PRINTED: 01/18/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495218	B. WING		C 12/20/2022	
	ROVIDER OR SUPPLIER	EHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 188 OLD FINCASTLE ROAD FINCASTLE, VA 24090		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 000	INITIAL COMMENT	S	F 000			
F 695 SS=J	survey was conduct One (1) complaint (1) with deficiencies) was survey. Corrections with the following 42 Term Care requirem immediate jeopardy citation was lowered. The census in this 5 at the time of the su consisted of six (6) two (2) closed recorn Respiratory/Trached CFR(s): 483.25(i) Respirat tracheostomy care and tracheal sucare, consistent with practice, the compressive care plan, the reside and 483.65 of this some the compressive care plan, the reside and 483.65 of this some the compressive care plan, the resident survey was and in the compressive care plan, the resident survey of the needs of four (4) residents with ventil Resident #2, Resident #1, On 12.00 Residen	6 certified bed facility was 51 rvey. The survey sample current resident reviews and d reviews. Ostomy Care and Suctioning cory care, including and tracheal suctioning. Sure that a resident who are, including tracheostomy actioning, is provided such a professional standards of enensive person-centered ents' goals and preferences,	F 695	Past noncompliance: no plan of correction required.		
ABORATORY	DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIVE'S SIGNATURE	<u>'</u>	TITLE	(X6) DATE	

Electronically Signed 01/17/2023

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495218	B. WING				C
NAME OF PR	ROVIDER OR SUPPLIER	100210		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	20/2022
				18	88 OLD FINCASTLE ROAD		
BRIAN CE	NTER HEALTH AND REI	HABILITATION		F	INCASTLE, VA 24090		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page	÷ 1	F	395			
	lowered to a D.						
	The findings include:						
	#1's medical provider the resident was provident the resident was provident the resident was provident the resident was provident the resident #1's ventilator assessment completed by a respir facility staff failed to eventilator alarm was the resident's ventilator with ventilator alarm is a saddition to the alarms. The remote alarm was door, in the hallway, or Resident #1's minimulassessment, with an a (ARD) of 11/8/22, was 11/22/22. Resident #1 make self understood others. Resident #1's Status (BIMS) summa as a 15 out of 15 (ind borderline cognition). as requiring assistant transfers, dressing, to hygiene. Resident #1 Respiratory Failure. It documented as received	n. The facility staff failed to ventilator care and/or ts were appropriately ratory therapist (RT). The insure Resident #1's remote urned on when the ras in use. (The remote upplemental alarm used in built into the ventilator. Is located near the top of the outside Resident #1's room.) In data set (MDS) In data set (MDS) In data set (MDS) In assessment reference date is dated as completed on the and as able to understand is Brief Interview for Mental ary score was documented in interview for Mental ary score was docum					
	- Settings for ventilate	I provider orders included: or use related to "CHRONIC URE WITH HYPOXIA"					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTIO	·N	(X3) DATE COMP	SURVEY LETED	
		495218	B. WING _				C 20/2022	
	ROVIDER OR SUPPLIER	HABILITATION		STREET ADDRESS 188 OLD FINCAS FINCASTLE, VA		1 12/	20/2022	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		(EAC	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 695	day) and with (physic (oxygen) to 10 (liters two times a day for NDEPENDENCE ON [VENTILATOR] STATE The facility policy an "Passy-Muir Valve" (indicated its use was respiratory therapist (ST). This documenthe Passy-Muir Valve weaning of a resider facilitate communicated the following that are in a residentian external audible at Resident #1's care power "resident is ventilators secondary to respiratory therapy aper order, and wean On 12/8/22 at 1:25 power than the facility's Administer being found unrespondation of 12/6/22. The Administer ventilator on 12/6/22. The Administer ventilator on 12/6/22. Respiratory Therapis	ar) trials 4 (hours two times a cal therapy) increase) and with (Passy Muir Valve) VEANING related to RESPIRATORY FUS" dated 11/28/22. d procedure titled this document was not dated) is the basic responsibility of (RT) and/or speech therapist ted stated the "purpose of is (PMV) is to aid in the int from an artificial airway and tion." Decedure titled "Ventilator document was not dated) g information: "All ventilators is room will be connected to alarm." Ian included a focus of or dependent via tracheostomy tory failure". This care ed the following hister oxygen as ordered, is ordered, ventilator setting ing protocol as indicated. I.m., the surveyor interviewed trator about Resident #1 insive on the evening of istrator stated it was ident #1 was removed from	F	95				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495218	B. WING _			C 12/20/2022
	ROVIDER OR SUPPLIER	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 188 OLD FINCASTLE ROAD FINCASTLE, VA 24090		12/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	on the ventilator on Administrator acknoweaning trial/trach return to the ventilator on 7:30 p.m. on 12/6/2 unresponsive while On 12/8/22 at 5:48 (RT) #1 was intervi #1 unresponsive on #1 confirmed they fur unresponsive on the approximately 7:30 they entered Resid something was workesident #1 if they resident did not res #1 was "extremely Resident #1 was for ventilator, but the ventilator, but the ventilator on it apper properly. RT #1 report ventilator on it apper properly. RT #1 reincluding the use of defibrillator (AED), Resident #1 was not on 12/9/22 at 10:10 (RT) #2 was intervievent referenced in provided care for R	and placed Resident #1 back 12/6/22 at 6:10 p.m. The owledged Resident #1's collar trial and the reported ator had not been documented. reported, that at approximately 22, RT #1 found Resident #1 redoing rounds. p.m., Respiratory Therapist rewed about finding Resident in the evening of 12/6/22. RT found Resident #1 reported, when rent #1's room, they knew rong. RT #1 stated they asked needed anything, but the reported anything, but the rentilator was in "standby" and reported when they turned the rentilator on and went to yell for red when they turned the reared as if it was working ported basic life support, fan automated external was provided. RT #1 reported out revived. O a.m., Respiratory Therapist rewed, via telephone, about the rentils complaint. RT #2 had resident #1 during dayshift	F 6	95		
	(7AM - 7PM) on 12 typical day. RT #2 the second weanin	/6/22. RT #2 reported it was a stated Resident #2 completed g trial / trach collar trial at p.m. on 12/6/22. RT #2				

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		495218	B. WING _			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO. 188 OLD FINCASTLE ROAD FINCASTLE, VA 24090		2/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 695	ventilator. RT #2 repoworking; RT #2 repoworking; RT #2 repowas in the 70s and the saturation was in the they suctioned Reside was not deep suction. Resident #2's rooms calling-out from anoth they turned on the veoutside Resident #1's believe I did not." On 12/8/22 at 1:37 p. Administrator and Diasked for copies of From Resident #1's was unable to provide a report of from Resident #1's was unable to provide information retrieved data. The data obtain ventilators was review use at the following trapproximately 6:10 provided to the surveinternal data was not the aforementioned to ventilator was being further evaluation. On 12/15/22 at 9:08. Resident #1's respiratory with the facility's Direct following issues were on 12/1/22's 7AM or respiratory documents.	esident #2 back on the forted the ventilator was ted Resident #1's heart rate are resident's oxygen upper 90%. RT #2 stated ent #1 twice; RT #2 stated it sing. RT #2 reported they left to respond to a resident are room. When asked if entilator alarm located aroom, RT #2 stated, "I sector of Respiratory were desident #1's ventilator as able from the internal data entilator. The facility staff was able from the ventilator's internal and from Resident #1's ventilator internal and from Resident #1 wed for evidence of ventilator internal and on 12/6/22 at .m. and on 12/6/22 at .m. The information eyor from the ventilators clear about ventilator use at imes. Resident #1's sent to the manufacture for a.m., the surveyor reviewed atory care documentation actor of Respiratory. The	Fé	95			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD			, ا	
		495218	B. WING			l	20/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BDIAN CE	NTER HEALTH AND	PEHARII ITATION		18	8 OLD FINCASTLE ROAD		
DIVIAN CL	MILKIILALIII AND	KEHABIEHAHON		FI	NCASTLE, VA 24090		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	ventilator check as was placed back of conclusion of the of the Director of Red did not have a polithe documentation trials. The Director progress note showhen the weaning initiated and that a should have been was restarted afte trial/trach collar trial on 12/2/22's 7AN respiratory docume evidence of a respiratory docume trial/trach collar trial/trach collar trial/trach collar trial/trach collar trial/trach collar trials should have compassessment at the back on the ventila collar trial. On 12/2/22's 7PN respiratory adminithe resident's weanot provided as or Respiratory confind documentation to collar trial had been Respiratory report the weaning trial/tria	/ trach collar trial and (b) a sessment when the resident on the ventilator after the veaning trial / trach collar trial. spiratory reported the facility cy and/or procedure detailing of weaning trials/trach collar of Respiratory reported a suld have been documented trial/trach collar trial was eventilator check assessment completed when the ventilator of the conclusion of the weaning al. If dayshift, Resident #1's entation failed to provide irratory therapist providing the collar trial; documentation of each collar trial was incensed practical nurse (LPN). spiratory reported a respiratory are provided the weaning al and a respiratory therapist leted a ventilator check time the resident was placed after after the weaning trial/trach If nightshift, Resident #1's estration record (RAR) indicated ining trial/trach collar trial was dered. The Director of	F	695			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
				_		1 (С
		495218	B. WING				20/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				1	88 OLD FINCASTLE ROAD		
BRIAN CE	NTER HEALTH AND F	REHABILITATION		F	FINCASTLE, VA 24090		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 695	Continued From pa	age 6	F	695			
	·	hen the resident was placed					
	· •	rach collar trial and (b) a					
	_	sessment when the resident					
	was placed back or	n the ventilator after the					
		eaning trial/trach collar trial.					
	The Director of Res	spiratory reported a progress					
	note should have b	een documented when the					
	weaning trial/trach	collar trial was initiated and					
		eck assessment should have					
		nen the ventilator was restarted					
	after the conclusion of the weaning trial/trach						
	collar trial. - On 12/4/22's 7AM dayshift, Resident #1's						
		entation failed to include (a) a					
	· -	hen the resident was placed rach collar trial and (b) a					
	_	sessment when the resident					
		n the ventilator after the					
		eaning trial/trach collar trial.					
		spiratory reported a progress					
		een documented when the					
	weaning trial/trach	collar trial was initiated and					
	that a ventilator che	eck assessment should have					
	been completed wh	nen the ventilator was restarted					
	after the conclusior	n of the weaning trial/trach					
	collar trial.						
		l dayshift, Resident #1's					
		entation failed to include (a) a					
	· •	when the resident was placed					
	_	rach collar trial and (b) a sessment when the resident					
		sessment when the resident n the ventilator after the					
		reaning trial/trach collar trial.					
		spiratory reported a progress					
		een documented when the					
		collar trial was initiated and					
	_	eck assessment should have					
		nen the ventilator was restarted					
	•	n of the weaning trial/trach					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED			
		495218	B. WING _			C 12/20/2022
	ROVIDER OR SUPPLIER	EHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 188 OLD FINCASTLE ROAD FINCASTLE, VA 24090		TEI EGLE
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	respiratory progressindicated the reside trial was not provide trials/trach collar triathe dayshift. The D confirmed there wa both of the provider collar trials had been on 12/8/22 at 1:42 Respiratory reporte in-serviced related receive in-service trowork their next strespiratory staff trait provided to the survey. All other observed to receive during each day of the facility staff beginning the extent 12/9/22. This moni planned to be contificablity's quality assimprovement (QAP of the 30-minute extent was provided to the the The facility's respiration implemented mand 12/7/22. The facility provided the survey staff communication rounds/report dated current respiratory staff corrections.	nightshift, Resident #1's so note, timed 7:05p.m., ent's weaning trial/trach collar end due to both weaning als had been provided during birector of Respiratory so no documentation indicating ordered weaning trials/trach en provided during the dayshift. p.m., the facility's Director of diall respiratory staff had been to ventilator care or will raining prior to being allowed hift. Documentation of the ning, dated 12/7/22, was veyor prior to the conclusion of the residents on ventilators were enoxygen per physician's order the survey. Igan every 30-minute grand ventilator alarms on toring was ongoing and was nued until reviewed by the urance and performance I) committee. Documentation ternal ventilator monitoring	F6	95		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495218	B. WING		C 12/20/2022		
	ROVIDER OR SUPPLIER	EHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 188 OLD FINCASTLE ROAD FINCASTLE, VA 24090	12/20/2022		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICE DEFICIENCY)	D BE COMPLETION		
F 695	Administrator report assurance and perficommittee will revie issues during the up. This is a complaint 2. The facility staff ventilator assessmerespiratory therapis times. The Director 8:40 a.m., provided "DAILY ROUNDS". ventilator assessmeleast twice per 12-h Resident #2's minin assessment, with an (ARD) of 9/9/22, wa 9/23/22. Resident #2 Status (BIMS) summas a 15 out of 15 (in borderline cognition as being independent eating, and toilet us as requiring supervipersonal hygiene. Included Respirator documented as recognition, tracheosymechanical ventilators.	2/20/22, the facility's ted the facility's quality formance improvement (QAPI) and any identified respiratory proming QAPI meeting. deficiency. failed to ensure Resident #2's ents were completed by a tax (RT) at the appropriate of Respiratory, on 12/9/22 at a copy of a document titled. This document indicated ents were to be completed at our shift. In the data set (MDS) in assessment reference date as dated as completed on the date of the date	F 699				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495218	B. WING _			C 12/20/2022
	ROVIDER OR SUPPLIER	EHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 188 OLD FINCASTLE ROAD FINCASTLE, VA 24090		12/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	focus of "(resident n dependent via trach respiratory failure". The facility policy/promanagement" (this control of the respiratory the Under the heading following steps: "1. Washes hands, maind 4. [sic] Obtains approvides privacy. 6. supplies/equipment. Check. a. If ventilate from service and plate Adjust ventilator to provide set to correct service set to correct service as the service set to correct service and plate a	#2's care plan included a ame omitted) is ventilator eostomy secondary to occedure titled "Ventilator document was not dated) ag information:	F	DEFICIENCY)		
	ETC02 analysis. 14 - Under the heading following items: "1. I 2. Ventilator settings status. 4. Resident Signature." On 12/19/22 at 12:3 ADON, and Director interviewed about LI care and/or weaning was reported that th written policy and/or	Document". of "Documentation" were the Date and time of procedure. 3. Resident respiratory response to therapy 3. [sic] 1, the facility's Administrator, of Respiratory were PN monitoring of ventilator prials/trach collar trials. It efacility did not have a procedure detailing LPN intoring ventilator care and/or				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	COM	E SURVEY PLETED
		495218	B. WING			C / 20/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 188 OLD FINCASTLE ROAD FINCASTLE, VA 24090	12	720/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 695	Continued From pag	ne 10	F 69	95		
	surveyor reviewed R documentation on the was noted that only was completed for the 12/6/22. Respiratory documented as compassessment on 12/6 time clock records in working at the time of ventilator assessment Respiratory reported should have been or respiratory therapists ventilator assessment Respiratory reported assessments should the 7AM - 7PM shift RT #3 was interviewed to 7.05 p.m. RT #3 early on the afternoof instructed by other redocument resident in licensed practical nuas part of the respiratory, on 12/6 had been uncomfort information collected. On 12/20/22 at 10:10 with the facility's Adr Respiratory. RT #3 collected by an LPN	le 12/20/22 at 9:14 a.m. It one (1) ventilator assessment one 7AM - 7PM shift on a Therapist (RT) #3 was pleting a ventilator (22 at 8:08 a.m. RT #3's indicated they (RT #3) was not of the aforementioned ont. The Director of the ventilator assessment completed by one of the sworking at the time the int was due. The Director of two (2) ventilator thave been completed during on 12/6/22. I have been completed during on 12/6/22, they were respiratory staff members to information collected by a rise (LPN) who was working atory staff. RT #3 stated they immation collected by the hey contacted the Director of (22, because they (RT #3) able with documenting the laby the LPN. Of a.m., the survey team met ministrator and Director of documenting information and only one (1) ventilator completed on 12/6/22 dayshift				

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED	
		495218	B. WING _			C 12/20/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 188 OLD FINCASTLE ROAD FINCASTLE, VA 24090		12/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 695	ventilator assessmer respiratory therapist times. The Director 8:40 a.m., provided a "DAILY ROUNDS". ventilator assessmer least twice per 12-horn Resident #3's minimassessment, with an (ARD) of 10/11/22, w 10/24/22. Resident #3's Status (BIMS) summas a 15 out of 15 (incorderline cognition) as requiring assistant dressing, toilet use, a Resident #3's diagnor Failure. Resident #3 receiving oxygen the tracheostomy care, a ventilator use. Resident #3's medican order dated 8/24/mechanical ventilator included a focus of "Independent via tracheostory failure"	ailed to ensure Resident #3's ats were completed by a (RT) at the appropriate of Respiratory, on 12/9/22 at a copy of a document titled This document indicated ats were to be completed at our shift. The data set (MDS) assessment reference date was dated as completed on #3 was assessed as able to d and as able to understand as Brief Interview for Mental dicating intact and/or and Resident #3 was assessed ce with bed mobility, and personal hygiene. The ses included Respiratory is was documented as rapy, suctioning, and invasive mechanical all provider orders included 22 for the use of a r. Resident #3's care plan resident is ventilator eostomy secondary to becedure titled "Ventilator orders included".	F 6	95			
	Management" (this d	ocument was not dated) g information: was the basic responsibility					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495218	B. WING		C 12/20/2022		
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION			1	STREET ADDRESS, CITY, STATE, ZIP CODE 88 OLD FINCASTLE ROAD FINCASTLE, VA 24090	12/20/2022		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION		
F 695	following steps: "1. Washes hands, mail 4. [sic] Obtains appr 5. Identifies resident provides privacy. 6. supplies/equipment. check. a. If ventilate from service and pla Adjust ventilator to provide to connect ventilator to provide set to correct shasess resident responsibility. The ETC02 analysis. 14 - Under the heading following items: "1. If 2. Ventilator settings status. 4. Resident Signature." On 12/19/22 at 12:3 ADON, and Director interviewed about LI care and/or weaning was reported that the written policy and/or responsibility in more weaning trials/trach. The facility's Director surveyor reviewed From documentation on the was noted that only was completed for the 12/6/22. Respirator documented as compassessment on 12/6	of "Procedure" were the Verifies physician order. 2. Intains standard precautions. opriate supplies/equipment. It, explains procedure, and Properly assembles 7. Perform operational or fails operational check pull doe defective sticker. 8. Or resident. 10. Confirm PEEP setting 11. Analyze Fl02. 12. Intains perform 11. Analyze Fl02. 12. Intains perform 12. Document". Of "Documentation" were the Date and time of procedure. It is a Resident respiratory response to therapy 3. [sic] 14. The facility's Administrator, of Respiratory were 15. The facility did not have a 16. Procedure detailing LPN intoring ventilator care and/or collar trials. It is procedure detailing LPN intoring ventilator care and/or collar trials. It is procedure detailing LPN intoring ventilator care and/or collar trials. It is procedure detailing LPN intoring ventilator care and/or collar trials. It is procedure detailing LPN intoring ventilator care and/or collar trials. It is procedure detailing LPN into the Respiratory and the Resident #3's clinical in 12/20/22 at 9:27 a.m. It one (1) ventilator assessment in 7AM - 7PM shift on y Therapist (RT) #3 was	F 695				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495218	B. WING _			C 12/20/2022	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZI 188 OLD FINCASTLE ROAD FINCASTLE, VA 24090	IP CODE	IL/LU/LULL	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETION DATE	
F 695	working at the time of ventilator assessment Respiratory reported should have been correspiratory therapists ventilator assessment Respiratory reported assessments should the 7AM - 7PM shift of RT #3 was interviewed at 7:05 p.m. RT #3 recarly on the afternoor instructed by other redocument resident inflicensed practical nursus part of the respirat documented the infor LPN. RT #3 stated the Respiratory, on 12/6/2 had been uncomfortat information collected On 12/20/22 at 10:10 with the facility's Adm Respiratory. RT #3 discollected by an LPN assessment being cowas discussed during 4. The facility staff fail had two (2) ventilator 12/6/22 during the da Director of Respirator provided a copy of a ROUNDS". This documents	the aforementioned t. The Director of the ventilator assessment impleted by one of the working at the time the t was due. The Director of two (2) ventilator have been completed during in 12/6/22. In d via telephone on 12/13/22 exported, when they came in n of 12/6/22, they were expiratory staff members to formation collected by a see (LPN) who was working ory staff. RT #3 stated they mation collected by the ey contacted the Director of 22, because they (RT #3) ble with documenting the by the LPN. a.m., the survey team met inistrator and Director of ocumenting information and only one (1) ventilator impleted on 12/6/22 dayshift	F	395			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495218	B. WING	B. WING		C 12/20/2022	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION			•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 88 OLD FINCASTLE ROAD FINCASTLE, VA 24090		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	(ARD) of 11/14/22, w 11/28/22. Resident # and/or never able to rarely and/or never a Resident #4 was do impaired cognitive si Resident #4 was ass on others for bed me eating, toilet use, an Resident #4's diagnor Failure. Resident #4 receiving oxygen the tracheostomy care, a ventilator use. Resident #4's medic an order dated 9/28/ mechanical ventilator included a focus of " dependent via trache respiratory failure". The facility policy/pro Management" (this of provided the followin - The policy stated it of the respiratory the - Under the heading following steps: "1. \ Washes hands, main 4. [sic] Obtains appro 5. Identifies resident provides privacy. 6. supplies/equipment. check. a. If ventilator from service and pla	um data set (MDS) assessment reference date was dated as completed on 44 was assessed as rarely make self understood and as able to understand others. cumented as having severely kills for daily decision making. sessed as being dependent obility, transfers, dressing, d personal hygiene. sess included Respiratory 4 was documented as erapy, suctioning, and invasive mechanical al provider orders included 22 for the use of a ar. Resident #4's care plan resident is ventilator eostomy secondary to coedure titled "Ventilator document was not dated) ag information: was the basic responsibility erapist. of "Procedure" were the /erifies physician order. 2. ntains standard precautions. opriate supplies/equipment. , explains procedure, and	F	695			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION NG	(>	(X3) DATE SURVEY COMPLETED		
495218 B. WIN		B. WING _			C 12/20/2022		
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP COD 188 OLD FINCASTLE ROAD FINCASTLE, VA 24090	E	12/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 695	Connect ventilator to valve set to correct shasess resident responsibility in more weaning trials/trach The facility's Director surveyor reviewed Facumentation on the was noted that no vecompleted for the 7/Respiratory Therapisas completing a response the complete on 12/6/22.	president. 10. Confirm PEEP setting 11. Analyze FI02. 12. piratory status. (HR, RR, ew admission perform. Document". of "Documentation" were the Date and time of procedure. 3. Resident respiratory response to therapy 3. [sic] 1, the facility's Administrator, of Respiratory were PN monitoring of ventilator a trials/trach collar trials. It is facility did not have a procedure detailing LPN sitoring ventilator care and/or collar trials. 1 of Respiratory and the desident #4's clinical set 12/20/22 at 9:35 a.m. It entilator assessments were AM - 7PM shift on 12/6/22. Set (RT) #3 was documented biratory assessment on RT #3's time clock records 3) was not working at the attioned respiratory tilator assessments should did during the 7AM - 7PM shift	F	695			
	at 7:05 p.m. RT #3 early on the afternoon	red via telephone on 12/13/22 reported, when they came in on of 12/6/22, they were espiratory staff members to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_			
		495218	B. WING			12/	20/2022
	ROVIDER OR SUPPLIER	HABILITATION		18	TREET ADDRESS, CITY, STATE, ZIP CODE 88 OLD FINCASTLE ROAD INCASTLE, VA 24090		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842 SS=D	licensed practical nurses part of the respirate documented the inform LPN. RT #3 stated the Respiratory, on 12/6/2 had been uncomfortal information collected. On 12/20/22 at 10:10 with the facility's Adm Respiratory. RT #3 docollected by an LPN assessment being collected by an LPN assessment Being collect	formation collected by a see (LPN) who was working ory staff. RT #3 stated they mation collected by the ley contacted the Director of 22, because they (RT #3) ble with documenting the by the LPN. a.m., the survey team meet inistrator and Director of ocumenting information and no ventilator impleted on 12/6/22 dayshift this meeting. Itentifiable Information 483.70(i)(1)-(5) Int-identifiable information. Itelease information that is on the public. Itelease information that is on an agent only in intract under which the agent disclose the information ine facility itself is permitted. Cords. Identifiable information in the facility itself is permitted. Cords. Identifiable information in the facility itself is permitted. Cords. Identifiable information in the facility itself is permitted. Cords. Identifiable information in the facility itself is permitted. Cords. Identifiable information in the facility itself is permitted.		842			1/9/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495218	B. WING		C 12/20/2022		
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 188 OLD FINCASTLE ROAD FINCASTLE, VA 24090	12/20/2022		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION		
F 842	all information contaregardless of the forrecords, except whe (i) To the individual, representative where (ii) Required by Law; (iii) For treatment, paperations, as permi with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement pur purposes, research predical examiners, a serious threat to he by and in compliance §483.70(i)(3) The factor for (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 yellegal age under State §483.70(i)(5) The me (i) Sufficient information (ii) A record of the record information (iii) The comprehens provided;	cility must keep confidential ned in the resident's records, in or storage method of the in release isport their resident is permitted by applicable law; anyment, or health care ted by and in compliance is; activities, reporting of abuse, violence, health oversight is administrative proceedings, poses, organ donation ourposes, or to coroners, funeral directors, and to avert eath or safety as permitted is with 45 CFR 164.512. Collity must safeguard medical gainst loss, destruction, or all records must be retained in State law; or are date of discharge when ent in State law; or are after a resident reaches in law. Dedical record must containion to identify the resident; sident's assessments; ive plan of care and services by preadmission screening	F 84				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		C	
		495218	B. WING	B. WING			20/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				18	88 OLD FINCASTLE ROAD		
BRIAN CE	ENTER HEALTH AND	REHABILITATION		F	INCASTLE, VA 24090		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 842	Continued From page	age 18	F	842			
	_ ·	nducted by the State;					
		rse's, and other licensed					
	professional's prog						
		diology and other diagnostic					
	services reports as	required under §483.50.					
	This REQUIREME	NT is not met as evidenced					
	by:						
	Based on interview			Resident #1 expired 12/6/22.			
		of a complaint investigation, the					
	facility staff failed t			Facility determined that all residents co	uld		
		ocumentation for one (1) of			be affected by deficient practice.		
	eignt (8) sampled i	residents (Resident #1).			Ctoff in comittee for DNI DN DT or		
	The findings include			Staff in-service for RN,LPN, RT on appropriate AED documentation will be			
	The indings includ	ic.			completed by 1/9/2023.		
	Resident #1's clinic	cal documentation failed to			, <u>,</u>		
	include the use of	an automated external			Audit will be completed by managemer	nt	
	defibrillator (AED)	when attempting to resuscitate			staff on Code Blue/AED documentation		
	the resident. Resident.	dent #1's clinical			times a week starting 1/4/2023 for eigh	t	
		luded progress notes by a			weeks. Will reevaluate at eight weeks a	and	
		st (RT) whose electronic			continue random audits thereafter.		
		ly identified the RT as a					
	licensed practical i	nurse (LPN).			Audit will be completed for all newly hir	ed	
	Posidont #1's mini	mum data sat (MDS)			Respiratory Therapy staff to ensure correct credentials have been assigned	1	
		mum data set (MDS)			<u> </u>	1	
		an assessment reference date was dated as completed on			for Point Click Care documentation. Human Resources will include		
	' '	it #1 was assessed as able to			Administrator on User Access Change		
		ood and as able to understand			form sent to IT department for accuracy	v of	
		this Brief Interview for Mental			credentials.	,	
		nmary score was documented					
	as a 15 out of 15 (indicating intact and/or				All corrective action completed by		
	,	n). Resident #1 was assessed			1/9/2023.		
	as requiring assist	ance with bed mobility,					
		, toilet use, and personal					
		t #1's diagnoses included					
		e. Resident #1 was					
		ceiving oxygen therapy,					
suctioning, tracheostomy care, and invasive		ostomy care, and invasive					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED			
495218		B. WING _	B. WING			C 12/20/2022	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION				STREET ADDRESS 188 OLD FINCAST FINCASTLE, VA		, , ,	
(X4) ID PREFIX TAG			ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SH			(X5) COMPLETION DATE
F 842	(RT) #1 was interview #1 was provided whe #1 reported the facilit Resident #1, but sho reported facility staff Emergency Medical On 12/19/22 at 1:02 Administrator stated care for Resident #1 the use of the AED in record. Review of Resident #1 the use of the AED in record. Review of Resident #1 the use of the AED in record. Review of Resident #1 the use of the AED in record. Review of Resident #1 the use of the AED in record. On 12/2 included multiple electronic-signature flicensed practice nur respiratory therapist a.m., Staff Member (employee) confirmed been entered incorrecelectronic records sy individual being incording incording the Director of Respiratory	m., Respiratory Therapist wed about the care Resident en found unresponsive. RT ty staff applied the AED to ck was not advised. RT #1 continued with CPR until Services (EMS) arrived. p.m., the facility's the nurse who was providing should have documented in the resident's clinical #1's clinical record revealed ple progress notes with an that identified RT #2 as a see (LPN) instead of a (RT). On 12/15/22 at 9:06 SM) #8 (a human resource dr. RT #2's information had ectly into the facility's stem resulting in the rectly identified as an LPN. D. p.m., the survey team ty's Administrator and ratory confirmed the facility in policy and/or procedure to umentation topics (e.g., e entries, and corrections). I documentation failing to	F	342			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495218 B. WING			C 12/20/2022		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		20/2022
DDIAN OF	NTED HEALTH AND DE	UARU ITATION		188 OLD FINCASTLE ROAD		
BRIAN CE	ENTER HEALTH AND REI	HABILITATION		FINCASTLE, VA 24090		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842			F 84	2		
	respiratory therapist (
F 908 SS=E		Safe Operating Condition	F 90	8		1/4/23
	and patient care equicondition. This REQUIREMENT by: Based on interviews facility staff failed to eventilators were main manufactures guidant ventilators located at The findings include: Review of ventilator in failed to provide evide changing of the ventil The following informa "Clinical Manual" for the foam located on the foam located the filters wowhen observed to be	S483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on interviews and document review, the facility staff failed to ensure the facility's ventilators were maintained according to manufactures guidance for 36 of the 36 ventilators located at the facility. The findings include: Review of ventilator maintenance documents failed to provide evidence of the monthly changing of the ventilators "air-inlet foam filter". The following information was found in the "Clinical Manual" for the type of ventilators used by the facility: "The air-inlet foam filter is the gray foam located on the back panel. It protects (ventilator) from dirt and dust. In the clinical environment, replace monthly and between		On 12/15/2022 all ventilator filters we changed by contracted provider. Facility determined that all ventilator residents could be affected by deficie practice. In-service the dedicated Respiratory Therapist on filter changes monthly at the required documentation for filter changes. Completion on In-service vecompleted on 1/4/2023. Director of Respiratory will audit the completion of filter changes and documentation each month for three months. Will reevaluate at three mon and continue random audits thereafted All corrective action completed by 1/4/2023.	ent ind vas	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495218	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	495210	B. WING	STREET ADDRESS, CITY, STATE, ZIP CO		12/20/2022	
BRIAN CE	NTER HEALTH AND RE	HABILITATION		188 OLD FINCASTLE ROAD FINCASTLE, VA 24090			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CORRECTIVE ACTIVE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 908	On 12/20/22 at 10:10 with the facility's Adm Respiratory. The fail the facility's ventilator detailed in the ventilar discussed. The Adm Respiratory reported procedure to guide the aforementioned ventile was reported the facility manufacturer's guidal staff reported an individual to 10.00 miles and 10	a.m., the survey team meet ninistrator and Director of ure of facility staff to change rs' air-inlet foam filters as stors' "Clinical Manual" was inistrator and the Director of there was no policy and/or ne changing of the illator air-inlet foam filters; it lity staff would follow nce. The administrative vidual from the equipment nged the air-inlet foam filters	FS	908			