| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495087 | A. BUILDING _____ B. WING _____ | C 11/02/2022 |

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| SALEM HEALTH & REHABILITATION | 1945 ROANOKE BLVD SALEM, VA 24153 |

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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 10/31/2022 through 11/02/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid survey was conducted 10/31/22 through 11/02/22. Corrections were required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.<br><br>One complaint was investigated during the survey:<br>1. VA00056579 - unsubstantiated<br><br>The Life Safety Code survey/report will follow.<br><br>The census in this 240 certified bed facility was 209 at the time of the survey. The survey sample consisted of 35 current resident reviews and 3 closed record reviews. | F 000 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration. (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-<br><br>§483.25(g)(1) Maintains acceptable parameters | F 692 | | 12/5/22 |

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

Electronically Signed | 11/21/2022

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| F 692 | Continued From page 1<br>of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review facility staff failed to ensure the resident maintained acceptable nutrition status as evidenced by failure to assess the resident's condition on admission for one of 35 residents in the survey sample (Resident #175).<br><br>Resident #175 was admitted to the facility with diagnoses including muscle weakness, unsteadiness on feet, unspecified fracture of occiput, subsequent encounter for fracture with routine healing, anemia, and dysphagia, oropharyngeal phase. On the minimum data set assessment with assessment reference date 10/19/2022, the resident scored 10/15 on the Brief Interview for Mental Status and was assessed as lacking signs of delirium, psychosis, or behaviors affecting care. Height 63 inches and weight 87 pounds with recent gain or loss unknown was documented.<br><br>During initial tour on 10/31/2022, the surveyor observed the resident looked thin. The resident reported being well-fed and treated well by staff. | F 692 | The statements made in the following plan of correction are not an admission to and do not constitute an agreement with 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.<br><br>F692<br><br>1. Resident #175 reweight was obtained, the dietician completed a current nutritional assessment reflecting the accurate weight and caloric need, the nutritional supplement was then ordered twice daily.<br><br>2. An audit of current residents' weights were completed to identify any significant | |

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| F 692 | Continued From page 2<br>Clinical record review revealed:<br>The Malnutrition Universal Screening Tool (MUST) dated 10/17/2022 documented the resident most recent weight 160.0 pounds and height 63 inches for a body mass index (BMI) 28.3. This BMI score indicated the resident was overweight with less than 5% weight loss over the past 3-6 months.<br>The diet order, dated 10/12/2022, was Regular diet Level 6 bite sized texture, regular liquids consistency.<br><br>The registered dietician progress note dated 10/17/22 read "Malnutrition Universal Screening Tool completed. See assessment for details. Rsd is a 91 y/o F admitted to the center post hospitalization s/p fall. PMH fracture afib, HLD, HTN, anemia, disorders of bone density and structure, TIA. Medications include metoprolol, cardizem,cholecalciferol, cyanocobalamin, excitalopram, furosemide, digoxin, lubiprostone, KCl, polyethylene glycol. CBW 160 lbs. BMI 28.3 appropriate for age. Potential for wt change related to fluid shifts, fracture, diuretic use. Per skin assessment, skin tear noted to R elbow. No other impairments noted. Diet is regular, L6, with 26-100% intake. Sorbitol allergy noted. Will continue to monitor and f/u PRN."<br><br>Weights documented on the vital signs page:<br>10/13/22 160 Lbs (wheelchair) *This weight was marked out as an error after the surveyor<br><br>recorded it and reported to administration on 11/1/22.<br>10/20/22 87.4 Lbs (wheelchair)<br>11/1/22 87.3 Lbs (standing) | F 692 | weight changes or discrepancies and reported to Dietician for any needed intervention.<br><br>3. Current licensed nursing staff and Registered dietitian were educated on obtaining weights and reweights.<br><br>4. DON or designee will review weights and reweights twice weekly in clinical meeting x4 weeks to ensure accurate weight monitoring , any issues will be addressed at time of observation .<br><br>5. Results of the audits and process will be discussed and reviewed during monthly QAPI meetings<br><br>Date of compliance: 12/5/2022 | |

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| F 692 | Continued From page 3<br>During a summary meeting on 11/1/22 at approximately 5 PM, the surveyor reported to the administrator, director of nursing, assistant director of nursing that the resident's initial weight was documented as 160 lbs. Subsequent weekly weights were 87.4 and 87.3 pounds. The dietician's order was based on the 160 weight and did not include an assessment of calorie needs.<br><br>On 11/2/22 at 8:30 AM The dietician offered the surveyor assessment done the evening before which acknowledged the 87 lb weights and a new order for supplements BID (twice per day). A registered dietician progress note documented the diet, calorie needs, and a summary of a meeting with the resident to plan interventions to promote weight gain.<br><br>During a summary meeting on 11/2/2022, the surveyor notified the administrator, director of nursing, and assistant director of nursing that the issue, discovered by the surveyor, remained a concern. | F 692 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility | F 812 | | 12/5/22 |

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| F 812 | Continued From page 4<br>gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and facility document review, the facility staff failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The facility staff failed to properly sanitize items used for food preparation and serving, stacked wet pans together, and failed to discard an out of date food item.<br><br>The findings included:<br><br>The facility staff failed to properly prepare sanitizing rinse solution used following manual washing of items used to prepare and serve food on two separate occasions. The facility staff nested (stacked) wet pans together and failed to discard a container of apple cider vinegar with a best by date of 7/22/22.<br><br>On 10/31/22 at 4:08 pm, during the initial tour of the facility kitchen, surveyor observed the three-section sink with the first section filled with soapy water, second section with clean water, and the third section with a clear liquid solution. The Dietary Manager (DM) verified the third sink contained the sanitizing rinse. There were no items in the sanitizing solution at the time of observation. At the request of the surveyor, the DM tested the concentration of the sanitizing | F 812 | F812<br><br>1. The three compartment sink was emptied and refilled per manufacture recommendations. Nesting pans were rewashed.<br><br>2. No other three compartment sinks are in use in the center, pans were inspected for wet nesting and identified pans were rewashed.<br><br>3.Current dietary Staff educated on manufacture recommendations for use of the three compartment sink, and process of drying pans fully prior to stacking to prevent wet nesting.<br><br>4. The Dietary Manager or designee will audit for proper use of the three compartment sink per manufacturer recommendations and fully drying pans 3X a week for 4 weeks.<br><br>5. Results of the audits and process will be discussed and reviewed during monthly QAPI meetings.<br><br>Date of compliance: 12/5/2022 | |

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| F 812 | Continued From page 5 | F 812 | | |

rinse solution using a Hydrion QT-40 Quaternary Test Paper strip. The DM submerged the test paper strip in the rinse solution, however the strip did not change color to indicate the presence of sanitizing solution. The DM then filled a small container with the sanitizer solution and tested it using a Hydrion test strip and the strip indicated a quaternary sanitizer concentration level of 400. The DM stated a normal reading was 200 to 400. The DM emptied the sanitizing rinse sink.

On 11/01/22 at 3:40 pm, surveyor again observed the three-section sink in the kitchen and the sanitizing rinse sink was full with a clear liquid solution with no items in the solution. At the request of the surveyor, the DM tested the concentration of the sanitizing rinse solution using a Hydrion QT-40 Quaternary Test Paper strip and the strip did not change color to indicate the presence of sanitizing solution. Again the DM filled a small container with the sanitizer solution and tested it using a Hydrion test strip and the strip indicated a level of 400. The DM then called over Dietary Staff Member (DSM) #1 and asked them how they prepared the sanitizing rinse solution. DSM #1 stated they turned on the sanitizing solution and then turned on the hot water to make the rinse solution hot. The DM informed DSM #1 that the sanitizing solution was already premixed with water through the system and the rinse solution temperature can be adjusted by using the hot/cold faucets. The water directly from the faucet must be turned off prior to running the sanitizer solution. DSM #1 was unaware that the faucet had to be turned off when filling the sink with the sanitizing solution system and did not realize the sanitizing solution was being diluted.

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| F 812 | Continued From page 6 | F 812 | | |

Facility provided a "Pot Sink Sanitation Record" for the time period of 10/01/22 through 11/01/22. On 10/31/22 the record documented the level of sanitizing solution as 400 for breakfast, lunch, and dinner. On 11/01/22 the record also documented the level as 400 for breakfast, lunch, and dinner.

Surveyor requested and received DSM #1's training records. The facility provided a copy of a document entitled "Job Expectations for PM Dietary Supervisor at (facility name omitted) which read in part "Pot Sink Sanitation Log. Should read on test strips between 200 and 400. Must be done 3 times a day". The document was signed by DSM #1 and dated 8/02/22.

On 10/31/22 at 4:07 pm, surveyor observed two separate stacks of four deep pans stacked together on a wire shelving unit. At the request of the surveyor, the DM picked up one stack of four pans and water dripped out onto the floor prior to separating the pans. DM then picked up the other stack of four pans and again water dripped onto the floor. DM placed all eight pans into the sink to be rewashed.

Surveyor requested and received the facility policy entitled "Manual Ware Washing" which read in part:
1. The Dining Services Director insures that the Dining Service staff is knowledgeable in proper technique including:
- Chemical sanitizer dispensing
- Chemical sanitizer testing and concentrations
3. The Dining Services Director insures that all service ware and cook ware are air dried prior and [sp] storage.

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| F 812 | Continued From page 7<br>On 10/31/22 at 4:18 pm, surveyor observed an unopened one-gallon container of apple cider vinegar with a best if used by date of 7/22/22 in the dry-storage area. The DM removed the vinegar from the area and stated they would discard it.<br><br>On 11/01/22 at 5:19 pm, surveyor met with the administrator, director of nursing, assistant director of nursing, and the regional nurse and discussed the concern of the sanitizing rinse solution, wet nested pans, and the out of date vinegar.<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 11/02/22. | F 812 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and | F 842 | | 12/5/22 |

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| F 842 | Continued From page 8<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided; | F 842 | | |

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| F 842 | Continued From page 9<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, and facility document review, the facility staff failed to maintain a complete and accurate clinical record for 1 of 35 residents in the survey sample, Resident #53.<br><br>The findings included:<br><br>For Resident #53, the facility staff failed to document the treatment application of Z-paste to the resident's sacrum.<br>Resident #53's diagnosis list indicated diagnoses, which included, but not limited to Paranoid Schizophrenia, Generalized Muscle Weakness, Alzheimer's Disease, and Transient Cerebral Ischemic Attack.<br><br>The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 10/26/22 assigned the resident a brief interview for mental status (BIMS) summary score of 9 out of 15 indicating the resident was moderately cognitively impaired.<br><br>Resident #53's current physician's orders included an order dated 10/26/22 for Z-paste to the sacrum every shift for protection for two weeks. Resident #53's clinical record included an assessment entitled "Skin Observation Tool -V2" dated 10/25/22 which documented in part "Seen | F 842 | F842<br><br>1. Resident #52 medical record was corrected to reflect documentation of treatments currently ordered<br><br>2. Current Residents treatment administration records were audited to ensure all ordered treatments have been transcribed correctly to the treatment administration record<br><br>3. Licensed Nursing staff have been educated on accurate treatment order entry<br><br>4. DON or designee will review orders report daily during clinical meeting to ensure accurate treatment order entry x 4 weeks<br><br>5. Results of the audits and process will be discussed and reviewed during monthly QAPI meetings<br><br>Date of compliance: 12/5/2022 | |

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| F 842 | Continued From page 10 | F 842 | | |

by (name omitted), NP (nurse practitioner) for follow-up wound care. Sacral area clear of MASD (moisture-associated skin damage) at this time. Treatment to continue for two weeks for protection".

A review of Resident #53's October 2022 and November 2022 Treatment Administration Record (TAR) revealed the order for Z-paste to sacrum had not been documented as being administered since ordered on 10/26/22.

On 11/02/22 at 1:09 pm, surveyor spoke with the assistant director of nursing (ADON) regarding Resident #53's treatment to the sacrum. The ADON stated the order for Z-paste was entered incorrectly resulting in no documentation required with the treatment. The ADON stated the treatment had been done.

On 11/02/22 at 3:45 pm, survey team met with the administrator, director of nursing, ADON, regional nurse consultant, and regional MDS coordinator and discussed the concern of the facility staff failing to document treatment provided to Resident #53.

No further information regarding this concern was presented to the survey team prior to the exit conference on 11/02/22.