STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495363	A. BUILDING ______ B. WING ______	C 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRMONT CROSSING HEALTH AND REHAB CENTER	173 BROCKMAN PARK DRIVE AMHERST, VA 24521

(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 Medicare/Medicaid standard survey was conducted 06/01/2022 through 06/02/2022. The facility's Emergency Preparedness Plan was in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000	**F656/12 VAC 5-371-250/ 12 VAC 5-371-250 (G)-Develop/Implement Comprehensive Care Plan** This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/1/2022 through 6/2/2022. One complaint was investigated during the survey. VA00055303 was substantiated without deficencies. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safetly Code will follow. The census in this 120 certified bed facility was 111 at the time of the survey. The survey sample consisted of 22 current resident reviews and 3 closed record reviews.	F 000	1.) Residents #103 and #89 were assessed by nursing staff and their medical records were reviewed. The residents' care plans have been updated to reflect current individualized plans of care. Fairmont Crossing Rehab Center has identified that all residents are at risk from this alleged deficient practice. 2.) The Director of Nursing/designee has performed an audit of all current residents' care plans. Care plans have been updated to ensure individualized needs are addressed appropriately and that results are being tracked and addressed appropriately. A process has been developed and implemented to identify resident care needs in the daily interdisciplinary team meeting, and to update the care plans to reflect the needs identified.	
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 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	F 656	3.) The Director of Nursing/designee has in-serviced nursing leadership and interdisciplinary team members regarding care plan updates. The in-service includes, but no limited to, the importance of care plan reviews and updates with any changes for each resident and care plans being reflective of individualized care needs.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda Kocher
TITLE: Administrator
(X6) DATE: 6/17/22

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 656	Continued From page 1 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 clinical record review and staff interview, the facility staff failed to develop a comprehensive care plan for 2 of 25 residents in the survey sample, Resident #103 and Resident #89. Resident #103's care plan did not include focus areas with goals and interventions for the use Insulin and for the use of the antidepressant Venlafaxine (Effexor). Resident #89's care plan did include a focus area with goals and interventions for the use of the diuretic	F 656	4.) The Director of Nursing/designee will conduct an audit of 25% of resident care plans weekly for four weeks to ensure that interventions are appropriate and reflect the individual needs of each resident. The Director of Nursing/designee will also audit the care plans of any new admissions daily for six weeks to ensure that interventions are appropriate and reflect the individual needs of each resident. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to update the resident care plans. The Director of Nursing/designee will identify any trends and/or patters and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 7/1/2022	

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F 656	Continued From page 2	F 656		

Furosemide (Lasix).

The findings include:

1a. Resident #103 was admitted to the facility with diagnoses that included muscle weakness, traumatic brain injury, chronic respiratory failure, COPD, type 2 diabetes, hypokalemia, major depression disorder, sleep apnea, hypothyroidism, obesity, and GERD. The most recent minimum data set (MDS) dated 05/06/2022 was an annual assessment and assessed Resident #103 as moderately impaired for daily decision making with a score of 8 out 15.

Resident #103's electronic clinical record (EHR) was reviewed on 06/01/2022. Observed on the order summary report was the following order: "Insulin Giargine Solution 100 UNIT/ML. Inject 5 unit subcutaneously at bedtime for diabetes. Order Date: 04/30/2022. Start Date: 04/30/2022. Also observed on the order summary report was the following order: "Venlafaxine (Effexor) HCl Tablet 100 mg. Give 1 tablet by mouth a day related to Major Depressive Disorder, Recurrent. Order Date: 04/30/2022. Start Date: 05/01/2022.

A review of the medication administration record (MAR) for April 2022 through June 2022 documented Resident #103 received the Insulin and the Venlafaxine (Effexor) as ordered.

Resident #103's care plans were reviewed and they did not include a focus area for the use of the Insulin or the use of the Venlafaxine (Effexor).

On 06/02/2022 at 9:02 a.m., the unit manager (LPN #1) where Resident #103 resided was interviewed about the above referenced

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F 656	Continued From page 3 medications and if care plans should have been developed. LPN #1 reviewed Resident #103's EHR and stated the Resident had been on both medications for some time and care plans should have been developed for the use of both medications. LPN #1 advised the MDS coordinators routinely completed the care plans. On 06/02/2022 at 3:21 p.m. the MDS Coordinator (registered nurse - RN #1) was interviewed regarding Resident #103's care plans. RN #1 reviewed Resident #103's EHR and stated care plans should have been developed Resident #103 was diagnosed with diabetes and depression and care plans should have been developed for the use of both the Insulin and Venlafaxine (Effexor). On 06/02/2022 at 4:40 pm., the above findings were reviewed with the administrator, DON and various clinical staff during a meeting. No additional information was received by the survey team prior to exit on 06/02/22 at 6:00 p.m. 2. Resident #89 was admitted to the facility with diagnoses that included palliative care, disorientation, hypo-osmolality, hyponatremia, type 2 diabetes, unilateral inguinal hernia, peripheral vascular disease, hyperlipidemia, stage 3 chronic kidney disease, anemia, adult failure to thrive, and muscle weakness. The most recent minimum data set (MDS) dated 05/06/2022 was a quarterly assessment and assessed Resident #89 as cognitively intact for daily decision making with a score of 15 out of 15. Resident #89's electronic clinical record was reviewed on 06/01/2022. Observed on the order	F 656		

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F 656	Continued From page 4 summary report was the following order: "Furosemide (Lasix) Tablet 20 mg. Give 1 tablet by mouth in the morning for diuretic. Order Date: 05/23/2022. Start Date: 05/24/2022. A review of the medication administration record (MAR) for May 2022 through June 2022 documented Resident #89 received the Furosemide (Lasix) as ordered. Resident #89's care plans were reviewed and they did not include a focus are for the use of the Furosemide (Lasix). On 06/02/2022 at 9:02 a.m., the unit manager (licensed practical nurse - LPN #1) where Resident #89 resided was interviewed regarding Resident #89's care plans. LPN#1 stated Resident #89 had been experiencing some localized swelling in his right arm and the nurse practitioner had originally thought it was related to gout and ordered Prednisone; however, after additional assessing and monitoring the Furosemide (Lasix) was ordered to reduce the swelling. LPN #1 stated the MDS coordinators routinely completed the care plans. On 06/02/2022 at 3:21 p.m., the MDS Coordinator (RN #1) was interviewed regarding Resident #89's care plans. RN #1 reviewed Resident #89's EHR and stated a care plan should have been developed for the use of the Furosemide (Lasix). On 06/02/2022 at 4:40 pm., the above findings were reviewed with the administrator, DON and various clinical staff during a meeting. No additional information was received by the	F 656		

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F 656	Continued From page 5 survey team prior to exit on 06/02/22 at 6:00 p.m.	F 656		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in	F 756	**F756/12 VAC 5-371-300(H)- Drug Regimen Review, Report Irregular, Act On** This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1.) A drug regimen review was completed for resident #42. The resident's medication regimen and care plan have been updated to reflect a current individualized plan of care. Fairmont Crossing Rehab Center has identified that all residents are at risk from this alleged deficient practice. 2.) The Director of Nursing/designee has performed an audit of all current resident medication regimen reviews to ensure completion. Any variances have been corrected and medication regimens and care plans have been updated to reflect a current individualized plan of care. A process has been developed and implemented to identify incomplete medication regimen reviews and address them.	

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F 756	Continued From page 6 the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility document review, the facility failed to ensure drug irregularities were noted in the pharmacy review for one of 25 residents, Resident #42. The pharmacy did not report an ongoing order of an as needed (PRN) anti-psychotic medication for Resident #42. The Findings Include: Resident #42 was admitted with diagnoses which included: Dementia with behaviors, cerebrovascular disease, dysphagia, and hypertension. The most current MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 3/30/22. Resident #42's cognitive score indicated having long and short-term memory problems and severely impaired cognitively. Resident #42's physician orders documented an order dated 2/4/22 that read: "Quetiapine (seroquel, antipsychotic) tablet 25 MG (milligrams) Give 1 tablet by mouth every 6 hours as needed for agitation..." Review of monthly pharmacy medication record review (MRR) from 2/28/22 through 5/30/22 evidenced that the reviews had been completed, but did not include any recommendations to stop the as needed Seroquel. On 06/02/22 at 11:52 AM, registered nurse (RN #1) reviewed the chart and said she was unable	F 756	3.) The Director of Nursing/designee has in-serviced nursing leadership, interdisciplinary team members, and consultant pharmacist regarding medication regimen reviews. The in-service includes, but no limited to, the importance of medication regimen reviews, timely completion of medication regimen reviews, and the importance of updating resident medication regimens to meet each resident's individualized care needs. 4.) The Director of Nursing/designee will conduct an audit of 25% of current resident's medical records weekly for four weeks to ensure that medication regimen reviews are completed, and medication regimens are updated accordingly. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patters and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 7/1/2022	

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F 756	Continued From page 7 to find pharmacy recommendations regarding discontinuing Seroquel. On 06/02/22 at 12:01 PM, RN #2 stated the process is for the pharmacy to review all orders monthly and make any necessary recommendations. The recommendations are then reviewed by the physician and faxed back to the pharmacy with any necessary changes. RN #2 went onto say, the as needed Seroquel should have been reviewed and a recommendation to discontinue the medication should have been in place by the end of February. Facility policy titled "Antipsychotic Medication Use" read in part: "15. PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication." On 06/02/22 at 4:38 PM, the above information was presented to the director of nursing and the administrator. No other information was presented prior to exit conference on 6/2/22.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		

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F 758	Continued From page 8 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758	**F758/12VAC 5-371-210(2)- Free from Unnecessary Psychotropic Meds/PRN Use** This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1.) Resident #42 has been assessed by nursing staff and provider to ensure current PRN psychotropic medication regimen is appropriate and that PRN psychotropic medication orders have been updated to include provider-ordered stop dates. The resident's care plan has been updated as related to the use of psychotropic medications. Fairmont Crossing Rehab Center has identified that all residents are at risk from this alleged deficient practice. 2.) The Director of Nursing/designee has performed an audit of all residents receiving PRN psychotropic medications to ensure current PRN psychotropic medication regimen is appropriate and that PRN psychotropic medication orders have been updated to include provider-ordered stop dates or provider documentation of the appropriateness of the medication continuing beyond 14 days. Any variances have been corrected and a process has been developed and implemented to ensure PRN psychotropic medications include provider-ordered stop dates.	

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F 758	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility document review, the facility failed to ensure an as needed anti-psychotic medication was limited to 14 days for one of 25 resident's. Resident #42's as needed order for Seroquel was in place for 4 months. The Findings Include: Diagnoses for Resident #42 included: Dementia with behaviors, cerebrovascular disease, dysphagia, and hypertension. The most current MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 3/30/22. Resident #42's cognitive score indicated having long and short-term memory problems and severely impaired cognitively. Resident #42's physician orders documented an order dated 2/4/22 that read: "Quetiapine (seroquel, antipsychotic) tablet 25 MG (milligrams) Give 1 tablet by mouth every 6 hours as needed (PRN) for agitation..." Review of Resident #42's medication administration record (MAR) evidenced the PRN order for Seroquel was available for distribution, but was not given from he time it was ordered (2/4/22) through 5/31/22. On 06/02/22 at 12:01 PM, RN #2 stated the process is for the pharmacy to review all orders monthly and make any necessary recommendations. The recommendations are then reviewed by the physician and faxed back to the pharmacy with any necessary changes. RN #2 went onto say, the as needed Seroquel should	F 758	3.) The Director of Nursing/designee has in-serviced licensed nurses (RNs and LPNs) regarding use of unnecessary psychotropic medications. The education included, but was not limited to, review of PRN psychotropic medication regimen, communication with providers, and ensuring PRN psychotropic medications have stop dates ordered by the provider or provider documentation of the appropriateness of the medication continuing beyond 14 days. 4.) The Director of Nursing/designee will audit all current PRN psychotropic medication orders five times weekly for 6 weeks to ensure PRN psychotropic medication orders include stop dates or provider documentation of the appropriateness of the medication continuing beyond 14 days. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and additional education and training will be provided to employees on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 7/1/2022	

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F 758	Continued From page 10	F 758		

have been reviewed and a recommendation to discontinue the medication should have been in place by the end of February.

Facility policy titled "Antipsychotic Medication Use" read in part: "15. PRN orders for natipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication."

On 06/02/22 at 4:38 PM, the above information was presented to the director of nursing and the administrator.

No other information was presented prior to exit conference on 6/2/22.

F 812 SS=E Food Procurement,Store/Prepare/Serve-Sanitary
CFR(s): 483.60(i)(1)(2)

§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional

F 812

F812/12VAC5-371-180(A)- Food Procurement, Store/Prepare/Serve-Sanitary

This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements.

1. Certified Dietary Manager/Cook has performed a walk-through inspection of walk-in refrigerators and has discarded out-of-date items and has ensured all products were sealed, dated, and labeled correctly. It is the policy of Fairmont Crossing Rehab Center to ensure food is procured, stored, and prepared in a sanitary manner. Residents receiving meals from the kitchen have the potential to be affected by this alleged deficient practice.
2. The Certified Dietary Manager/designee has performed morning and evening walk-through inspections of all walk-in refrigerators and food storage areas to verify all items are sealed, labeled, and dated per policy. Any items found out of compliance have been discarded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495363	A. BUILDING ______ B. WING ______	C 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRMONT CROSSING HEALTH AND REHAB CENTER	173 BROCKMAN PARK DRIVE AMHERST, VA 24521

(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
F 812	See below	F 812	See below	

F 812

Continued From page 11

standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review, the facility staff failed to ensure food was properly stored in the main kitchen.

Findings were:

Initial tour of the kitchen was conducted on 06/01/2022 at approximately 10:40 a.m. with the dietary manager (DM). In the walk in refrigerator was a cart with an opened partial gallon of whole milk. The manufacturer's stamped date on the milk jug was 05/27/2022. On the side of the jug was written, "Opened 05/30/2022." He was asked what the dates signified. He stated that date of 05/30/2022 was when the milk had been opened by the dietary staff. He was asked what the manufacturer's stamped date of 05/27/2022 meant. He stated, "I am going to throw that out." On a shelf in the refrigerator were three additional gallon jugs of whole milk. All with the manufacturer's stamped date of "05/27/2022". The DM was asked if the manufacturer's date on the milk jugs was a "use by date" or a "sell by date". He stated, "I'm not sure, but I will make some calls and find out." Also observed in the walk in refrigerator was an unopened 48 ounce container of ricotta cheese. The manufacturer's stamped date was "05/29/2022". The DM stated, "I think that is a use by date on the ricotta cheese, I am throwing it away." The DM was asked who was responsible for checking expiration dates on the items in the refrigerator. He stated, "I am, but I haven't done it yet this week." He was asked if the dietary staff should check the dates on items before use. He stated, "Yes."

F 812 (Plan of Correction)

3. The Certified Dietary Manager/designee has re-educated culinary staff on the proper dating of stored food as per policy. The education included, but was not limited to, sanitary food storage, labeling, dating, and wasting of out-of-date food.
4. Certified Dietary Manager/designee will perform AM/PM walk-through audits of food storage areas five times weekly for 4 weeks and then weekly for 3 months until substantial compliance is achieved. Any variances identified will be immediately corrected and further education will be provided to staff regarding prevention of these variances. Certified Dietary Manager will present audit findings and any trends/patterns to the QAPI committee on a quarterly basis.
5. Date of Compliance: 7/1/2022

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F 812	Continued From page 12 Observed in the walk-in freezer on the top shelf was a box of pepperoni. The top and sides of the box were covered in thick white ice. Above the box was a condenser that was also covered in ice. The DM was asked about the thick ice accumulation on the box. He stated, "The condenser leaks water down and it freezes, it happens again as soon as we clean it up. He was asked if food should be stored under the leak. He stated he would move the box. On 06/01/2022 at approximately 4:00 p.m., the DM stated, "The dates on the milk were a sell by date...they should be used within 3-4 days after the date...the milk should have been used by yesterday at the latest...I threw it all away." He presented documentation from the vendor/manufacturing company of the milk which contained the following: "The sell by date represents the last day that the product should be purchased on the market. If the product is purchased on this date and has maintained proper temperature during distribution, the product should be consumable for 3-4 days after this date." No further information was obtained prior to the exit conference on 06/02/2022.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (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	F 842		

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F 842

Continued From page 13

except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§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-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(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.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-

F 842

F842- Resident Records - Identifiable Information

This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements.

1. An interdisciplinary care-plan meeting was held for resident #71. The resident's advance directives were determined per the resident's wishes, and the EHR was updated to include a physician's order for the resident's code status. The resident and/or responsible party, and provider were notified of resident #71's advance directives and code status. The resident's plan of care was reviewed and updated to reflect their resident-specific needs. Fairmont Crossing Rehab Center has identified that all residents are at risk from this alleged deficient practice.
2. The Director of Nursing/designee has performed an audit of all current resident advance directives to ensure each resident's advance directives are included in the EMR (electronic medical record). Any variances have been corrected and staff has notified residents and/or responsible parties and providers of updated orders and plans of care.
1. The Director of Nursing/designee has educated staff, including RNs, LPNs, and Social Workers, regarding ensuring each resident has advance directives included in the EMR. The education includes, but is not limited to, the importance of documentation of advance directives, the importance of accurate code status orders, and how to record each in the EMR.

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F 842	Continued From page 14 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. 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 a complete and accurate record for for one of 25 residents, Resident #71. Resident #71's advance directives were not included in the EMR (electronic medical record). Findings include: Resident #71 was admitted with diagnoses which included, but were not limited to: diabetes mellitus, chronic kidney disease, vascular dementia, constipation, and osteoarthritis. The resident's most current MDS (minimum data set) was an annual assessment dated 04/21/22. This MDS assessed the resident with a cognitive score of 14, indicating the resident was intact for daily decision making skills.	F 842	2. The Director of Nursing/designee will review medical records of all new admissions five times weekly for six weeks to ensure that the medical records include advance directives and a code status order. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and provide education as needed on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 3. Date of Compliance: 7/1/2022	

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	495363	A. BUILDING ____ B. WING ____	C 06/02/2022

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F 842	Continued From page 15	F 842		

On 06/01/22 at 3:20 PM, Resident #71's clinical EMR were reviewed. The physician's order for the resident included an order for: "...DNH (Do Not hospitalize)..."

The physician's orders did not include an order for "full code and/or CPR (cardiopulmonary resuscitation)" or "DNR (Do Not Resuscitate)."

On 06/02/22 at 3:54 PM, the administrative assistant was asked about an advance directive/code status for Resident #71. The administrative assistant stated that the resident should have an order and stated that she would investigate and attempt to find out the resident's code status.

The policy titled, "Cardiopulmonary Resuscitation (CPR)" documented, "...CPR...Code Status refers to the level of medical interventions a person wishes to have started in their heart or breathing stops...DNR..refers to a medical order issued by a physician...not to administer CPR...Staff will confirm that physician admission and readmission orders address the resident's code status and that the orders conform to the resident's wishes..."

The administrative assistant stated, "The resident is actually a DNR" and presented the paper copy of the DDNR (durable do not resuscitate) order and stated that the order should have been in the EMR under the physician's orders and that the DDNR order should have been scanned into the EMR as well.

No further information and/or documentation was presented prior to the exit conference.

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F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure	F 849	**F849/12VAC5-371-360(D)- Hospice Services** This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1.) The medical records of resident #89 were reviewed and weekly hospice visit records have been obtained per the hospice services agreement. The resident's care plan has been updated to reflect a current individualized plan of care. Fairmont Crossing Rehab Center has identified that all residents are at risk from this alleged deficient practice. 2.) The Director of Nursing/designee has performed an audit of all current residents with hospice orders. Any missing weekly hospice visit records have now been obtained and entered into the resident medical record. The resident's care plans have been updated to reflect a current individualized plan of care. 3.) The Director of Nursing/designee has educated licensed nursing staff on obtaining weekly hospice visit records. The in-service includes, but is not limited to, the importance of obtaining weekly hospice visit records and entering the visit records into the resident medical record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 849	Continued From page 17 that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and	F 849	4.) The Director of Nursing/designee will conduct an audit of all residents with hospice orders weekly for four weeks to ensure that weekly hospice visit records are obtained and entered into the residents' medical record. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to obtain the weekly hospice visit records and re-educate staff. The Director of Nursing/designee will identify any trends and/or patters and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 7/1/2022	

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F 849	Continued From page 18 delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related	F 849		

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F 849	Continued From page 19 conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.	F 849		

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F 849	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility document review, the facility staff failed to ensure professional standards of practice by a hospice provider for 1 of 25 residents in the survey sample, Resident #89. Records of weekly hospice visits for Resident #89 were not provided to the facility as required in the hospice services agreement. The findings include: Resident #89 was admitted to the facility with diagnoses that included palliative care, disorientation, hypo-osmolality, hyponatremia, type 2 diabetes, unilateral inguinal hernia, peripheral vascular disease, hyperlipidemia, stage 3 chronic kidney disease, anemai, adult failure to thrive, and muscle weakness. The most recent minimum data set (MDS) dated 05/06/2022 was a quarterly assessment and assessed Resident #89 as cognitively intact for daily decision making with a score of 15 out of 15. Under Section O - Special Treatments, Procedures, and Programs, the MDS assessed Resident #89 has receiving "Hospice" Services. Resident #89 was interviewed on 06/01/2022 during the initial tour regarding the quality of care and quality of life since being admitted to the facility. Resident #89 stated things were going well and everyone treated him nice. Resident #89 shared he was seen twice weekly by the hospice provider and he looked forward to seeing them for the visits. Resident #89's electronic clinical record (EHR) was reviewed on 06/01/2022. Observed on the	F 849		

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F 849	Continued From page 21 order summary report was an order for hospice with an order date of 03/10/2022 and a start dated of 03/11/2022. Observed on the care plans was a focus area including goals and interventions for hospice care related to "declining condition". Observed within the miscellaneous section of the EHR was the hospice physician's orders/plan of care dated 03/20/22 to 06/17/22 and the hospice certification statement for 90-day period of 03/20/22 to 06/17/2022. Additional review of the EHR did not provide any hospice visits notes. On 06/02/2022 at 9:02 a.m., the unit manager (LPN #1) was interviewed about the hospice notes. LPN #1 stated the hospice notes were filed in Resident #89's paper/hard chart. A review of this chart documented hospice visits notes with the most recent note dated 04/19/2022. LPN #1 was asked how and when did the facility receive the hospice visits notes. LPN #1 stated the hospice provided the printed notes normally during their visits. LPN #1 was advised the most recent hospice note observed in the paper/hard chart was dated 04/19/2022. LPN #1 stated she was not aware why the notes were not current as hospice visited Resident #89 twice weekly. A review of the " Agreement For Provision Of Hospice Services" dated February 12, 2004 between the facility and hospice provider documented on page 8 the following: "... V. Records: 5.1 Compilation of Records: a. Preparation: The Nursing Facility and Hospice shall each prepare and maintain complete and detailed clinical records concerning each Residential Hospice Patient receiving Nursing Facility Services and Hospice Services under this	F 849		

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	495363	A. BUILDING ______ B. WING ______	C 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRMONT CROSSING HEALTH AND REHAB CENTER	173 BROCKMAN PARK DRIVE AMHERST, VA 24521

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F 849	Continued From page 22 Agreement in accordance with prudent record-keeping procedures and as required by applicable federal and state law and regulations and application Medicare and Medicaid program guidelines. Each clinical record shall completely, promptly and accurately document all services provided to, and events concerning, each Residential Hospice Patient (including evaluations, treatments, progress notes, authorizations to admissions to Hospice and/or the Nursing Facility and physician orders, entered pursuant to the Agreement). The Nursing Facility and Hospice shall cause each entry made for services provided hereunder to be signed by the person providing the services...." On 06/02/2022 at 4:40 pm., the above findings were reviewed with the administrator, DON and various clinical staff during a meeting. No additional information was received by the survey team prior to exit on 06/02/22 at 6:00 p.m.	F 849		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to implement an	F 881		

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F 881	Continued From page 23	F 881		

antibiotic stewardship program. The facility's documented program regarding protocols and monitoring of antibiotic use was not implemented. The census in the facility was 111 residents.

Findings were:

On 06/01/2022 at approximately 1:55 p.m., the interim DON (director of nursing), who also identified herself as the IP (Infection preventionist) was interviewed regarding the antibiotic stewardship program at the facility. She stated, "I'm not sure what we have, I will need to look...I've been doing this position less than 24 hours."

At approximately 3:00 p.m. she presented a policy and procedure "Antibiotic Stewardship Program" that contained the following: "...The goals of the program include: Ensuring residents...are prescribed the appropriate antibiotic, reducing the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use. The Antibiotic Stewardship team will analyze infection data [including type of infection or symptoms being treated, antibiotic utilization, and adverse outcomes, etc.] monthly and feedback will be provided to the QAPI Committee regarding antibiotic stewardship practices..." The policy included specific procedure and guidance to be followed for the antibiotic stewardship program The Interim DON was asked if there was documentation regarding the use of antibiotics. She stated, "This policy is all we have...the former DON was doing it. I talked to her and she said there is supposed to be a book for tracking and other information but we don't have one." She was asked if the former

F881/12 VAC 5-371-370(A)- Antibiotic Stewardship Program

This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements.

1. It is the policy of Fairmont Crossing Rehab Center to implement an antibiotics stewardship program. Fairmont Crossing Rehab Center has determined that all residents have the potential to be affected by this alleged deficient practice.
2. Fairmont Crossing Rehab Center has implemented an antibiotics stewardship program under the supervision on the Director of Nursing/Infection preventionist.
3. The Director of Nursing/Infection preventionist has educated all licensed clinical staff, including RNs and LPNs on the antibiotic stewardship program. The education included, but was not limited to, the importance of antibiotic stewardship in infection control, and the individual responsibilities of nurses in supporting and adhering to the antibiotic stewardship program.
4. The Director of Nursing /Designee will perform an audit of all antibiotics used in the facility five times weekly for four weeks and then weekly for six weeks to ensure that antibiotics are administered, and antibiotic orders written, in accordance with the antibiotic stewardship program. Results of audits will be shared with the QAPI committee. Any patterns or trends will be reported to the Quality Assurance and Performance Improvement Committee at least quarterly.
5. Date of Compliance: 7/1/2022

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F 881	Continued From page 24 DON was onsite for interview. She stated, "Yes." At approximately 3:15 p.m., the former DON was interviewed. She stated, "The former ADON (assistant director of nursing) was doing it...she went out on FMLA in December and then resigned...I can't find any of her books...I took it over in December and I have some tracking back to then, but we really don't have the information that you are looking for." No further information was obtained prior to the exit conference on 06/02/2022.	F 881		
F 908 SS=B	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 and staff interview, the facility staff failed to ensure proper function of the condenser in the walk in freezer of the main kitchen. The condenser was leaking water creating thick white ice on food stored underneath. Findings were: Initial tour of the kitchen was conducted on 06/01/2022 at approximately 10:40 a.m. with the dietary manager (DM). Observed in the walk-in freezer on the top shelf was a box of pepperoni. The top and sides of the box were covered in thick white ice. Above the box was a condenser that was also covered in ice. The DM was asked about the thick ice accumulation on the box. he	F 908		

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F 908	Continued From page 25	F 908		

stated, "The condenser leaks water down and it freezes, it happens again as soon as we clean it up. He was asked if food should be stored under the leak. He stated he would move the box. He was asked if maintenance had looked at the condenser. He stated, "Yes, I talked to (Name), he was the former maintenance worker, he said it couldn't be fixed...we have a new guy now (name)." He was asked if a work order ad been put in regarding the leaking condenser. He stated, "No, just word of mouth to (Name of previous maintenance worker)."

On 06/01/2022 at approximately 11:55 a.m., the administrator was asked if the maintenance director was available for interview. She stated, "(Name) was let go about 15 minutes before you got here. (Name) is filling in...he's been here for 14 years, I think he can help you."

At approximately 12:10 p.m., the maintenance worker was interviewed. The condenser in the freezer was discussed. He stated, "(Name of DM) actually called me down there to look at it...you're right, it shouldn't be doing that...the water should be draining out not dripping down. Something might be clogging up the line. I've got a call into the refrigerator company to get them to come in and look at it."

At approximately 1:30 p.m., the DM stated, "(Name) from the refrigeration company will be here on Friday to look at that condenser and get it taken care of."

No further information was obtained prior to the exit conference on 06/02/2022.

F908- Essential Equipment, Safe Operating Condition

This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements.

1. The condenser in the walk-in freezer of the main kitchen has been repaired and is currently operating properly. It is the policy of Fairmont Crossing Rehab Center to ensure all mechanical, electrical, and patient care equipment are in safe operating condition. Residents receiving meals from the kitchen have the potential to be affected by this alleged deficient practice.
2. The Administrator/designee has performed inspections of all mechanical and electrical kitchen equipment to ensure the equipment in safe operating condition. Any items found out of compliance have been repaired and are now in safe operating condition.
3. The Certified Dietary Manager/designee has re-educated culinary staff on reporting to maintenance any equipment that is not functioning properly. The education included, but was not limited to, safe operating conditions, importance of properly functioning equipment in foodservice sanitation, and the process for reporting equipment that is not in safe operating condition.
4. The Administrator/designee will perform inspections of inspections of all mechanical and electrical kitchen equipment to ensure the equipment in safe operating condition five times weekly for 4 weeks and then weekly for 3 months to ensure that dishwasher is operating at a safe temperature. Any variances identified will be immediately corrected and further education will be provided to staff regarding prevention of these variances. Administrator will present audit findings and any trends/patterns to the QAPI committee on a quarterly basis.
5. Date of Compliance: 7/1/2022