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	495306	A. BUILDING ______ B. WING ______	C 10/19/2022

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/17/2022 through 10/19/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 10/17/22 through 10/19/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey: 1. VA00053507 - unsubstantiated The Life Safety Code survey/report will follow. The census in this 190 certified bed facility was 138 at the time of the survey. The survey sample consisted of 27 current resident reviews and 4 closed record reviews.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		12/1/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/11/2022

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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F 584	Continued From page 1 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and facility document review, the facility staff failed to maintain a clean, comfortable home-like environment for 1 of 3 units (2nd Floor) and 5 of 27 residents in the survey sample, Resident #18, #106, #58, #41, and #55. The findings included:	F 584	F-584 1. 1. Shower chair was immediately removed from resident care area and was cleaned and disinfected by Environmental Services on 10/19/2022. 2. All other shower chairs that were in use in the facility received deep cleaning on 10/19/2022. 3. Environmental services Director	

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F 584	Continued From page 2 1. The facility staff failed to maintain a clean, sanitary resident shared shower chair and failed to maintain a window in good repair on the 2nd Floor. On 10/19/22 at 1:15 pm, surveyor and the 2nd Floor Unit Manager (UM) entered the unit shower room and observed the shower chair. At the request of the surveyor, the UM turned the shower chair over revealing a black, damp appearing substance with strands of hair intertwined on the lower section of the chair legs and around the wheels. A light tan dried substance was visible on the upper section of the chair legs and underneath the seat where the seat was attached to the chair. The UM stated "That's pretty awful ain't it" and they would put in a housekeeping ticket. UM stated one resident had used the shower room earlier in the day. On 10/19/22 at 1:20 pm, the Director of Nursing (DON) and the Quality Assurance (QA) Coordinator entered the 2nd Floor shower room and observed the shower chair and the QA Coordinator removed the shower chair and said it would be taken out of service. At 1:34 pm, the QA Coordinator stated shower chairs were cleaned between each resident use. On 10/19/22 at 1:11 pm, surveyor observed the window at the end of the hall on 2nd Floor and noted five (5) linear cracks. The cracks were not sharp to the touch and no starburst patterns were present. At 1:32 pm, surveyor notified the administrator of the window cracks. At 3:27 pm, the administrator returned and stated the facility felt the window was stable with the inner window wire but would need to be replaced.	F 584	educated environmental services team regarding weekly deep cleaning of 100% of facility shower chairs. Staff Development Coordinator will inservice all nursing staff regarding cleaning and disinfecting shower chairs after each use. 4. Environmental Services Director or Designee will audit 100% of all facility shower chairs for cleanliness weekly x 4, biweekly x 2, monthly x 2. 5. Findings will be reported to the monthly QAPI Committee for review and recommendations. F-584 1. Maintenance Assistant evaluated the window on 2nd floor corridor and determined that it was stable on 10/19/2022. The window has been replaced effective 11/9/2022. 2. All windows in the facility have been evaluated by the maintenance department to ensure that windows are intact and safe. 3. Inservice training has been provided to all staff to report any broken or damaged windows to their supervisor. 4. To monitor compliance, Maintenance Director or Designee will audit at least 10 windows in resident care areas weekly x 4, biweekly x 2, and monthly x 2. 5. Findings will be reported to the monthly QAPI Committee for review and recommendations. F-584 2. 4. 6.	

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On 10/19/22 at 3:13 pm, the survey team met with the Administrator, DON, and QA Coordinator and discussed the concern of the soiled shower chair and the broken window.

No further information regarding this concern was presented to the survey team prior to the exit conference on 10/19/22.

2. For Resident #18, the facility staff failed to maintain a clean, sanitary wheelchair.

Resident #18's diagnosis list indicated diagnoses, which included, but not limited to Severe Dementia with Other Behavioral Disturbance, Parkinson's Disease, Sequelae of Cerebral Infarction, and Mood Disorder.

The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 7/29/22 assigned the resident a brief interview for mental status (BIMS) summary score of 5 out of 15 indicating the resident was severely cognitively impaired. Resident #18 was coded as requiring extensive assistance with transfers, locomotion on unit, eating and being totally dependent on staff for personal hygiene.

On 10/18/22 at 11:10 am, surveyor observed Resident #18 sitting in a wheelchair in the 2nd Floor dining room/common area. The resident's wheelchair cushion had a large amount of a dried white substance on the left side and a small amount on the right side with crumbs and debris around the edges of the cushion. The wheelchair spokes and wheels had a large amount of dust and debris present.

On 10/18/22 at 11:30 am, surveyor spoke with the

F 584

1. Resident #18, #58, and #55's wheelchair and associated equipment received deep cleaning on 10/18/2022.
2. 100% of all residents' wheelchairs and associated equipment received deep cleaning on 10/18/2022.
3. Staff were educated to report wheelchairs in need of deep cleaning to the Environmental Services Director. The Environmental Services Director has formulated a wheelchair cleaning schedule to ensure routine cleaning.
4. The Environmental Services Director or designee will audit for cleanliness of 10% of wheelchairs currently in use weekly x 4, biweekly x 2, and monthly x 2.
5. Findings will be reported to the monthly QAPI Committee for review and recommendations.

F-584 3.
1. Resident #106's bathroom doorframe was cleaned on 10/19/2022.
2. 100% of all resident bathroom doorframes were audited for cleanliness and any issues identified were corrected.
3. Environmental Services Director has educated housekeeping staff to ensure that doorframes are included in room cleanings. The Staff Development Coordinator will educate all facility staff regarding procedure for cleaning doorframes on an as needed basis.
4. The Environmental Services Director or Designee will audit 10% of doorframes in resident bathrooms for cleanliness weekly x 4, biweekly x 2, and monthly x 2.
5. Findings will be reported to the

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F 584	Continued From page 4 Administrator, Director of Nursing (DON) and the Quality Assurance (QA) Coordinator who stated there was no policy or schedule for the cleaning of wheelchairs and they were cleaned on an as needed basis by housekeeping. Surveyor requested the last time Resident #18's wheelchair was cleaned. On 10/18/22 at 11:42 am, surveyor spoke with the Housekeeping Assistant Supervisor (HAS) who stated the previous housekeeping supervisor had a wheelchair cleaning schedule but does not know what happened to the schedule when they left. HAS stated there was no current wheelchair cleaning schedule. HAS stated when a wheelchair needed cleaning, staff will verbally notify housekeeping as they pass by. HAS stated they pressure washed Resident #18's wheelchair last week or the week before. On 10/19/22 at 3:13 pm, the survey team met with the Administrator, DON, and QA Coordinator and discussed the concern of Resident #18's soiled wheelchair. No further information regarding this concern was presented to the survey team prior to the exit conference on 10/19/22. 3. For Resident #106, the facility staff failed to maintain a clean, sanitary bathroom and privacy curtain. Resident #106's diagnosis list indicated diagnoses, which included, but not limited to Severe Dementia with Other Behavioral Disturbance, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, History of Traumatic Brain Injury, and Unspecified Mood	F 584	monthly QAPI Committee for review and recommendations. F-584 3. 1. Resident # 106's privacy curtain was replaced on 10/19/2022. 2. 100% of all privacy curtains in resident rooms were audited for cleanliness and any issues identified were corrected. 3. A schedule has been formulated to address routine cleaning of privacy curtains in all resident rooms. All staff have been educated regarding the need to replace curtains when they are noted to be soiled. 4. The Environmental Services Director or designee will audit 10% of resident rooms for cleanliness of privacy curtains weekly x 4, biweekly x 2, and monthly x 2. 5. Findings will be reported to the monthly QAPI Committee for review and recommendations. F-584 5. 1. Resident #41's floor was cleaned on 10/19/2022. 2. 100% of all resident room floors were audited for cleanliness and any issues identified were corrected. 3. Environmental Services Staff have received education regarding proper cleaning procedure for resident room floors. 4. The Environmental Services Director or Designee will audit 10% of resident	

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Disorder.

The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 9/20/22 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems. Resident #106 was coded as requiring limited assistance with transfers, walking, personal hygiene and extensive assistance with toilet use.

On 10/19/22 at 12:57 pm, surveyor observed Resident #106's bathroom and noted six (6) separate areas of a dark brown dried substance on the right side of the inner doorframe. Surveyor also observed an area of a dark brown dried substance on each side of the resident's privacy curtain nearest the bathroom along with multiple light brown stains on the outer side of the privacy curtain.

On 10/19/22 at 3:13 pm, the survey team met with the Administrator, DON, and QA Coordinator and discussed the concern of Resident #106's soiled bathroom and privacy curtain.

No further information regarding this concern was presented to the survey team prior to the exit conference on 10/19/22.

4. For resident #58, the facility staff failed to ensure the wheel chair the resident was sitting in was clean.
Resident #58's diagnosis list includes, but is not limited to, the following: unspecified dementia,

F 584

rooms for cleanliness of the floors weekly x 4, biweekly x 2, and monthly x 2.
5. Findings will be reported to the monthly QAPI Committee for review and recommendations.

F-584
1. There is a plan in place to replace windows with drafts located on second floor "B" Hall.
2. A 100% audit will be conducted of windows in patient care areas to ensure there are no drafts or plastic covering the windows.
3. There is no systemic change needed.
4. There is no audit needed.

F-584 7.
1. Resident #94 was provided with a baseboard heater and ensured that the room temperature was comfortable for this individual when the ambient air temperature measured between 71 and 81 degrees Fahrenheit on 10/19/2022. Resident #122 was also provided with a fire marshal approved baseboard heater and she verbalized she was comfortable when her room temperature was measured at 73 degrees.
2. A 100% audit of all resident care rooms on B hall had ambient temperature checks and residents were questioned regarding their comfort level with fire marshal approved auxiliary heaters provided to those residents who complained of a cold room.

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F 584	Continued From page 6 major depressive disorder, anxiety disorder, cognitive communication deficit, dysphagia, debility, and protein-calorie malnutrition. Resident #58's most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 8-8-2022, assigned the resident a BIMS (brief interview for mental status) summary score of 0 out of 15 in section C, cognitive patterns, indicating the resident was severely cognitively impaired. On 10/18/2022 at 11:00 A.M., surveyor observed resident #58 in the dining room and noted that the wheel chair the resident was sitting in was dirty. There was a thick, dry brown substance noted on each of the pedals of the chair, as well as the left inside panel of the chair. There were white flakes and dried white splatters of an unknown substance on the foot pedals as well as on both arm rests. There were dried food particles noted in the seat and the cushion of the chair. Surveyor met with the Administrator and Director of Nursing (D.O.N.) on 10/18/2022 at 11:30 A.M. and asked for a copy of the wheel chair cleaning schedule. The Administrator stated, "There is no definitive schedule for cleaning chairs" she went on to say that chairs are cleaned by housekeeping on an as needed basis. Surveyor met with the assistant housekeeping director at 11:43 A.M. who concurred that there was no schedule for cleaning chairs because the previous housekeeping director took the document when employment ended. He stated that the Certified Nursing Assistants will generally stop him and let him know when they notice a chair needs cleaning.	F 584	3. The Maintenance Director and assistants have received education regarding the need to place fire marshal approved auxillary heaters in resident rooms in response to resident and/or staff concerns of cold temperatures. 4. The Maintenance Director or Designee will conduct ambient air temperature checks on B Hall weekly x 4, biweekly x 2, and monthly x 2. 5. All findings will be reported to the monthly QAPI Committee for review and recommendations.	

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On 10/19/22 at 3:13 P.M. Surveyor met with the Administrator, D.O.N. and QA nurse to review the concern of the soiled wheel chair for resident #58.

No further information regarding this concern was provided to the survey team prior to the exit conference.

5. For Resident #41 facility staff failed to clean the floor of the bedroom and bathroom, leaving blood on the floor of the bathroom for 3 days.

Resident #41 was admitted to the facility with diagnoses including cardiopulmonary disease exacerbation, chronic respiratory failure, pulmonary fibrosis, difficulty walking, opioid dependence, ataxia, type 2 diabetes mellitus, hypertension, chronic pain, anxiety, and depression. On the Minimum Data Set quarterly assessment with assessment reference date 8/15/22, the resident scored 12/15 on the brief interview for mental status and was assed as not exhibiting signs of delirium, psychosis, or behaviors affecting care.

During initial tour on 10/17/2022 at approximately 2 PM, the resident stated that the floors were not kept clean. The floors were dirty under and around the resident beds and the resident had cut her leg the day before and no one had yet cleaned up the blood on the bathroom floor. The surveyor observed food and paper debris in the floor around both beds. There was a discarded dressing with bloody (rust-colored,dry) gauze and tape on the floor near the door to the hall. On the

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bathroom floor, the surveyor observed red spots dime to dollar coin size on the bathroom floor. On 10/18/22 at 10:24 AM, the surveyor noted there was still debris on the bedroom floor, including dust and debris around the resident's chair and under the bed. There appeared to be some partially mashed beans on the floor by the room mate's bed. The floor in the bathroom appeared to have been partially cleaned, but one dollar coin size and several small blood-colored spots remained.

The administrator and director of nursing were notified of the concern during a daily summary meeting on 10/18/2022.

On 10/19/2022 at 3 PM the surveyor noted there was still one blood-colored spot on the bathroom floor between the leg of a bedside commode frame and the toilet base.

6. For Resident #55, the facility staff failed to ensure the residents wheelchair was clean. The wheelchair was observed to have dried debris present on the wheels, cushions, and arm rests.

Resident #55's clinical record included the diagnoses, diabetes and post-traumatic stress disorder.

Section C (cognitive patterns) of Resident #55's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 08/06/22 included a brief interview for mental status (BIMS) summary score of 00 out of a possible 15 points. Indicating the resident had severe impairment in cognitive skills. Section G (functional status) was coded to indicate Resident #55 used a wheelchair for mobility.

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10/18/22 9:50 a.m., the surveyor and Registered Nurse (RN) #1 observed Resident #55 in their wheelchair. The wheelchair was observed to have dried debris on the wheels, cushions, and arm rests. RN #1 stated housekeeping cleaned the wheelchairs in the evenings and acknowledged the wheelchair needed cleaning.

10/18/22 11:42 a.m., housekeeping staff #1 stated the previous housekeeping director had a cleaning schedule but lately the certified nursing assistants (CNA's) asked them to clean the wheelchairs as they passed by.

10/18/22 3:45 p.m., the Administrator, Director of Nursing (DON), and Quality Assurance Coordinator were made aware of the issue with Resident #55's wheelchair during an end of the day meeting.

No further information regarding this issue was provided to the survey team prior to the exit conference.

7. The facility failed to maintain a temperature range between 71-81 Fahrenheit (F) on the second floor on the B hall.

During initial tour of the facility Resident #94 stated they did not know how to control the heat in their room. Maintenance and LPN (licensed practical nurse) #1 were made aware of the residents concern.

Resident #94 diagnoses included chronic obstructive pulmonary disease, asthma, and diabetes. Section C of Resident #94's quarterly minimum data set (MDS) assessment with an

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assessment reference date (ARD) of 09/17/22 included a brief interview for mental status (BIMS) summary score of 15 out of a possible 15 points. Indicating the resident was alert and orientated.

10/18/22 11:51 a.m., the surveyor observed several windows with plastic covering the inside. The Administrator and Director of Nursing (DON) stated the plastic was in place to cut down on drafts and they had a plan to replace the windows. The building appeared to be currently under construction. The Administrator stated it was a holiday and the construction crew was off the entire week.

10/19/22 10:45 a.m., the surveyor observed the hallway on unit 2/floor 2, hall B to be cold. No residents were observed in the hallway. Random temperature checks were completed on the hallway with the Maintenance Director (MD) with readings of 68, 68.5 and 69 degrees F being obtained. The MD obtained these temperatures using what they identified as an infrared thermometer.

10/19/22 11:00 a.m., MD checked temperature in Resident #94's room. Temperatures obtained were 63.5 F and 64.5 F. Resident #94 denied being cold and was observed to be fully dressed in street clothes and a sweater. The bathroom temperature registered 57 F. The MD stated they were going to obtain a different type of thermometer and left the unit/floor.

10/19/22 11:03 a.m., Resident #122 stated they were cold. The thermometer on the wall in the Resident #122's room read 65 degrees.

Resident #122's diagnoses included, but were not

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F 584	Continued From page 11 limited to, dementia, depression, anxiety, and peripheral vascular disease. Section C of the resident #122's quarterly MDS assessment with an ARD of 09/22/22 included BIMS summary score of 10 out of a possible 15 points. 10/19/22 11:05 a.m., the MD returned to the unit with what they identified as an ambient heat thermometer, checked Resident #122's room temperature, and obtained a temperature reading of 67 F. The MD checked the heater and stated the fan was not working. The Administrator was on the floor and was aware of the issues regarding the temperature(s). 10/19/22, the MD checked the temperature outside of the elevator on the B hall and obtained a temperature reading of 69.4 F rechecked and obtained a temperature reading of 69.6 F. Rechecked Resident #94's room with the ambient thermometer and received a reading of 70 F in room 68 F in the bathroom. 10/19/22 11:17 a.m., Certified Nursing Assistant (CNA) #2 stated the hall was usually burning up but it was chilly in some spots. CNA #2 identified Resident's #37 and #95 as stating it was cold. Both of these residents denied being cold when asked by the surveyor. 10/19/22 11:19 a.m., LPN #3 stated they were comfortable and no resident had complained of being cold. 10/19/22 11:23 a.m., Licensed Practical Nurse (LPN) #5 (hall nurse) stated no resident had	F 584		

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	495306	A. BUILDING ______ B. WING ______	C 10/19/2022

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F 584		F 584		

Continued From page 12
complained of being cold.

10/19/22 11:23 a.m., CNA #3 stated no residents complained of being cold. However, the residents were elderly and always stated they were cold.

10/19/22 11:44 a.m., the MD stated they had spoken with the Fire Marshall and they obtained information on what kind of heaters were approved for use and they were going out of the facility to obtain these type of heaters. The MD also stated they had another heating system on the hall and they were in the process of getting it turned on.

10/19/22 12:10 p.m., Quality Assurance (QA) coordinator stated they offered Resident #122 a room change but they had refused and the MD had went out to purchase Fire Marshall approved heaters.

10/19/22 12:44 p.m., the QA coordinator and Director of Nursing (DON) provided the surveyor with a progress note transcribed by the social service department that read, "SS (social service) offered resident a room change d/t (due to) heat currently not working in room. Resident stated ____ does not want to move."

10/19/22 1:45 p.m., Resident #122 stated they did not want to move out of their room. The surveyor observed silver tape on the window sills in room. Thermostat in room at doorway read 65 F. The surveyor identified 7 rooms on the B hall with plastic covering the windows. Resident #131 stated they liked to of froze last night. Resident #131's diagnoses included Alzheimer's, ataxia, and anxiety. Section C of their quarterly MDS assessment with an ARD of 09/28/22 included a

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F 584	Continued From page 13 BIMS score of 15 out of a possible 15 points. Resident #72 observed resting on bed in room, stated they were warm. Diagnoses included, hypertension and diabetes. Section C of their quarterly MDS assessment with an ARD of 09/14/22 included a BIMS score of 14 out of a possible 15 points. The facility policy titled, "Homelike Environment" read in part, "...comfortable and safe temperatures (71 F-81 F)..." 10/19/22 3:15 p.m., during a meeting with the Administrator, DON, and QA coordinator the issue with the resident room(s) heat and temperature(s) on the B hall was reviewed. The Administrator stated the MD had not returned to the facility as of yet, this time of the year is the change of season, it is the coldest weather we have had this year, we do have some residents complain of being cold, and it's hard to keep everyone happy. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 584		
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 staff failed to accurately code a discharge minimum data set (MDS) assessment for 1 of 3 closed record reviews, Resident #139.	F 641	F-641 1. Resident #139's MDS was corrected to reflect the accurate discharge disposition on 11.9.2022	12/1/22

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F 641 Continued From page 14

The findings include:

The facility staff coded the residents discharge MDS assessment as if the resident was discharged to an acute care hospital. Resident #139 was discharged home.

The clinical record included the diagnoses, chronic kidney disease, fracture of other parts of pelvis, and difficulty walking.

Section A (identification information) of the residents discharge MDS assessment with an assessment reference date (ARD) of 07/30/22 had been coded to indicate Resident #139 was discharged to an acute care hospital. Section C (cognitive patterns) was coded to indicate the resident had short term memory problems and required modified independence for cognitive skills for daily decision making.

Resident #139's clinical record included a progress note dated 07/30/22 that read, "Pt discharged home."

10/19/22 8:24 a.m., Registered Nurse (RN) #2/MDS coordinator reviewed the clinical record with the surveyor and acknowledged the MDS had been coded incorrectly.

10/19/22 3:15 p.m., the Administrator, Director of Nursing, and Quality Assurance Coordinator were notified of the inaccurate MDS assessment.

No further information regarding this issue was provided to the survey team prior to the exit conference.

F 641

2. A 100% audit of all discharges in the last three months was conducted to ensure that the correct discharge disposition was documented in the MDS and any needed corrections were made.
3. The MDS team has received education to ensure that discharge disposition is coded accurately.
4. The MDS Director or Designee will audit 25% of all discharge MDS's to ensure correct coding of discharge disposition weekly x 4, biweekly x 2, and monthly x 2.
5. Findings will be reported to the monthly QAPI Committee for review and recommendations.

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F 908	Continued From page 15	F 908		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to maintain essential equipment for 1 of 27 resident (Resident #122) and for 3 of 3 facility elevators. The findings include: 1. For Resident #122, the facility staff failed to ensure the residents heater was in working order. Resident #122's diagnoses included, but were not limited to, dementia, depression, anxiety, and peripheral vascular disease. Section C (cognitive patterns) of the resident #122's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 09/22/22 included a brief interview for mental status (BIMS) summary score of 10 out of a possible 15 points. 10/19/22 10:45 a.m., the surveyor observed the hallway on unit 2/floor 2, hall B to be cold. 10/19/22 11:03 a.m., Resident #122 stated they were cold. The thermometer on the wall in the Resident #122's room read 65 degrees Fahrenheit (F). 10/19/22 11:05 a.m., Maintenance Director (MD)	F 908	F-908 1. 1. Resident #122 was provided with a baseboard heater and ensured that the room temperature was comfortable for this individual when the ambient air temperature measured 73 degrees Fahrenheit on 10/19/2022. 2. A 100% audit of all resident care rooms on "B" hall had ambient air temperature checks and residents were questioned regarding their comfort level with fire marshal approved auxiliary heaters provided to those residents who complained of a cold room on 10/19/2022. 3. The Maintenance Director and assistants have received education regarding the need to place fire marshal approved auxillary heaters in resident rooms in response to resident and/or staff concerns of cold temperatures. 4. The Maintenance Director or Designee will conduct ambient air temperature checks on "B Hall" weekly x 4, biweekly x 2, and monthly x 2. 5. All findings will be reported to the monthly QAPI Committee for review and recommendations. F-908 2. 1. The elevator inspection has been	12/1/22

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F 908

Continued From page 16

checked the room temperature using an ambient heat thermometer. Temperature read 67 F. The MD checked the heater and stated the fan was not working. The Administrator was on the floor and was aware of the issues regarding the temperature(s).

10/19/22 11:17 a.m., Certified Nursing Assistant (CNA) #2 stated the hall was usually burning up but it was chilly in some spots.

10/19/22 11:23 a.m., Licensed Practical Nurse (LPN) #5 (hall nurse) stated no resident had complained of being cold.

10/19/22 12:10 p.m., Quality Assurance (QA) coordinator stated they offered Resident #122 a room change but they had refused and the MD had went out to purchase Fire Marshall approved heaters.

10/19/22 12:44 p.m., the QA coordinator and Director of Nursing (DON) provided the surveyor with a progress note transcribed by the social service department that read, "SS (social service) offered resident a room change d/t (due to) heat currently not working in room. Resident stated ____ does not want to move."

10/19/22 1:45 p.m., Resident #122 stated they did not want to move out of their room. The surveyor observed silver tape on the window sills in room. Thermostat in room at doorway read 65 F.

The facility policy titled, "Homelike Environment" read in part, "...comfortable and safe temperatures (71 F-81 F)..."

10/19/22 3:15 p.m., during a meeting with the

F 908 (Plan of Correction)

scheduled.
2. There are no other potential affected areas. The facility has documentation from Elevating Equipment Inspection Services that they were behind in performing semi-annual inspections due to staffing.
3. There is no systemic change needed.
4. There is no audit needed.

F-908 2.

1. The West Wing Elevator Certificate Holder was repaired by maintenance on 10/19/2022. The exposed area containing the circuit board and broken plastic edges was covered by maintenance on 10/19/2022. A replacement part has been ordered.
2. A 100% audit was conducted on all facility elevators to ensure that no broken or unsafe areas were noted.
3. All facility staff were educated to report any broken or unsafe areas to their supervisor and/or maintenance staff.
4. The Maintenance Director or Designee will conduct audits to observe for any unsafe areas on facility elevators weekly x 4, biweekly x 2, and monthly x 2.
5. All findings will be reported monthly to the QAPI Committee for review and recommendations.

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F 908	Continued From page 17 Administrator, DON, and QA coordinator the issue with the heat/temperatures was reviewed. The Administrator stated the MD had not returned to the facility as of yet, this time of the year is the change of season, it is the coldest weather we have had this year, we do have some residents complain of being cold, and it's hard to keep everyone happy. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. On 10/19/22 at 02:57 PM the West wing and Main elevator certificates show every 6 month inspections with the last inspection date on both certificates was 8/2021. The West wing elevator certificate holder had been partially pulled from the wall with a sharp corner sticking out and the floor indicator assembly was broken with an opening exposing a circuit board and broken edges of plastic. The administrator was informed of the concern. The administrator was not aware the elevators had not been inspected for over a year. Code of Virginia § 36-105.01. Elevator inspections - requires annual inspections of elevators. On 10/19/22 at 03:23 PM the administrator provided an email dated 10/19/2022 from the elevator inspection company stating that the company only has 1 inspector in Virginia, so it has been unable to keep up with the inspections	F 908		

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F 908	Continued From page 18 every 6 months. The company did not offer a prospective inspection date for the facility's three elevators.	F 908		