STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495358	A. BUILDING _____ B. WING _____	C 05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMELIA REHABILITATION AND HEALTHCARE CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 5/9/23 through 5/10/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Five complaints were investigated during the survey (VA00057845 - substantiated without deficiency; VA00057627 - unsubstantiated; VA00056053 - substantiated with deficiency; VA00055800 - substantiated with deficiency; and VA00055024 - substantiated with deficiency). The census in this 100 certified bed facility was 93 at the time of the survey. The survey sample consisted of seven current resident reviews.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident,	F 583		6/5/23

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

Electronically Signed | 05/15/2023

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F 583	Continued From page 1 including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility staff failed to maintain the confidentiality of resident information on one of two medication carts on the south unit, cart "A." The findings include: Observation was made of the south unit, medication cart "A" on 5/9/2023 at 12:19 p.m. RN (registered nurse) #2 was in a resident's room. The medication cart was outside the door. The drawers of the medication cart were facing away from the door. The computer was open with the screen visible and displaying resident information. There was a "report sheet" on top of the cart facing up, that contained each resident's name on the hall, room numbers, and documented vital signs. A second observation was made of RN #2 administering medications on 5/9/2023 at 1:24 p.m. There was an open box for the medication,	F 583	It is the intended practice of the facility to maintain the residents personal privacy and confidentiality of personal and medical records. 1. Upon notification from surveyor on 5/9/2023 that RN#2 left resident information unprotected by leaving the computer unlocked, report sheet visible, & open box of medication with resident information visible on the med cart A unattended, then the DON contacted the nurse agency to complete education for RN#2. 2. Residents who reside in the facility have the potential to be affected. 3. DON and/or designee will educate licensed nursing staff on properly & diligently protecting resident information during medication pass. 4. DON and/or designee will audit 2 med carts/med passes to ensure resident information is protected 3 days a week x4	

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F 583	Continued From page 2 Trelegy (1), with the resident's name and instructions on how to take the medications on the prescription label. There was also the "report sheet" face up on the medication cart with residents names and information visible. The computer screen was again open and displayed resident names and information. RN #2 was in a resident's room with her back to the door/medication cart. An interview was conducted with RN #2 on 5/9/2023 at 1:28 p.m. When asked if the residents names should be displayed on the computer screen while she was in a resident room, with her back to the medication cart, and should her report sheet be face up with resident information in view for anyone to read, RN#2 stated, no, she shouldn't have left the computer screen up with resident names, she forgot. An interview was conducted with LPN (licensed practical nurse) #1 on 5/10/2023 at 8:42 a.m. When asked what a nurse should do before leaving her medication cart, LPN #2 stated, first you put the privacy screen on the computer and lock it. LPN #2 stated there should be no papers visible with resident information on it, it should be flipped over. The facility policy, "Confidentiality of Information and Personal Privacy" documented in part, "Policy Statement:Our facility will protect and safeguard resident confidentiality and personal privacy. Policy Interpretation and Implementation:1.The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. 2.The facility will strive to protect the resident's privacy regarding his or her: b. medical treatment. 4.Access to	F 583	weeks and then monthly x2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be June 5, 2023.	

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F 583	Continued From page 3 resident personal and medical records will be limited to authorized staff and business associates." ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing were made aware of the above findings on 5/9/2023 at 4:45 p.m. No further information was obtained prior to exit. (1) Trelegy is used to control wheezing, shortness of breath, coughing, and chest tightness caused by chronic obstructive pulmonary (COPD; a group of diseases that affect the lungs and airways, that includes chronic bronchitis and emphysema). It is also used in adults to control wheezing, shortness of breath, coughing, and chest tightness caused by asthma. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a618017.html	F 583		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584		6/5/23

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F 584	Continued From page 4	F 584		

physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review, the facility staff failed to maintain a homelike environment in four of seven resident rooms in the survey sample, Residents #3, #4, #6, and #7.

The findings include:

1. For Resident #3 (R3), the facility staff failed to maintain a homelike environment on the walls of the resident's room.

It is the intended practice of the facility to establish and maintain a safe, clean, comfortable, and homelike environment.

1. Upon notification from surveyor on 5/10/2023 that residents #3, & #7 room has walls that need painted in addition resident #7 door needs repaired, resident #6 room has tiles that need replaced and repairs needed to the wall under the sink & to the door, & Resident #4 has furniture

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F 584	Continued From page 5 On 5/10/23 at 9:30 a.m., R3 was observed sitting up in bed. The long wall closest to the foot of the resident's bed had multiple areas of chipped paint and bare drywall. This wall also contained multiple black friction marks. The wall behind the resident's head contained multiple areas of chipped paint and bare drywall. On 5/10/23 at 9:20 a.m., OSM (other staff member) #1, the maintenance director, was interviewed. He stated he goes through some, but not all, resident rooms each morning to look for items that need repair. He stated he also has work orders in a maintenance software program. He stated the staff can put information in the software about items they have noticed. He stated he gets through the items as quickly as possible, triaging the most important tasks first. OSM #1 accompanied the survey team to R3's room. When shown the walls, he stated: "No, that's not homelike." He stated he would not want that disrepair in his own home. On 5/10/23 at 10:30 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. ASM #1 stated the facility staff perform room rounds daily, and the staff members enter any repair tasks into the facility's maintenance software program. She stated OSM #1 and OSM #2, the environmental services director, each have a list of daily work, based on the software system's data. She added that the facility is missing a maintenance staff member, and it is taking extra time to complete repairs. A review of the facility policy, "Quality of Life - Homelike Environment," revealed, in part:	F 584	that needs replaced & tiles that need replaced - maintenance was made aware, work order entered into work order system, and repair work started on resident #3, #4, #7,& #6 rooms to include but not limited to walls being painted, door repairs, floor tiles fixed or replaced, wall repairs, and furniture being fixed or replaced. 2. Residents who reside in the facility have the potential to be affected. 3. Admin and/or designee will educate maintenance staff on maintaining a homelike environment. 4. Maintenance Director and/or designee will audit 5 resident rooms within the facility 3 days a week x4 weeks and then monthly x2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be June 5, 2023.	

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Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible...Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include:
a. Clean, sanitary and orderly environment;
b. Comfortable (minimum glare) yet adequate (suitable to the task) lighting;
c. Inviting colors and décor;
d. Personalized furniture and room arrangements."

No further information was provided prior to exit.

2. For Resident #4 (R4), the facility staff failed to maintain a homelike environment on the floor and chest of drawers in the resident's room.

On 5/9/23 at 1:38 p.m., R4 was observed sitting up in bed. The tiles in the area at the foot of the resident's bed (both under the bed and not under the bed) contained approximately 20 dark brown circles. Each circle was between a quarter and fifty cent piece in diameter. R4's chest of drawers contained multiple scarred areas on the wood veneer on each of the drawers. One of the drawers was without a handle.

On 5/10/23 at 9:20 a.m., OSM (other staff member) #1, the maintenance director, was interviewed. He stated he goes through some, but not all, resident rooms each morning to look for items that need repair. He stated he also has

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F 584	Continued From page 7	F 584		

work orders in a maintenance software program. He stated the staff can put information in the software about items they have noticed. He stated he gets through the items as quickly as possible, triaging the most important tasks first. OSM #1 accompanied the survey team to R3's room. When shown the floor and chest of drawers, he stated: "No, that's not homelike." He stated he would not want the stained tiles or the scarred chest of drawers in his own home.

On 5/10/23 at 10:04 a.m., OSM #2, the environmental services director, was interviewed. She stated she tries to go in "and catch a couple of rooms each day" for extra cleaning needs. She stated she particularly looks at walls and floors. She stated if she identifies something that needs extra cleaning, she tries to schedule an extra staff person in the next few days to address the need. She stated the brown circular areas on the tiles are grease stains from new beds. She stated attempts have been made to clean and strip the stained tiles, but these efforts have not been successful. She stated the rooms need new tiles, and she could provide the survey team with evidence the facility had these repairs in process.

On 5/10/23 at 10:30 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. ASM #1 stated the facility staff perform room rounds daily, and the staff members enter any repair tasks into the facility's maintenance software program. She stated OSM #1 and OSM #2, the environmental services director, each have a list of daily work, based on the software system's data. She added that the facility is missing a maintenance staff member, and it is taking extra time to complete repairs.

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No further information was provided prior to exit.

3. For Resident #6 (R6), the facility staff failed to maintain a homelike environment on the floor and door, and under the sink in the resident's room.

On 5/9/23 at 1:38 p.m., R6 was observed sitting up in bed. The resident's door had multiple areas of chipped wood. The tiles in the area at the foot of the resident's bed (both under the bed and not under the bed) contained approximately 20 dark brown circles. Each circle was between a quarter and fifty cent piece in diameter. The area under the sink had multiple areas of chipped paint and bare drywall, as well as multiple black friction marks.

On 5/10/23 at 9:20 a.m., OSM (other staff member) #1, the maintenance director, was interviewed. He stated he goes through some, but not all, resident rooms each morning to look for items that need repair. He stated he also has work orders in a maintenance software program. He stated the staff can put information in the software about items they have noticed. He stated he gets through the items as quickly as possible, triaging the most important tasks first. OSM #1 accompanied the survey team to R3's room. When shown the door, floor, and area under R6's sink, he stated: "No, that's not homelike." He stated he would not want this kind of disrepair in his own home.

On 5/10/23 at 10:04 a.m., OSM #2, the environmental services director, was interviewed. She stated she tries to go in "and catch a couple of rooms each day" for extra cleaning needs. She stated she particularly looks at walls and floors.

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She stated if she identifies something that needs extra cleaning, she tries to schedule an extra staff person in the next few days to address the need. She stated the brown circular areas on the tiles are grease stains from new beds. She stated attempts have been made to clean and strip the stained tiles, but these efforts have not been successful. She stated the rooms need new tiles, and she could provide the survey team with evidence the facility had these repairs in process.

On 5/10/23 at 10:30 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. ASM #1 stated the facility staff perform room rounds daily, and the staff members enter any repair tasks into the facility's maintenance software program. She stated OSM #1 and OSM #2 each has a list of daily work, based on the software system's data. She added that the facility is missing a maintenance staff member, and it is taking extra time to complete repairs.

No further information was provided prior to exit.
4. For Resident #7, the facility staff failed to maintain a homelike environment.

Observation was made of Resident #7's room on 5/9/2023 at approximately 1:30 p.m. The wall behind the bed had two large areas of plaster, with no paint. The door had multiple areas of gouged wood, including an area that had crumbling wood filler.

On 5/10/23 at 9:20 a.m., OSM (other staff member) #1, the maintenance director, was interviewed. He stated he goes through some, not all, resident rooms each morning to look for items that need repair. He stated he also has work

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F 584	Continued From page 10 orders in a maintenance software program. He stated the staff can put information in the software about items they have noticed. He stated he gets through the items as quickly as possible, triaging the most important tasks first. OSM #1 accompanied the survey team to R7's room. When shown the wall and door, he stated: "No, that's not homelike." He stated he would not want that kind of disrepair in his home. On 5/10/23 at 10:30 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. ASM #1 stated the facility staff perform room rounds daily, and the staff members enter any repair tasks into the facility's maintenance software program. She stated OSM #1 and OSM #2, the environmental services director, each have a list of daily work, based on the software system's data. She added that the facility is missing a maintenance staff member, and it is taking extra time to complete repairs. No further information was obtained prior to exit.	F 584		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		6/5/23

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F 761	Continued From page 11 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility staff failed to secure medications on one of two medication carts on the south unit, cart "A." The findings include: Observation was made on 5/9/2023 at 12:19 p.m. of cart "A" on the south unit. There were five plastic bottles of over-the-counter medications on the top of the cart. The cart drawers were facing away from the resident room that the nurse was in, and her back was to the medication cart. The computer screen was up and blocking the view from the back of the cart where the nurse was. An interview was conducted with RN (registered nurse) #2, on 5/9/2023 at 1:28 p.m. The above observation was shared with RN #2. RN #2 concurred that the medications should not be left on the medication cart if she was in the resident's room with her back to her medication cart.	F 761	It is the intended practice of the facility to store & secure medications in accordance with state and federal laws 1. Upon notification from surveyor on 5/9/2023 of five over the counter bottles of medication being left on the medication care "A" - the DON contacted the nurse agency to educate RN#2. 2. Residents who reside in the facility have the potential to be affected. 3. DON and/or designee will educate licensed nursing staff on securing medications in the facility. 4. DON and/or designee will audit 2 med carts/med passes to ensure medications are properly secured 3 days a week x4 weeks and then monthly x2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance	

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	495358	A. BUILDING _____ B. WING _____	C 05/10/2023

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AMELIA REHABILITATION AND HEALTHCARE CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

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F 761	Continued From page 12 The facility policy, "Storage of Medications" documented in part, "The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications.3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner." ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 5/9/2023 at 4:45 p.m. No further information was obtained prior to exit.	F 761	will be June 5, 2023.	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility staff failed to serve palatable food for one of seven residents in the survey sample, Resident #1, and failed to prepare	F 804	It is the intended practice of the facility to serve food and drink that is palatable, attractive, and at a safe and appetizing temperature.	6/5/23

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F 804	Continued From page 13 puree food in a palatable manner. The findings include: 1. For Resident #1 (R1), the facility staff failed to serve grilled cheese at an appetizing temperature. On the most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 2/2/2023, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. An interview was conducted with R1 on 5/9/2023 at 12:21 p.m. The resident stated the food is served cold for many meals. R1 stated they got a hamburger that was cold and the cheese on it wasn't even melted. During the interview, the resident's lunch tray was served. The tray contained a hot plate with a dome lid on it. The plate under the lid had a grilled cheese sandwich. The resident felt the sandwich and stated, "See this is cold." This surveyor put on a glove and felt the sandwich, it was cold, there was no warmth to the sandwich. R1 requested a CNA (certified nursing assistant) to come to their room so they could ask for a hot sandwich. An interview was conducted with OSM (other staff member) #4, the dietary director, on 5/9/2023 at 4:13 p.m. The above observation was shared with OSM #4. When asked the process for a grilled cheese sandwich to get to the resident, OSM #4 stated they are pre-made and kept on the tray line. When asked if the grilled cheese sandwich should be hot when the resident gets it, OSM #4	F 804	1. Upon notification from surveyor on 5/9/2023 regarding resident #1 grilled cheese being cold - a replacement grilled cheese was brought to the resident. Upon notification from surveyor on 5/9/2023 regarding the puree food not being prepared in a palatable manner, the cook remade the pureed food. 2. Residents who reside in the facility have the potential to be affected. 3. Food Service Director and/or designee will educate the dietary staff on maintaining appropriate temperatures & ensuring the food is palatable prior to serving. 4. Food Service Director and/or designee will audit 5 resident trays to ensure appropriate temperatures & food is palatable at time of serving within the facility 3 days a week x4 weeks and then monthly x2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be June 5, 2023.	

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F 804	Continued From page 14 stated, yes. A policy on maintaining the temperature of food was requested. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing were made aware of the above findings on 5/9/2023 at 4:45 p.m. 2. The puree pork was not served at a palatable taste. A test tray was requested and presented to the survey team on 5/9/2023 at 12:00 p.m. The plates consisted of pork chop with gravy, spinach, steak fries, peas and carrots, mashed potatoes, puree spinach, puree bread and puree pork with a beef gravy on top. All food was tasted by OSM #4 and the survey team. The puree pork did not taste like pork, the portion tasted like more thickener than pork. All three agreed to this observation. OSM #4 stated he would have the staff add more pork to the puree pork before serving it today. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 5/9/2023 at 4:45 p.m. No further information was obtained prior to exit.	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident	F 806		6/5/23

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F 806	Continued From page 15 allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based observation, resident interview, and facility staff interview, the facility staff failed to honor food preferences for one of seven residents in the survey sample, Resident #1. The finding include: The facility staff failed to serve soup to Resident #1 (R1) for lunch on 5/9/2023. An interview was conducted with R1 on 5/9/2023 at 12:21 p.m. R1 stated they do not get what they've ordered most of the time. During the interview, R1's lunch tray was served. R1 stated they had ordered a grilled cheese sandwich and tomato soup for lunch. There was no soup on the tray. An interview was conducted with OSM (other staff member) #4 on 5/9/2023 at 4:13 p.m. When asked why R1 did not get soup on his lunch tray, OSM #4 looked at the resident work sheets, that documented on 5/9/2023 R1 had requested a grilled cheese with a bowl of soup. A second worksheet with all resident names on it documented for 5/9/2023 that R1 had requested grilled cheese with a bowl of soup. When asked if the resident's preferences were honored, OSM #4 stated, no, but they were given a cup of soup after the kitchen was made aware of it not being on the tray. A request for a policy on honoring	F 806	It is the intended practice of the facility to honor resident food preferences. 1. Upon notification from surveyor on 5/9/2023 that resident #1 was not served soup with his lunch meal as per the meal ticket, the dietary staff brought soup to the residents room. 2. Residents who reside in the facility have the potential to be affected. 3. Food Service Director and/or designee will educate the dietary staff on honoring food preferences & ensuring meal tickets & meal trays are accurate. 4. Food Service Director and/or designee will audit 5 resident trays to ensure food preferences are honored & meal tickets & meal trays are accurate 3 days a week x4 weeks and then monthly x2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be June 5, 2023.	

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F 806	Continued From page 16 resident preferences for food was requested. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 5/9/2023 at 4:45 p.m. No further information was obtained prior to exit.	F 806		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		6/5/23

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F 880	Continued From page 17 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 880	It is the intended practice of the facility to	

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F 880	Continued From page 18 document review, and clinical record review, the facility staff failed to implement infection control practices for one of seven residents in the survey sample, Resident #3. The findings include: For Resident #3 (R3), the facility staff failed to sanitize their hands between dirty and clean portions of wound care on 5/10/23. On 5/10/23 at 9:30 a.m., R3 was observed sitting up in bed. RN (registered nurse) #1, the wound care nurse, was observed providing care to R3's right heel pressure ulcer/injury (1). RN #1 removed the dirty dressing from the resident's right heel then changed gloves without sanitizing her hands. After applying clean gloves, she cleansed the wound with wound cleanser and gauze, discarded the dirty gauze, removed her gloves, and put on a new pair of gloves without sanitizing her hands. She applied the clean dressing and removed her gloves. On 5/10/23 at 9:48 a.m., RN #1 was interviewed. When asked if she remembered what she did after she removed the resident's dirty wound dressing, she stated she put on clean gloves. She added: "Oh no, I forgot to sanitize my hands." She stated she should have sanitized her hands between the dirty and clean portions of the procedure, both after removing the old dressing and discarding the gauze she had used to clean the wound. On 5/10/23 at 10:30 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.	F 880	establish and maintain a comprehensive infection control program to include appropriate hand hygiene. 1. Upon notification from surveyor on 5/10/2023 that the wound nurse, RN#1, did not use hand sanitizer in between glove changes during wound care for resident #3, the wound nurse, RN#1, received one to one education and completed a hand hygiene competency. 2. Residents who reside in the facility have the potential to be affected. 3. DON and/or designee will educate licensed nursing staff on performing appropriate hand hygiene during wound treatments. Licensed nursing staff will complete hand hygiene competencies to show understanding of the steps involved with appropriate hand hygiene. 4. DON and/or designee will audit 3 licensed nursing staff performing hand hygiene during wound treatments 3 days a week x4 weeks and then monthly x2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be June 5, 2023.	

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F 880	Continued From page 19 A review of the facility policy, "Handwashing/Hand Hygiene," revealed, in part: "This facility considers hand hygiene the primary means to prevent the spread of infections...Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations...Before handling clean or soiled dressings, gauze pads, etc...After handling used dressings, contaminated equipment, etc." No further information was provided prior to exit. NOTES (1) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue." This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf .	F 880		