, usually she's in moderate to severe pain, but sometimes [R24] requests the Dilaudid.

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F 697	Continued From page 14	F 697		

When asked where the pain scale is documented, LPN #1 stated it should be on the MAR. When asked where the location is documented, LPN #1 stated, it's in a note on the MAR. When asked if a pain scale should be documented with the pain medications, LPN #1 stated those medications should have some kind of parameters to give like mild to moderate pain or moderate to severe pain or by the pain scale.

The facility policy, "Resident Comfort/Pain Management" documented in part, "The physician and staff in collaboration with the resident/resident's representative will establish a treatment regiment based on considerations of the following: a. The resident's medical condition. b. Current medication regimen. c. Nature, severity and cause of the pain. d. Course of the illness and e. Treatment goals....Pain management interventions shall reflect the sources, type and severity of pain... Pain Scale will be used each tine a prn (as needed) pain medication is administered. Pain Scale is posted in each MAR binder. Pain rating will be recorded along with the reason for the medication and with the results."

ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, and ASM #3, the quality assurance/staff development/infection preventionist nurse were made aware of the above findings on 4/6/2022 at 5:19 p.m.

No further information was provided prior to exit.

(1). This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html.

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F 697	Continued From page 15 (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682013.html.	F 697		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §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 facility document review, it was determined the facility staff failed to maintain clean kitchen equipment in one of two kitchens, the main kitchen. The findings include: Observation was made of the main kitchen on 4/5/2022 at 11:28 a.m. The oven racks appeared to be covered in a brown substance. When asked	F 812	1. No residents were found to be affected by the deficient practice. 2. All residents were at potential risk related to the deficient practice of the dirty oven racks, based upon the potential for debris to get into food that is baked in the ovens. The oven racks were cleaned thoroughly 4/5/22.	4/22/22

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F 812	Continued From page 16 what the cleaning schedule was, OSM (other staff member) #3, the executive chef, stated they should be cleaned on a weekly basis, but may have been missed last week. When asked if they could provide documentation when the ovens were cleaned last, OSM #1, the certified dietary manager, stated it was unlikely that they could provide that. On 4/6/2022 at 10:41 a.m. OSM #1 was asked if they found the documentation of the oven having been cleaned, OSM #1 stated, she doubted [OSM #3] could find that documentation. The facility policy, "Cleaning and Sanitizing of Work Surfaces." documented in part, "When cleaning fixed equipment, (mixers, slicers, and other equipment that cannot be readily immersed in water), the removable parts are washed and sanitized and non-removable parts are cleaned with detergent and hot water." ASM #1, ASM #2, the director of nursing, and ASM #3, the quality assurance/staff development/infection preventionist nurse were made aware of the above findings on 4/6/2022 at 5:19 p.m. No further information was provided prior to exit.	F 812	3. A new weekly sanitation schedule will be implemented for the oven/racks. A new process for tracking the cleaning will also be implemented. Dining Staff will be re-educated/retrained on adherence to weekly sanitation for the oven/racks and the new tracking process. All education will be completed by 4/27/22. 4. Dining Director, Chef or Designee will assign kitchen equipment cleaning per weekly sanitation sheets. Dining Director, Chef or Designee will audit sanitation sheets and actual kitchen equipment (oven/racks) 3x/weekly for 2 months, to ensure that kitchen equipment (oven/racks) are clean. Any noncompliant findings will be corrected immediately. All audit findings will be reported to the QAPI Committee for further review and oversight. 5. 5/2/22 and ongoing	