STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495121	A. BUILDING _____ B. WING _____	R-C 09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYDALE HEALTH AND REHABILITATION CENTER	3710 LEE HIGHWAY ARLINGTON, VA 22207

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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey, conducted on 8/16/22 through 8/18/22, was conducted 9/26/2022 through 9/27/2022. New findings were identified at previously cited Federal tags F-580, F-657, F-755, and F-812, while new findings were cited under F-759. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated during the survey. The census in this 180 certified bed facility was 175 at the time of the survey. The survey sample consisted of 11 current resident reviews (Resident #'s 101 through #111).	{F 000}		
{F 580} SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	{F 580}		10/24/22

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

Electronically Signed | 10/20/2022

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{F 580}	Continued From page 1 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, the facility staff failed to notify the physician of medications not available for one of eleven residents. The physician was not notified that Resident #110 did not have a Flovent inhaler available for administration on 09/21/2022. Findings were:	{F 580}	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of	

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{F 580}	Continued From page 2 Resident #110 was admitted with the following diagnoses, including but not limited to: Cerebrovascular disease, asthma, chronic respiratory failure, and hemiplegia. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 09/13/2022, assessed Resident #110 as moderately impaired with a cognitive summary score of "11". Review of the clinical record on 09/26/2022 at approximately 2:00 p.m., included the MAR (medication administration record) for September 2022. Resident #110 was scheduled to receive Flovent 110 mcg two puffs orally twice a day for asthma. The MAR for the morning (09:00 a.m.) dose was marked on the MAR with a "5" and the nurse's initials. Review of the progress note section included the following entry regarding the Flovent: "pending pharmacy delivery". There was no documentation that the physician had been notified that the medication was not available for administration. During a meeting on 09/27/2022 at approximately 11:15 a.m., with the administrator, the DON (director of nursing), and two corporate consultants, the survey team asked what was supposed to happen when medications were not available from the pharmacy to be given to residents. Administrative staff #3 stated, "We should contact the physician, get an order to hold the medication, and document it in the clinical record." The DON was asked if there was a policy regarding physician notification and if so to please provide a copy to the survey team. Prior to the exit summary on 09/27/2022 at 3:30 p.m., the survey team again asked for a policy regarding physician notification. The	{F 580}	correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F580 Resident # 110 physician was notified immediately that the Flovent inhaler was not available for administration. Medication was received the same day and administered later in the day. A review of current residents in the centers was completed for the last 30 days to ensure medications were available for administration. All clinical staff was educated by the Director of Nursing/designee on ensuring medications are available for administration and to ensure medications are re-ordered per policy. In addition, all clinical staff was educated on notifying the physician when medications are not available and documentation in the EMR (electronic medical record). The DON/designee will review in daily clinical meeting 5x/weekly to ensure medications are available for administration and if not, there is documentation in the EMR of notification to the physician. The results of the review will be reviewed and discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exits, the monitoring will occur on a random basis. Date of completion: 10/24/2022	

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{F 580}	Continued From page 3 administrative team stated that they could not find a policy. The DON was asked what the expectation was if medications were not available for administration. She stated, "They should notify the physician." No further information was obtained prior to the exit conference on 09/27/2022.	{F 580}		
{F 657} SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	{F 657}		10/24/22

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{F 657}	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, and clinical record review the facility failed for one of 11 residents to review and revise a comprehensive care plan. Resident #101's care plan was not updated to indicate a peripheral catheter (intravenous line, IV) had been discontinued. The Findings Include: Diagnoses for Resident #101 included; Sepsis , schizophrenia, congestive heart failure, and, depression. The most current MDS (minimum data set) was a 5 day assessment with an ARD (assessment reference date) of 7/25/22. Resident #101 was assessed with a cognitive score of 13 indicating cognitively intact. On 9/26/22 Resident #101's medical record was reviewed. The care plan documented Resident #101 had a IV in place and gave interventions for the care of the IV. Review of Resident #101's current physician orders did not indicate that Resident #101 had in IV in place. Further review of inactive orders documented a discontinue order for the IV on 8/22/22. On 9/26/22 at 3:50 PM Resident #101 was interviewed. During the conversation resident #101 verbalized he no longer had an IV in place. On 9/27/22 at 11:00 AM registered nurse (RN #1, unit manager) was interviewed concerning the care plan that was in place for Resident #101's IV. RN #1 said it was her responsibility to update care plans and after reviewing Resident #101's care plan regarding an IV, RN #1 said the care	{F 657}	F657 Resident #101 care plan was revised for removal of the peripheral IV which had been discontinued. A review of care plans the last 30 days for residents ordered Peripheral IV(s) was reviewed to ensure the care plan reflected the current status of the IV. The IDT team was educated by the Regional MDS/designee on updating/revising care plans to reflect the residents□ current status. The Regional MDS/designee will review residents with orders for IV(s) weekly to ensure the care plan reflects the current status of the IV. The results of the monitoring will be reviewed and discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exits, the monitoring will occur on a random basis. Date of completion: 10/24/2022	

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{F 657}	Continued From page 5 plan should have been updated to reflect the discontinuation of Resident #101's IV. On 9/27/22 at 11:15 AM the above information was presented to the director of nursing and administrator during a meeting with the administrative staff. No other information was presented prior to exit conference on 9/27/22.	{F 657}		
{F 755} SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	{F 755}		10/24/22

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{F 755}	Continued From page 6 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, medication pass observation, and facility document review, the facility staff failed to ensure two of eleven residents had medications available for administration. Resident #110 did not have a Flovent inhaler available on 09/21/2022. Resident #101 did not have Folic Acid or Olanzapine available for administration during a medication pass observation on 09/27/2022. Findings were: 1. Resident #110 was admitted with the following diagnoses, including but not limited to: Cerebrovascular disease, asthma, chronic respiratory failure, and hemiplegia. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 09/13/2022, assessed Resident #110 as moderately impaired with a cognitive summary score of "11". Review of the clinical record on 09/26/2022 at approximately 2:00 p.m., included the MAR (medication administration record) for September 2022. Resident #110 was scheduled to receive Flovent 110 mcg two puffs orally twice a day for asthma. The MAR for the morning (09:00 a.m.) dose was marked on the MAR with a "5" and the nurse's initials. Review of the progress note section included the following entry regarding the Flovent: "pending pharmacy delivery".	{F 755}	F755 Resident #110 is now receiving the Flovent inhaler as per physician order. Resident #101 is know receiving their Folic Acid as per physician order. All residents receiving medications in the center have the potential to be affected. All clinical staff was educated by the Director of Nursing/designee on ensuring medications are available for administration and to ensure medications are re-ordered per policy. In addition, all clinical staff was educated on notifying the physician when medications are not available and documentation in the EMR (electronic medical record). The DON/designee will review in daily clinical meeting 5x/weekly to ensure medications are available for administration and if not, there is documentation in the EMR of notification to the physician. The results of the review will be reviewed and discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exits, the monitoring will occur on a random basis. Date of completion : 10/24/2022	

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{F 755}	Continued From page 7	{F 755}		

During a meeting on 09/27/2022 at approximately 11:15 a.m., with the administrator, the DON (director of nursing), and two corporate consultants, the DON was asked what the "5" on the MAR indicated. She stated, "It means hold and see note." She was asked why the medication had not been available for administration. She stated, "I spoke with the pharmacy we try to order the medication five days prior to running out, but the insurance would not allow the refill until the day we ran out. We got the medicine here by the evening dose that night." She was asked if there was any documentation regarding the pharmacy's inability to refill the prescription due to insurance coverage. She stated she would look.

On 09/27/2022 at approximately 12:00 p.m., the DON stated she could not find the documentation that had been requested, but she was attempting to get something from the pharmacy.

On 09/27/2022 at 2:40 p.m., the survey team spoke with OS (other staff) #1 and OS #2 at the pharmacy. Both stated, they were unable to see if the insurance company had rejected the refill request, but that it might not be available to them on their screens.

No further information was obtained prior to the exit conference on 09/27/2022.

2. Resident #101's Olanzapine 10 milligrams (mg) given for Schizophrenia and Folic Acid 1 mg given for anemia was unavailable for distribution.

The Findings Include:

Diagnoses for Resident #101 included; Sepsis ,

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{F 755}	Continued From page 8	{F 755}		

schizophrenia, congestive heart failure, depression, and anemia. The most current MDS (minimum data set) was a 5 day assessment with an ARD (assessment reference date) of 7/25/22. Resident #101 was assessed with a cognitive score of 13 indicating cognitively intact.

On 09/27/22 at 9:00 AM a medication pass and pour observation was conducted. Resident #101's Olanzapine 10 mg and Folic Acid 1 mg was ordered to be given at 9:00 AM. License practical nurse (LPN #1) could not find either of the medications in the medication cart. LPN #1 said he would check to see if the missing medications were in the Omni Cell (pharmaceutical distribution center located in the medication room) to see if the medications were at the facility.

LPN #1 then went to the Omni Cell and discovered the medications were not there. LPN #1 verbalized he would notify the physician and call the pharmacy to send medications to the facility.

On 9/27/22 Resident #101's physician orders were reviewed. An order dated 7/25/22 read "Folic Acid Tablet 1MG give 1 tablet by mouth in the morning for Anemia." Another order dated 7/26/22 read "Olanzapine Tablet 10 MG Give 1 tablet by mouth in the morning related to Schizophrenia."

On 9/27/22 at 10:30 AM the director of nursing (DON) informed this surveyor that the nurse practitioner gave orders to hold the Olanzapine until the medication arrives in the evening and to give 800 micrograms (mcg) of Folic Acid. The DON was asked, when should a nurse reorder

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{F 755}	Continued From page 9 medications to ensure continued administration of medications. The DON verbalized medications should be ordered when there are 5 pills left. The DON was asked to find out if the medications in question were reordered. On 9/27/22 at 11:15 AM the above information was presented to the DON, administrator and nurse consultant during a staff/surveyor meeting. On 9/27/22 at 1:15 PM the DON presented a copy for the reordering of the Folic Acid but said she was unable to find documentation of the reordering of Olanzapine and verbalized that the nurses may have called the pharmacy to reorder the Olanzapine. The facilities policy titled "Ordering and Receiving Non-Controlled Medications" read in part: "Reorder medications based on the estimated refill date (ERD) on the pharmacy Rx label, or at least three days in advance, to ensure adequate supply is on hand (...)" No other information was presented prior to exit conference on 9/27/22.	{F 755}		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview, clinical record review, and facility	F 759	F759 Resident #101 is now receiving their Folic	10/24/22

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F 759	Continued From page 10 document review the facility staff failed to ensure a medication error rate less than 5 percent. There were two errors out of 27 opportunities resulting in a medication error rate of 7.41 percent. Resident #101's Olanzapine 10 milligrams (mg) ordered for Schizophrenia and Folic Acid 1 mg ordered for anemia was unavailable for administration. The Findings Include: On 09/27/22 at 9:00 am a medication pass and pour observation was conducted. Resident #101's Olanzapine 10 mg and Folic Acid 1 mg was ordered to be given at 9:00 AM. License practical nurse (LPN #1) could not find either of the medications in the medication cart. LPN #1 said he would check to see if the missing medications were in the Omni Cell (pharmaceutical distribution center located in the medication room) to see if the medications were at the facility. LPN #1 then went to the Omni Cell and discovered the medications were not there. LPN #1 verbalized he would notify the physician and call the pharmacy to send medications to the facility. On 9/27/22 at 10:30 am the director of nursing (DON) informed this surveyor that the nurse practitioner gave orders to hold the Olanzapine until the medication arrives in the evening and to give 800 micrograms (mcg) of Folic Acid. The DON was asked, when should a nurse reorder medications to ensure continued administration of medications. The DON verbalized medications should be ordered when there are 5 pills left. The DON was asked to find out if the medications in question were reordered.	F 759	Acid and Olanzapine as per physician order. All residents receiving medications in the center have the potential to be affected. All clinical staff was educated by the Director of Nursing/designee on ensuring medications are available for administration and to ensure medications are re-ordered per policy. In addition, all clinical staff was educated on notifying the physician when medications are not available and documentation in the EMR (electronic medical record). Education also included the 5 R(s) of medication administration. The DON/designee will review in daily clinical meeting 5x/weekly to ensure medications are available for administration and if not, there is documentation in the EMR of notification to the physician. In addition, DON/designee will observe 3 nurses per week to ensure the 5 R(s) of medication administration is being completed. The results of the review/observations will be reviewed and discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exits, the monitoring will occur on a random basis. Date of completion: 10/24/2022	

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F 759	Continued From page 11 On 9/27/22 at 11:15 am the above information was presented to the DON, administrator and nurse consultant during a staff/surveyor meeting. On 9/27/22 at 1:15 pm the DON presented a copy for the reordering of the Folic Acid but said she was unable to find documentation of the reordering of Olanzapine and verbalized that the nurses may have called the pharmacy to reorder the Olanzapine. The facilities policy titled "Ordering and Receiving Non-Controlled Medications" read in part: "Reorder medications based on the estimated refill date (ERD) on the pharmacy Rx label, or at least three days in advance, to ensure adequate supply is on hand (...)" No other information was presented prior to exit conference on 9/27/22.	F 759		
{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.	{F 812}		10/24/22

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	495121	A. BUILDING _____ B. WING _____	R-C 09/27/2022

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{F 812}	Continued From page 12 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview the facility staff failed to ensure food was stored, prepared, and served in a sanitary manner. Tray line temps were not properly recorded/obtained on the serving line/steam tables of the fourth and fifth floors, dishwasher temperatures were not recorded in the main kitchen, eighteen cartons of 2% milk were observed as "out of date" and available for distribution to residents, and a scoop was observed in a bag of sugar in the main kitchen. The findings include: On 09/27/2022 at approximately 8:15 a.m. the serving line/steam table on the fourth floor of the facility was observed. OS (other staff) #4 was observed removing containers of food from a cart and placing them on the steam table. Asked if temperatures had been obtained of the breakfast foods, OS #4 stated, "I do them now." OS # 4 obtained a thermometer and began the process of obtaining temperatures. She stated, "The scrambled eggs are 138." The thermometer was observed with the reading of 138 F. OS #4 wrote 163.9 degrees in the temperature log book. When she was told the correct temperature was 138, OS #4 stated, "Yes" and changed the entry to 163.8. OS #4 continued to temp the breakfast foods. The blueberry muffins were 42 degrees, she wrote down 142, the oatmeal was 78, she wrote down 178, the pureed meat was 140, she wrote down 640. The bacon was temped at 38.8	{F 812}	F812 Expired foods were immediately discarded the day they were discovered. OS#4 was educated on when and how to obtain food temps prior to serving to residents and to ensure food items meet the acceptable temperature. Scoop was immediately removed from the bag of sugar. Dishwasher temps are now being recorded three times per day Current residents in the center have the potential to be affected. All dietary staff including the Dietary Manager was educated by the Regional Dietary Manager/designee on ensuring food is prepared and served in a sanitary manner including how to obtain accurate temperature with documentation on the appropriate forms. In addition, education was also provided for ensuring dishwasher temps are completed 3x/day and recorded on the appropriate forms. Education was also provided to notify the Dietary Manager/designee if the food temps or dishwasher fall outside the acceptable range. The Regional Dietary Manager/designee will monitor weekly to ensure food temps are recorded, foods are being served and prepared in a sanitary manner and expired items are discarded.	

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{F 812}	Continued From page 13 degrees, the thermometer was observed with a "C" on the dial, indicating she had switched the temperature reading from Fahrenheit to Celsius. When told the thermometer was on Celsius, OS #4 stated, "Yes, 38." Throughout the process of temping the foods, OS #4 was observed repeatedly pushing all the buttons on the thermometer. At approximately 8:45 a.m., the regional culinary supervisor (OS #5) was told of the above observations and replied, "I know the oatmeal was hot because I temped it down here...she doesn't need to be on the line up there." OS #5 then went to the fourth floor and retemped the oatmeal with a reading of 171 degrees. OS #5 stated, "She had the thermometer on Celsius." On 09/27/2022 at approximately 10:00 a.m. the dishwasher in the main kitchen was observed. OS #5 stated, "It was leaking when you were here before. It is fixed now." The temperature log for the dishwasher was requested and observed. There were no temperatures recorded for 09/21/2022, dinner shift 09/23/2022, no temps on 09/24/2022, no temperatures recorded for breakfast or lunch on 09/25/2022, and no temperatures recorded on 09/26/2022. Asked why the temperatures were not recorded, OS #5 stated, "I don't know." Asked why the temperatures should be recorded, OS #5 stated, "We record them three times a day to make sure the machine is working properly." Review of the temperature log showed three columns to be completed at breakfast, lunch, and dinner. The columns were labled "wash, Rinse, sanitizer". The temperatures that were recorded showed wash temperatures less than 145 degrees, and rinse temperatures less than 170 degrees. When	{F 812}	The results of the monitoring will be reviewed and discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exits, the monitoring will occur on a random basis. Date of compliance: 10/24/2022	

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{F 812}	Continued From page 14	{F 812}		

asked about the temperatures, OS #5 stated, "That isn't the form we should use...they are recording the prewash temperatures under wash, and the wash temperatures under the rinse column. The rinse temperatures are being recorded under the sanitizer column."

Tour of the kitchen was conducted at that time. Observed in the walk-in refrigerator was a milk crate containing 18 cartons of 2% milk, all with a use by date of 09/25/2022, and available for distribution to residents. OS #5 stated, "They just delivered milk yesterday, we check the dates before we serve it." Asked if it was possible that the milk could be served since it was in the refrigerator and readily available for distribution, OS #5 stated, "Yes, but we do check it." Also observed during the kitchen tour was a large bag of white cane sugar. Inside the bag was a serving scoop. Asked if the scoop was supposed to be in the sugar, OS #5 stated, "No", and removed the scoop from the bag.

During lunch on 09/27/2022 the tray line was again observed on the fourth floor. OS #4 was removing food from a warmer and placing it on the steam table. She could not arrange the pans to get them all in the hot water to keep them warm. OS #6 came to the steam table with OS #4. OS #6 stated, "I'm here to watch her." OS #6 then rearranged the pans on the steam table to get them all positioned so they were in the warm water. Observed next to the steam table was a plate warmer which was not plugged in. OS #6 was asked if that was correct. She stated, "No, that is supposed to be plugged in a couple of hours before we serve, it warms the plates and helps keep their food warm." OS #6 obtained the tray line/steam table temps. The mechanical

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meat was temped at 129 degrees. OS #4 was in place to plate the food. OS #6 pointed to the mechanical meat and stated to OS #4, "That's not hot enough, I need to get it heated up, the temperature has to be 135 degrees." OS #4 proceeded to plate the mechanical meat that was not up at the correct temperature. OS #6 stopped her and took the mechanical meat to the kitchen to be reheated.

The fifth floor steam table/serving line was observed next at approximately 12:55 p.m.. OS #7 was observed plating food for to be served to residents. Asked if he had already gotten temperatures of the food on the serving line, OS #7 stated, "No, I do not have a thermometer." OS #7 continued to plate the food and hand it to the CNAs (certified nursing assistants) who were waiting to serve lunch to the residents. OS #6 came to the floor at that time and asked OS #7 if he had done temps. OS #7 responded, "No, I do not have a thermometer." OS #6 stated. "Yes, you do." She went to a cabinet and obtained supplies to obtain temperatures. She asked the CNAs how many plates had been plated. They stated, "Six." OS #6 then temped the food on the serving line. All temps were within range except the soup, which was not on the serving line, but sitting on a table behind the serving line. The soup temped at 119 degrees. OS #6 told OS #7, "You have to get all the food on the steam table to keep it hot." She rearranged the steam table to make a place for the soup. She stated, "I'm going to get this reheated and then I'll bring it back."

The above lunchtime observations were discussed with OS #5 at approximately 1:15 p.m. He stated, "(Name of OS #4) just doesn't need to be on the line, I'll have to find more for her to do

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{F 812}	Continued From page 16 down here." The above information was discussed with the administrator, the DON (director of nursing) and the two corporate consultants prior to the exit on 09/27/2022 at 3:30 p.m. with no further information obtained.	{F 812}		