STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495385	A. BUILDING _____ B. WING _____	03/15/2023

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VMRC, COMPLETE LIVING CARE	1475 VIRGINIA AVENUE HARRISONBURG, VA 22802

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/13/2023 through 3/15/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 85 at the time of the survey. The survey sample consisted of 18 current resident reviews and 3 closed record reviews.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of practice for one of thirteen residents in the survey sample. The Findings include: The facility nursing staff failed to enter a verbal physician's order into the electronic clinical record regarding Foley catheter placement for one of 21 residents, Resident #9. Diagnoses for Resident #9 included; Urine retention, inguinal hernia, depression, and congestive heart failure. The most current MDS (minimum data set) was an admission assessment with an ARD (assessment reference	F 658	1. The physician was contacted for resident #9 and an order was obtained and placed in the electronic clinical record for Foley catheter placement. 2. The DON or designee will audit the medical records of all residents with a Foley catheter placed to ensure that physician's verbal orders are in their electronic clinical record for the placement of the catheter. 3. The DON or designee will provide education to the nursing staff about placing verbal orders for Foley catheters in the electronic medical record.	05/12/23

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

Rebecca Kline, RN | Director of Nursing | 04/21/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 658	Continued From page 1 date) of 2/3/23, Resident #9 was assessed with a cognitive score of 13 indicating cognitively intact. On 3/13/23 12:13 PM during an interview, Resident #9 was asked about his catheter. Resident #9 verbalized that he thought that the staff had placed the catheter because he was having trouble urinating and he possible had a urinary tract infection. Resident #9 went on to say the nurses are taking care of it and was not having any trouble with the catheter. On 3/13/23 Resident #9's clinical record did not indicate any orders for a Foley catheter to be placed or any orders for the care of a Foley catheter. On 3/14/23 at 1:50 PM license practical nurse (LPN #6) was interviewed regarding Resident #9's catheter orders. LPN #6 reviewed the clinical record and was able to find orders for Resident #9's catheter along with care orders for the catheter and according to the orders the catheter was placed on 3/11/23. Further review of the catheter orders documented that the orders were not created until 3/14/23. Nursing progress notes were then reviewed and revealed a progress note dated 3/11/23 that read in part: "Patient only able to void a small amount 2 times this shift, urine noted to bed dark tea colored with small blood clots present. Abdomen noted to be slightly firm and tender upon palpation, bladder scan showed 417 milliliters, patient cathed with Foley, patient had 650 ml out, Foley left in place due to having retention greater than 400 ml [...]." On 3/14/23 at 2:23 PM LPN #7 (the nurse that	F 658	4. The DON or designee will audit the medical records of all residents with Foley catheters weekly for 3 weeks to ensure compliance. The findings will be reported to the QAPI Committee.	

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F 658	Continued From page 2 wrote the progress note) was interviewed. After reviewing her progress note, LPN #7 said she had talked with the physician at the time of the concern and had gotten a telephone order for placement of the catheter but failed to enter the physician order into the clinical record. On 3/14/23 at 4:08 PM LPN #7 (unit manager) was interviewed regarding catheter orders. LPN #7 said she (LPN #7) had created the orders earlier today and entered a start date of 3/11/23 after realizing there were no catheter orders for Resident #9. During the interview, LPN #7 also said that any nurse can put telephone orders in and orders should have been placed for the catheter and the care of the catheter when it was first ordered as this would alert other nursing staff to the catheter and catheter care instructions. A policy titled "Telephone/Verbal Orders" read in part: "1. When a new order is received from the provider [...] nursing staff will enter a verbal order into the orders on the electronic medical record. 4. Telephone/verbal orders will be transcribed/transferred onto the electronic medication administration record. 5. The resident's medical record will reflect progress notes that describe the condition and communication that occurred between the nursing staff and the provider." On 3/14/23 at 4:34 PM the above information was presented to the administrator and director of nursing. No other information was provided prior to exit conference on 3/15/23.	F 658		
F 732 SS=C	Posted Nurse Staffing Information	F 732		

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F 732	Continued From page 3 CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 732	1. The nurse staffing information was posted in all nursing areas, including the six residential houses on the facility campus. 2. The DON or designee will audit all nursing areas that are accessible to both residents and visitors for staffing numbers. 3. The DON or designee will provide education to the staffing coordinator on posting staffing numbers in locations accessible to both residents and visitors including the six residential houses. 4. The DON or designee will audit all nursing areas, including the six residential houses on the facility campus weekly x3 weeks to ensure that staffing information is posted. Findings will be reported to the QAPI Committee.	05/12/23

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F 732	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to post nurse staffing information for all nursing areas. There was no nurse staffing posted for the six residential houses on the facility campus. The findings were During a meeting at 4:30 p.m. on 3/14/2023, that included the Administrator, Director of Nursing, and the survey team, the Administrator was asked where nurse staffing was posted. The Administrator said the staffing was posted in the lobby of the Oak Lea building. The Oak Lea building houses the administrative offices as well as the Transitional Care Unit. At approximately 10:00 a.m. on 3/15/2023, the nurse staffing was observed posted in the Oak Lea lobby. The posting included staffing for the Oak Lea Transitional Care Unit as well as six residential houses; the Brunk, Burkholder, Harman, Mumaw, Warsack, and Wenger. At approximately 10:15 a.m. on 3/15/2023, a tour of the six residential houses was conducted. At each house, the staff was asked if nurse staffing was posted for that particular house. In each of the six houses, staff responded that nurse staffing was not posted, but that it was posted in the Oak Lea lobby. At approximately 10:30 a.m., during a meeting prior to the Exit Conference, that included the Administrator, Director of Nursing, and the survey team, the failure to post nurse staffing in each of the six residential houses was discussed. It was	F 732		

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F 732	Continued From page 5 pointed out that the posting is to be accessible to both residents and visitors. Residents of the six residential houses, some of whom were not mobile, would need to go to the Oak Lea lobby to view the nurse staffing. Visitors to any of the six residential houses are able to access the houses without passing through the Oak Lea lobby. Therefore, they would not be able to view the nurse staff posting. There was no further discussion prior to the Exit Conference.	F 732		
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, staff interview, resident interview, and facility document review, the facility staff failed to serve food at a palatable temperature for two of 21 residents in the survey sample, Resident #70 and Resident #30. Findings included: Review of the facility policy titled "Meal Service Policy", revised 12/11/2013, revealed "Food	F 804	1. Residents #70 and #30 were served food that was not a palatable temperature during survey. This has been corrected as described in #2, #3 and #4. 2. The Meal Coordinator will audit the food served to all residents to ensure it is served at a palatable temperature. 3. The Meal Coordinator or designee will provide education to staff serving meals on serving food at a palatable temperature. 4. The Meal Coordinator will audit the food served to 5 residents, 3x/ week for 3 weeks to ensure food is served at a palatable temperature. The findings will be reported to the QAPI Committee.	05/12/23

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F 804	Continued From page 6 temperatures will be obtained and monitored periodically throughout the meal service to ensure proper hot of cold temperatures are maintained. Temperatures will be logged as indicated ..." Food temperatures for the noon meal on 3/13/23, recorded on the undated "Food Safety Checklist", and taken in the main kitchen prior to placing the food into the insulated containers intended for the cottages, revealed holding temperatures of fried chicken at 165 degrees Fahrenheit (F), collard greens at 176 degrees F, and macaroni and cheese at 172 degrees F. During an observation on 3/13/23 at 11:30 am, food for the noon meal was observed on the kitchen island in Wenger House. Food service began at 11:40 am. The food served was fried breaded chicken breast, collard greens, macaroni and cheese, and a roll. Food temperatures were not obtained prior to the service starting, nor at any other time during the meal. During the observation on 3/13/23 at 11:54 am, after the last tray was served at Wenger Cottage, a test tray was prepared, and the food temperatures were obtained, using a facility calibrated thermometer. The fried chicken breast registered a temperature of 109 degrees F, the temperature of the macaroni and cheese was 106 degrees F, and the temperature of the collard greens was 99 degrees F. The temperatures were verified with Certified Nursing Aide (CNA) #5. The food tasted cold. During an interview on 3/13/23 at 11:45 am, CNA #4, stated that she did not take food temperatures of the food served at lunch on 3/13/23 prior to serving the food in Wenger	F 804		

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F 804	Continued From page 7 Cottage. When questioned further, CNA #4 stated that temperatures should be taken and documented on the food temperature logs kept at each cottage kitchen. During an interview on 3/13/23 at 12:45 pm, Resident #70 stated that sometimes the food was served cold. When questioned further, Resident #70 stated that she only ate a couple of bites for lunch on this day, but that the food tasted cold. Review of Resident #70's admission "Minimum Data Set" (MDS), with an Assessment Reference Date (ARD) of 2/13/23, indicated Resident #70's Brief Interview for Mental Status (BIMS) score was 15 out of 15, which indicated that Resident #70 was cognitively intact. During an interview on 3/13/23 at 12:50 pm, Resident #30 stated that sometimes the food was served cold, and that her lunch had tasted cold on that day. Review of Resident #30's quarterly "MDS", with an ARD date of 3/2/23, indicated Resident #30's BIMS score was 15 out of 15, which indicated that Resident #30 was cognitively intact. During an interview on 3/14/23 at 10:20 am, the Dietary Services Director verified the food holding temperatures recorded for the noon meal on 3/13/23 were taken approximately one hour before the food left the main kitchen. During an interview on 3/14/23 at 4:45 pm, the above findings were discussed with the Administrator and Director of Nursing, who stated that the expectation was that food temperatures would be taken prior to and during service of the meals to residents and that when served, the food would be at palatable temperatures.	F 804		

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F 804	Continued From page 8 During an interview on 3/15/23 at 9:20 am, the above findings were discussed with the Dietician, who stated that the expectation was that the food should be at palatable temperatures at all meals. When questioned further, the Dietician stated that temperatures of the bulk foods should be taken moments prior to the food leaving the main kitchen for delivery to the cottages, prior to meal service, and periodically throughout the meal service. No further information and/or documentation was presented prior to the exit conference on 3/15/23 at 11:40 am.	F 804		
F 806 SS=E	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 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 on observation, staff interview, resident interview, and facility document review, the facility staff failed to accommodate food preferences, food intolerance's and/or allergies for two of 21 residents in the survey sample, Resident #71 and Resident #72. Findings include:	F 806	1. Residents #71 and #72 were not served food that accommodated their food preferences, intolerances and/or allergies during survey. This has been corrected as described in #2, #3 and #4. 2. The Meal Coordinator will audit residents with food preferences, intolerances and/or food allergies to ensure they are not served foods that were identified. 3. The Meal Coordinator or designee will provide education to staff serving meals about accommodating residents food preferences, intolerances and/or allergies.	05/12/23

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F 806	Continued From page 9 1. The facility failed to ensure Resident #71's food preferences were honored. Resident #71's diagnoses included, but were not limited to: diabetes mellitus, thrombocytopenia, chronic atrial fibrillation, gastric reflux and iron deficiency. The resident's most recent MDS (minimum data set) was a quarterly assessment dated 02/14/23. The resident was assessed as a 14 cognitively, which indicated the resident was intact for daily decision making skills. The resident was also assessed as requiring supervision with at least one person assist for most ADL's (activities of daily living) and supervision with set up only for eating/meal consumption. On 03/13/23 at approximately 12:00 PM, Resident #71 was observed sitting at the dining room table. The resident had a piece of boneless fried chicken, some macaroni and cheese, collard greens and a piece of apple pie. When the resident was asked how he liked the lunch, the resident stated that he did not like chicken and didn't eat chicken. The resident was asked if the staff were aware or knew that he didn't like chicken and the resident stated, yes. The resident was asked why he was given chicken, the resident stated he didn't know and then stated that it was ok and that he would eat what he wanted and wouldn't eat what he didn't like or didn't want. On 03/13/23 at 12:13 PM, CNA #1 was asked, why Resident #71 was served chicken when the resident stated that he didn't like chicken. The CNA stated that they (Brunk house) didn't have a	F 806	4. The Meal Coordinator will audit the meals served to 5 residents 3x/ week for 3 weeks to ensure accommodations for their food preferences, intolerances and/or allergies. The findings will be reported to the QAPI Committee.	

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F 806	Continued From page 10 menu for this week yet and stated that they didn't know what they were having until they got it from the kitchen today. The CNA was asked again if she knew the resident didn't like chicken, the CNA responded yes. The CNA was asked again why the resident was served chicken if she knew he didn't like chicken. The CNA stated that she just found out when the food was served that he didn't like chicken. The CNA then went over to Resident #71 and asked him if wanted something else besides the chicken and the resident stated that he did not. On 03/13/23 at 2:53 PM, The resident was interviewed and asked about his food preferences. The resident stated that he tends to be picky and he just doesn't like chicken. The resident was asked if staff had asked him for his food pretences upon admission (November 2022). The resident stated that he didn't remember if they had. The resident stated that he likes hotdogs, hamburgers and raw vegetables, and further stated that he doesn't like cooked vegetables. The resident stated, "I don't think you can get a hamburger around here." On 03/14/23 at approximately 10:00 AM, the administrator and DON (director of nursing) were asked where are residents food preference information and were asked for assistance in locating that information. On 03/14/23 at approximately 11:00 AM, the administrator presented a blank dining preference interview sheet and stated that each resident should have one of these forms and they are filed in a notebook in each house. On 03/14/23 at 1:51 PM, LPN (Licensed	F 806		

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F 806	Continued From page 11 Practical Nurse) #2 (also known as the Care Guide for Brunk House) was interviewed regarding the residents dining preference interview information. The LPN looked and found the sheets in a notebook (all were blank) and stated that they didn't have one filled out for Resident #71. The LPN stated that the forms were sent to her via email and she printed them off and put them in the book. The LPN was asked where was the completed form for Resident #71. The LPN stated that she got the sheets today and did not have one for Resident #71. The LPN stated that OS #1 (other staff), also known as the food service guide sent the email with the forms and stated that she (OS#1) will document in the resident's record the likes and dislikes and the forms are also completed and put in the notebook. No information was given why Resident #71 did not have a food preference sheet. A policy on food preferences was requested at this time. A policy titled, "Dietary Preferences" documented, "...procedures related to obtaining food and beverage preferences for residents at the time of admission and periodically thereafter...when a new admission enters...preferences will be obtained at least by the completion of the initial comprehensive assessment's care plan meeting...reviewed during quarterly care plan meetings and updated when indicated...preferences are maintained in an accessible location for direct care staff..." On 03/14/23 at approximately 5:00 PM, the administrator and DON were made aware of the above information. The DON stated that she would make sure that Resident #71 was made aware of the 'always available menu' that has	F 806		

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F 806	Continued From page 12 hamburgers and other food items available everyday. No further information and/or documentation was presented prior to the exit conference on 03/15/23 at 11:30 AM. 2.) The facility failed to follow accommodate food allergy restrictions for Resident #72. Findings include A review of Resident # 72's (R72) Face Sheet, revealed R72 had diagnoses that included major depressive disorder, diarrhea, and essential hypertension. A review of R72's "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 12/6/22, indicated R72 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated R72 was cognitively intact. Review of R72's Care Plan, dated 3/3/23, indicated " ...Patient will be free from adverse reactions and/or complications related to allergy thru [sic] next review ..." The allergies listed included onions. During an observation on 3/13/23 at 12:40 PM, R72 was observed in her bedroom with her noon meal. R72 had not eaten the collard greens served with the meal. Onions were observed in the collard greens. R72 stated she liked the meal but could not eat the collard greens because they contain onions. R72 stated that she was allergic to onions and would break out in hives if they were consumed. On 3/13/23 at 12:45 PM, Certified Nursing Assistant (CNA) 4, who had served food during	F 806		

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F 806	Continued From page 13 the meal service, stated she was aware that R72 had allergies to onions, but was not aware the collard greens contained onions. During an interview on 3/14/23 at 10:20am, the Dietary Services Manager (DSM) verified that the collard greens were mixed with onions during preparation. The DSM also stated that the food items on the menu that day are served to the cottages in bulk. The Food Service Guide (FSG) 1 stated that the facility had a computer program that matched food allergies with foods and ingredients served but it was not operational. A review of the noon meal menu dated 3/13/23, which was provided by the DSM, revealed that buttermilk fried chicken breast, macaroni and cheese, pot liquor collard greens, park house rolls, apple pie, and beverages were on the menu. A review of "Recipe ID 820600", dated 3/2/23, which was provided by the DSM, revealed that onions were used in the preparation of the pot liquor collard greens. During this interview, the DSM verified that "Recipe ID 820600" was the recipe used in the preparation of the pot liquor collard greens served on 3/13/23. During an interview on March 14th 2023 at 4:45 PM, the above findings were presented to the administrator and director of nursing, who stated that it was the expectation that food allergies would be accounted for during meal services. During an interview with Facility Dietician on 3/15/23 at 9:20, the Dietitian stated the current process was that food was provided in bulk and all resident allergies were listed on the refrigerator in note form in each building. The Dietitian stated that a computer was available for	F 806		

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F 806	Continued From page 14 CNA's in each cottage to review the electronic medical record for the allergies of each resident. The Dietitian stated that if there was a food served that a resident was allergic to, the CNA was required to serve a substitute of nutritive value to the resident in question. The Dietitian stated that the main kitchen was responsible for ensuring foods were prepared in a manner that addressed food allergies. No further information and/or documentation was presented prior to the exit conference on 03/15/23 at 11:30 AM.	F 806		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility	F 812	1. The food temperatures were not obtained or maintained in logs during the survey for meals being served in 4/6 homes. This has been corrected as described in #2, #3 and #4. 2. The Meal Coordinator will audit all food temperature logs to determine if food temperatures are obtained, documented and maintained for all meals being served to residents. 3. The Meal Coordinator or designee will provide education to staff who are serving meals about obtaining, documenting and maintaining food temperatures and logs for all meals served to residents.	05/12/23

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F 812	Continued From page 15 document review the facility staff failed to ensure food temperatures were obtained prior to serving food and failed to maintain food temperature logs in 4 of six houses (Brunk, Harman, Wenger, Mumaw). Findings include: 1. The facility staff failed to ensure food temperatures were obtained prior to serving food and failed to maintain food temperature logs for the Brunk House. On 03/13/23 at 12:13 PM in the Brunk House, CNA # 1 (certified nursing assistant) was observed plating and serving food to the residents. CNA #1 was asked if she had checked the food temperatures for the food being served. CNA #1 stated that they (staff) had not checked the temps for lunch, but stated, "I can do it now." CNA #1 was made aware that the food temperatures should be obtained prior to serving the food. CNA #1 stated, "We did temps for breakfast, but not for lunch." CNA #1 was asked for the food temperature logs. CNA #1 presented a book for the Brunk House. The food temps were reviewed and revealed that on 03/12/23 there were no temps recorded for dinner. The food temp log for 03/11/23 had temps for lunch and dinner, but not breakfast. CNA #1 stated that she didn't know why temps were not checked on those days, at those times. CNA #1 stated that the main kitchen will temp the food and that they (Brunk House staff) are supposed to temp foods prior to serving. On 03/13/23 at 12:43 PM, LPN (Licensed	F 812	4. The meal coordinator will audit the food temperature logs for in all locations to ensure food temperatures are obtained, documented and maintained 3x/ week for 3 weeks. The findings will be reported to the QAPI Committee.	

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F 812	Continued From page 16 Practical Nurse) #2 (also known as the Care Guide for Brunk House) was made aware of the above information. LPN #2 stated that temps should be taken for each meal prior to plating and servicing the food. A policy was requested at this time on obtaining food temps. On 03/14/23 at 9:55 AM, the DON (director of nursing) presented a policy titled, "Meal Service Policy." The policy documented, "...comply with state and federal regulations concerning the holding and servicing temperature of foods...food safety requires temperatures are maintained at a controlled temperature from the time the food leaves the kitchen, during transportation and distribution...food temperatures will be obtained and monitored...temperatures will be logged as indicated..." When asked if staff should be checking food temperatures before each meal, the DON stated, "Yes Ma'am." On 03/14/23 at approximately 4:45 PM, the administrator and DON were again made aware of the above information in a meeting with the survey team. No further information and/or documentation was presented prior to the exit conference on 03/15/23 at 11:30 AM. 2. The facility staff failed to ensure food temperatures were obtained prior to serving food and failed to maintain food temperature logs for the Harman House. Findings include: On 3/13/23 at approximately 12:30 p.m. a meal	F 812		

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F 812	Continued From page 17 observation was conducted in Harman House. The staff did not obtain food temperatures prior to plating food and serving to the residents. On 3/13/23 at 3:00 p.m. LPN (licensed practical nurse) # 3 was asked to see the food temperature logs. The logs only documented breakfast and lunch temperatures from 3/1/23 through 3/7/23. There were no dinner temperatures recorded, and no breakfast, lunch or dinner temperatures recorded from 3/8/23 to 3/13/23. LPN # 3 was asked about the temperatures recorded, why there were no dinner temperatures, the lack of temperatures recorded for the dinner meal from 3/1/23 through 3/13/23, and no temperatures recorded 3/8/23 through 3/13/23. LPN # 3 stated, "We used to to have a food service coordinator, but that person is gone, and the CNA's are responsible for getting the food cart from the main kitchen, putting the food in the preheated ovens, and then plating the food...I don't know what else to tell you, or how to fix it, and it seems like that's just one more thing for them to do...I've never had any complaint of cold food...it is literally taken out of the oven and served." The facility policy titled "Meal Service Policy" under "Procedure" directed "Food temperatures will be obtained and monitored periodically throughout the meal service to ensure proper hot or cold holding temperatures are maintained. Temperatures will be logged as indicated." The administrator and DON were informed of the above findings during an end of the day meeting 3/14/23 at approximately 4:35 p.m. No further information was provided prior to the	F 812		

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F 812	Continued From page 18 exit conference. 3. The facility staff failed to ensure food temperatures were obtained prior to serving food and failed to maintain food temperature logs for the Wenger and Mumaw Houses . Findings include: Review of the facility's policy titled "meal Service Policy", revised 12/11/13, indicated "Food temperatures will be obtained and monitored periodically throughout the meal service to ensure proper hot or cold temperatures are maintained. Temperatures will be logged as indicated ..." During an observation on 3/13/23 at 11:40 am, bulk food containers containing fried breaded chicken breasts, collard greens, macaroni and cheese, and rolls were observed on the kitchen island in Wenger House. Certified Nurse Aide (CNA) 5 stated that the food had arrived from the main kitchen approximately five minutes earlier. During an observation on 3/13/23 at 11:40 am, CNA 4 and CNA 5 were observed serving food to the Wenger House residents from the bulk containers. Food temperatures were not taken during the meal service. During an interview on 3/13/23 at 11:54 am, CNA 4 confirmed that the temperatures of the food had not been taken when it arrived from the kitchen or prior to beginning the food service. When questioned further, CNA 4 stated that the temperatures should be taken and documented on the food temperature logs kept at each house kitchen.	F 812		

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F 812	Continued From page 19 Review of the food temperature logs, located in the Wenger House kitchen, revealed no food temperature logs for 1/1/23 through 2/4/23. Incomplete logs were noted for meals on 2/5/23, 2/7/23, 2/18/23, and 2/20/23. There were no food temperature logs for 2/21/23 through 3/13/23. Review of the food temperature logs from Mumaw House, located in the cottage's kitchen and dated 1/12/23 through 3/12/23, reveled no food temperature had been recorded since 1/1/23. During an interview on 3/13/23 at 12:10 pm, CNA 6 stated that she did not know why the food temperatures had not been completed since 1/1/23 at Mumaw House. During an interview on 3/14/23 at 10:20 am, the Dietary Services Manager (DSM) stated that the only temperatures taken on bulk foods in the main kitchen were holding temperatures, which are taken approximately one hour before the food left the main kitchen for delivery to the cottages. The DSM provided a "Food Safety Checklist", dated 3/13/23, which recorded the holding temperatures of the foods served for the noon meal on 3/13/23. The Checklist documented that the temperatures of the food from the stove on 3/13/23 at 10:30 am were as follows: fried chicken breast -165 degrees Fahrenheit (F); collard greens - 176 degrees F; and macaroni and cheese - 172 degrees F. During an interview on 3/13/23 at 9:20 am, the facility Dietician stated that the temperatures of the bulk foods should be taken moments prior to the food leaving the main kitchen for delivery to the cottages, prior to meal service, and periodically throughout the meal service.	F 812		

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F 812	Continued From page 20 During an interview on 3/14/23 at 4:45 pm, the above findings were discussed with the Administrator and DON, who stated that it was the expectation that the food temperatures be taken prior to and during the service of the meal to residents, as indicated in the facility policy. No further information and/or documentation was provided prior to the exit conference.	F 812		
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,	F 880	1. LPN #1 did not ensure infection control practices were followed during medication administration during survey. This has been corrected as described in #2, #3 and #4. 2. The DON or designee will audit the medication administration pass performed by LPN #1 to ensure LPN is following infection control practices during medication administration. 3. The DON or designee will provide education to licensed nursing staff about glove use and hand hygiene during medication administration.	05/12/23

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F 880	Continued From page 21 but are not limited to: (i) A system of surveillance designed to identify 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.	F 880	4. The DON or designee will audit medication administration on 5 residents 3x/week for 3 weeks to ensure infection control practices are followed during medication administration. The findings will be reported to the QAPI Committee.	

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F 880	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on a medication pass and pour observation, staff interview and facility document review, the facility staff failed to ensure infection control practices were followed for the administration of medications. Findings include: On 03/13/23 at approximately 3:58 PM, LPN (Licensed Practical Nurse) #1 prepared medications for Resident #43. LPN #1 donned (applied) gloves and prepared a glucometer to check the resident's blood glucose level. Once completed, LPN #1 discarded the glucometer strip, wiped off the glucometer, put it away and began to prepare medications for Resident #43. LPN #1 did not remove the gloves used to check the resident's blood glucose level after that task was completed. LPN #1 proceeded to dispense two Tylenol tablets into a plastic dispensing cup, then dispensed one Renvela, when attempting to dispense a second Renvela, the pill dropped to the floor. LPN #1 reached down with a gloved hand and picked the pill up and tossed it in the trash and resumed, by dispensing two more Renvela tablets (a total of three) into the cup. LPN #1 then took the medications and administered them to the resident. LPN #1 exited the room, returning to the medication cart, removed the gloves into the trash can and moved the cart down the hall and then sanitized her hands. At approximately 4:00 PM, LPN #1 was asked if she realized what she had done with the gloves (not removing) and dropping the pill on the floor and not removing the gloves and not	F 880		

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F 880	Continued From page 23 handwashing and/or sanitizing her hands during that process and continuing to pull medications for administration for Resident #43. LPN #1 stated that she did realize what she had done after she had already done it. On 03/14/23 at approximately 3:00 PM, LPN #2 (also known as the Care Guide for Brunk House) was interviewed and made aware of the above information and asked for a policy regarding infection control, hand washing and glove use during medication administration. A policy was presented titled, "Infection Control During Medication/Treatment Administration...general infection control with the preparation and administration of medications...follow standard precautions (unless otherwise noted) and perform hand hygiene before, during and after medication/treatment administration...staff should not touch the medication...if a medication...is dropped, facility staff should discard it...discard used medication supplies...perform hand hygiene as indicated..." A policy titled, "Hand Hygiene" documented, "...wash your hands...before and after treating a cut or wound...touching garbage...before handling medications...regular handwashing, particularly before and after certain activities, is one of the best ways...to prevent the spread of germs...if soap and water are not available, use alcohol-based hand sanitizer..." On 03/14/23 at approximately 4:30 PM, the administrator and DON (director of nursing) were made aware of the above findings in a meeting with the survey team.	F 880		

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F 880	Continued From page 24 No further information and/or documentation was presented prior to the exit conference on 03/15/23 at 11:30 AM.	F 880		