STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HLTH & REHAB CNTR	2401 LEE HIGHWAY PULASKI, VA 24301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 6/20/23 through 6/23/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 6/20/23 through 6/23/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Five (5) complaints were investigated during the survey: 1. VA00057203 - Compliant with regulations 2. VA00057483 - Compliant with regulations 3. VA00058994 - Compliant with regulations 4. VA00059027 - Compliant with regulations 5. VA00059067 - Noncompliant with regulations with deficient practice cited The Life Safety Code survey/report will follow. The census in this 102 certified bed facility was 90 at the time of the survey. The survey sample consisted of 25 current resident reviews and 5 closed record reviews.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		7/26/23

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

Electronically Signed | 07/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HLTH & REHAB CNTR	2401 LEE HIGHWAY PULASKI, VA 24301

(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 684	Continued From page 1 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and document reviews, the facility staff failed to provide care and/or treatment according to medical provider orders for three (3) of 30 sampled residents (Resident #101, Resident #32, Resident #301). The findings include: 1. LPN #7 initiated cardiopulmonary resuscitation (CPR) on a resident (Resident #101) who had an active Do Not Resuscitate (DNR) order. Resident #101's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 6/12/23, was dated as completed on 6/16/23. Resident #101 was documented as able to make self understood and as able to understand others. Resident #101's Brief Interview for Mental Status summary score was documented as 15 out of 15; this indicated intact and/or borderline cognition. Resident #101 was assessed as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. During a telephone interview on the afternoon of 6/21/23, Licensed Practical Nurse (LPN) #7 reported they found the resident unresponsive sitting "semi-up right" on the floor. Resident #101 was assessed to be not breathing and without a pulse. LPN #7 confirmed they started cardiopulmonary resuscitation (CPR) and called Emergency Medical Services (EMS). CPR was	F 684	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 correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F684- 1. LPN #7 will receive education from DON/Unit Manager/ designee to look in residents medical record for code status order before initiating CPR by 7/26/23. Licensed staff will receive education from DON/Unit Manager/designee to look in resident's medical record for code status before initiating CPR by 7/26/23. An audit will be completed of current residents to ensure that code status is correct in medical record by DON/Unit Manager/medical records coordinator by 7/26/23. DON/Unit Manager/Designee will audit this 1-2x weekly by asking 2-3 charge nurses what is the procedure for determining a resident□s code status for 1 month. Above audits will be reviewed in QA any noncompliance will be addressed and result in education and or corrective action. 2. LPN #2 no longer works at the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HLTH & REHAB CNTR	2401 LEE HIGHWAY PULASKI, VA 24301

(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 684	Continued From page 2 not successful. LPN #7 reported that information provided during report indicated Resident #101 was a full code. LPN #7 reported EMS arrived at the facility and contacted a medical provider at a local emergency department to get orders to stop CPR. LPN #7 reported it wasn't until after CPR was stopped that it was discovered that Resident #101 had a DNR order. Resident #101's clinical documentation indicated CPR was attempted when the resident was found unresponsive, pulseless, and not breathing. Resident #101's clinical record indicated an active DNR order was in place at the time CPR was started when the resident was discovered unresponsive, pulseless, and not breathing. The following information was found in a facility policy and procedure titled "Cardio-Pulmonary Resuscitation (CPR)" (with an effective date of 3/24/20): "Cardio-Pulmonary Resuscitation (CPR) will be initiated as a resuscitation procedure to restore breathing and/or heartbeat if any patient is found to be in cardiopulmonary arrest, EXCEPT where the patient's physician has specifically and appropriately documented a DNR order in the patient's permanent medical record. " On 6/23/23 at 12:45 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), and Regional Director of Clinical Services. During this meeting, the surveyor discussed LPN #7 providing CPR, to Resident #101, when the resident had a current, active DNR order. 2. For Resident #32, the facility staff failed to	F 684	Corrective action was written for LPN # 2 as well as medication error report on 6/14/2023. Licensed staff will receive education regarding medication administration by DON/designee by 7/26/23. An audit will be completed of current residents that were assigned to LPN#2 on 6/13/2023. Any medications noted not to be administered will be reported to the Physician by 7/26/23. DON/Unit Manager/Designee will audit licensed nurse medication pass 2-3x weekly for one month to ensure medication is being administered per order. Above audits will be reviewed in QA any noncompliance will be addressed and result in education and or corrective action. 3. DON/Unit Manger/Designee will educate LPN #4 on medication administration. A medication error form was completed FOR RESIDENT #301, and the physician was notified of the error on 6/22. Physician changed dosage of B12 on 6/22 for resident #301. Licensed staff will receive education regarding medication administration by DON/designee by 7/26. DON/Unit Manager/designee will complete an audit of current residents with B12 orders to ensure orders are accurate by 7/26/23. 4. DON/Unit Manager/Designee will audit licensed nurse medication pass 2-3x weekly for one month to ensure medication is being administered per order.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HLTH & REHAB CNTR	2401 LEE HIGHWAY PULASKI, VA 24301

(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 684	Continued From page 3 administer the residents evening medications on 06/13/23 per the providers orders. Resident #32's diagnoses included, but were not limited to, Parkinson's disease, diabetes with neuropathy, muscle weakness, essential hypertension, and anxiety disorder. Section C (cognitive patterns) of Resident #32's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 05/03/23 included a brief interview for mental status (BIMS) summary score of 15 out of a possible 15 points. Indicating this resident was alert and orientated. Resident #32's comprehensive care plan included the intervention administer medications as ordered. Resident #32 reported to the facility staff that Licensed Practical Nurse (LPN) #2 had not administered their evening medications on 06/13/23. 06/20/23 2:37 p.m., Resident #32 stated to the surveyor that LPN #2 did not give them their nighttime medications and the Director of Nursing (DON) took care of the issue. Resident #32 was unsure of the date when interviewed by the surveyor. A review of Resident #32's electronic medication administration records (eMARs) revealed that LPN #2 had documented that they had administered all of Resident #32's evening medications on 06/13/23. Administrator stated that they had investigated	F 684	Above audits will be reviewed in QA any noncompliance will be addressed and result in education and or corrective action. 5. Date of completion :7/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HLTH & REHAB CNTR	2401 LEE HIGHWAY PULASKI, VA 24301

(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 684	Continued From page 4	F 684		

the residents allegation and they had discovered during their investigation that LPN #2 had documented for the residents narcotic Alprazolam on the eMAR, but they had not signed out this narcotic on the controlled drug administration record. With this information they were able to verify that this resident did not receive their medications.

The facility staff provided the surveyor with an employee corrective action document and a medication error report both dated 06/14/23 regarding this issue. LPN #2 had signed the corrective action document on 06/14/23 but did not sign the medication error report.

LPN #2 no longer worked at the facility.

06/21/23 5:10 p.m., the issue regarding Resident #32's medications was reviewed with the Administrator and Nurse Consultant.

No further information regarding this issue was provided to the survey team prior to the exit conference.

3. For Resident #301, the facility nursing staff administered 1000 mcg (microgram) of B12 when the provider order was for 100 mcg of B12.

06/21/23 8:10 a.m., the surveyor observed Licensed Practical Nurse (LPN) #4 prepare and administer Resident #301's morning medication to include their B12. LPN #4 obtained 1000 mcg of B12 from the stock medication supply in the medication cart and administered this to Resident #301.

06/21/23, the surveyor reviewed Resident #301's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HLTH & REHAB CNTR	2401 LEE HIGHWAY PULASKI, VA 24301

(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 684	Continued From page 5 medication orders. The clinical record included a provider order dated 06/09/23 for B12 100 mcg's by mouth in the morning. 06/21/23 10:15 a.m., the surveyor and LPN #4 checked the medication cart for the B12. LPN #4 pulled the B12 bottle from the medication cart and confirmed the providers order read 100 mcg's and the bottle read 1000 mcg's. LPN #4 stated they did not have another bottle of B12 on the medication cart. 06/21/23 10:25 a.m., call placed to facility pharmacy who confirmed the B12 was available in a 100 mcg dosage. 06/21/23 5:10 p.m., end of the day meeting with the Administrator and Nurse Consultant. The issue with the B12 dosage was reviewed. 06/22/23, the facility provider changed the dosage of B12 to 500 mcg's in the morning due to B12 deficiency. 06/22/23 8:52 a.m., the Director of Nursing (DON) provided the surveyor with a copy of a policy titled, "Administration Procedures for All Medications." This policy read in part, "...Prior to removing the medication from the container. Check the label against the order on the MAR..." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 684		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F 760		7/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HLTH & REHAB CNTR	2401 LEE HIGHWAY PULASKI, VA 24301

(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 760	Continued From page 6 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure residents were free of significant medication errors for 1 of 30 residents in the survey sample, Resident #92. The findings included: For Resident #92, the facility staff failed to administer Phenobarbital as ordered by the medical provider on two separate occasions. Phenobarbital is a medication used to control seizures. Resident #92's diagnosis list indicated diagnoses, which included, but not limited to Bilateral Osteoarthritis of the Knee, Somatization Disorder, Chronic Post-Traumatic Stress Disorder, History of Traumatic Brain Injury, and Seizures. The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 5/31/23 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #92's comprehensive person-centered care plan included a focus area stating the resident had a risk for complications secondary to a convulsive disorder with an intervention to administer medication as ordered. On 6/22/23 at 2:30 pm, surveyor spoke with Resident #92 who stated they missed the first few	F 760	F760 1. DON/Unit Manager/Designee will educate RN#1 regarding management/ medication unavailability by 7/26/23. 2. DON/Unit Manager/Designee will educate licensed staff regarding management/ medication unavailability by 7/26/23. 3. DON/Unit Manager/Designee will complete and audit on current residents receiving Phenobarbital to ensure availability by 7/26/23. 4. DON/Unit Manager/Designee will complete an audit 1-2x weekly on residents receiving Phenobarbital to ensure medication is available for administration for 1 month. Above audits will be reviewed in QA any noncompliance will be addressed and result in education and or corrective action. 5. Date of completion: 7/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HLTH & REHAB CNTR	2401 LEE HIGHWAY PULASKI, VA 24301

(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 760	Continued From page 7	F 760		

doses of their seizure medication following admission to the facility.

Resident #92's physician's orders included an order dated 5/24/23 for Phenobarbital 100 mg two tablets one time a day for seizures. According to Resident #92's May 2023 Medication Administration Record (MAR), the resident did not receive the Phenobarbital on 5/25/23 and 5/26/23, for each administration a "9" was documented indicating "Other/See Progress Notes".

A nursing progress note dated 5/25/23 at 10:30 am stated the Phenobarbital was not available from the pharmacy and was not stocked in the Omnicell (the facility in-house medication supply). A 5/26/23 10:39 am nursing progress note stated the Phenobarbital was not available from the pharmacy and a script was faxed.

On 6/23/23 at 10:11 am, surveyor spoke with registered nurse (RN) #1, the writer of the 5/25/23 nursing note, who stated Resident #92's Phenobarbital had not arrived from the pharmacy and was not stocked in the Omnicell. RN #1 stated they contacted the pharmacy and was told the medication was out for delivery that day. RN #1 stated they notified the provider but could not remember who or what was said in response.

On 6/23/23 at 9:45 am, surveyor spoke with Resident #92's physician who stated they could not get the Phenobarbital from the pharmacy at first, but the family brought the medication to the facility. Surveyor asked if the two missed doses could have caused the resident's seizure on 5/27/23, the physician stated it may have increased the likelihood if in fact the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HLTH & REHAB CNTR	2401 LEE HIGHWAY PULASKI, VA 24301

(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 760	Continued From page 8	F 760		

were having seizures. Physician further stated they were not sure if the resident was having seizures or pseudo-seizures.

On 6/23/23 at 10:24 am, surveyor spoke with the Director of Quality (DQ) for the facility pharmacy who stated the order for Phenobarbital was entered into Resident #92's clinical record on admission on 5/24/23 however the order was not transmitted to the pharmacy because it required a valid script. DQ stated the pharmacy received a script for the Phenobarbital on 5/29/23 and the medication was dispensed with the evening delivery on 5/29/23.

Surveyor reviewed the facility Omnicell in-house medication supply inventory and Phenobarbital was not available.

Surveyor requested and received the facility policy entitled "Medication Management/Medication Unavailability" with a revised date of 4/21/22 which read in part " ...3. If medications are determined to be unavailable for administration, licensed nurse will notify the provider of the unavailability. Licensed nurse will document notification to the provider of the unavailability in the medical record. Licensed nurse will notify provider of the unavailability of medication and request an alternate treatment if possible. If alternate treatment is not available, then licensed nurse will activate backup pharmacy process and procedures."

On 6/23/23 at 12:45 pm, the survey team met with the administrator, director of nursing, and the regional nurse and discussed the concern of Resident #92 not receiving Phenobarbital as ordered on 5/25/23 and 5/26/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HLTH & REHAB CNTR	2401 LEE HIGHWAY PULASKI, VA 24301

(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 760	Continued From page 9 No further information regarding this issue was presented to the survey team prior to the exit conference on 6/23/23.	F 760		
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 observations, interviews, and document review, the facility staff: (a) failed to ensure food items were stored in a manner to promote food safety for one (1) of the two (2) resident refrigerators on the resident units and (b) failed to ensure the ice machine, located in the kitchen, was clean and in a safe operating condition. The findings include:	F 812	F812 1. Pantry refrigerators were cleaned out on 6/22/23. Dietary Manager/Administrator/Designee will educate staff regarding resident food storage by 7/26/23 Dietary Manager/ Administrator/Designee will audit resident refrigerators 1-2x daily to ensure food is stored correctly with resident□s name and date and items that	7/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HLTH & REHAB CNTR	2401 LEE HIGHWAY PULASKI, VA 24301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 10 The facility staff failed to ensure resident food items kept in refrigerators on the nursing units were correctly labeled and stored. On 6/21/23 at 4:35 p.m., the surveyor observed storage of residents' food items on the nursing units with Licensed Practical Nurse (LPN) #1. The following food items were observed: - (a) a small bag of sliced apples was not labeled with name and/or date; - (b) a half of a sandwich dated 6/12 (provided by the facility) was still in the pantry refrigerator; - (c) a small, opened bottle of store-bought iced tea was not labeled with a name and/or date; - (d) a salad dated 6/5/23 was still in pantry refrigerator; - (e) a bowl of mixed fruit containing strawberries and melon was not dated. All the aforementioned foods were immediately tossed by LPN #1. The following information was found in a facility policy and procedure titled "Outside Food for Patients" (with an effective date of 11/1/19): "1. Prepared/ready-to-eat outside food that needs refrigeration may be placed in the refrigerator at the nurse's station, if there is space, for a short period of time, not to exceed three (3) days. 2. The items must be labeled and dated with the patient's name, room number, and the use-by-date." On 6/20/23 at 2:15 p.m., the surveyor, with Staff Member (SM) #6 (a dietary employee) present, noted one of the drainage pipes from the ice machine in the kitchen had water running back up the underside of the drainage pipe; the underside of the drainage pipe was also noted to have a	F 812	have expired are discarded FOR 1 month. 2. Maintenance Director cleaned and adjusted ice machine pipe in kitchen on 6/20/2023. Administrator/Designee will educate Maintenance director regarding drainage of ice chest by 7/26/23. Administrator/Designee will educate dietary staff regarding proper drainage of ice chest by 7/26/23. 3, Drainage pipe on a chest in kitchen will be checked 2-3xweekly to ensure that pipe is clean and draining correctly for 1 month. Above audits will be reviewed in QA any noncompliance will be addressed and result in education and or corrective action. Date of compliance: 7/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HLTH & REHAB CNTR	2401 LEE HIGHWAY PULASKI, VA 24301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 11	F 812		

black substance which ran the length of the drainage pipe to the pipe elbow connector. The Maintenance Director was asked to look at the ice machine. The Maintenance Director acknowledged the aforementioned observations. The Maintenance Director reported the drain in question was coming from the lower ice storage bin.

On 6/20/23 at 3:45 p.m., the surveyor, with the Maintenance Director, observed the aforementioned ice machine drainage pipe. The Maintenance Director reported the drainage pipe had been cleaned. The Maintenance Director repositioned the pipe to allow it to drain freely; when repositioned pulled water in the tube was observed to flow into the floor drain.

The Maintenance Director provide the "Installation Owner/Operator Use and Care Manual" for the ice machine to the surveyor. This manual included the following information: "Follow these guidelines when installing drain lines to prevent water from flowing back into the ice machine and storage bin: Drain lines must have a 1.5 inch drop per 5 feet of run (2.5 cm per meter), and must not create traps." On 6/20/23 at 5:16 p.m., The Maintenance Director reviewed the aforementioned information. The Maintenance Director confirmed the pipe had shifted limiting the flow of the water from the drain; the Maintenance Director acknowledged some pooled water had drained from the drain pipe when it was repositioned.

On 6/23/23 at 12:45 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), and Regional Director of Clinical Services. During this meeting, the surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HLTH & REHAB CNTR	2401 LEE HIGHWAY PULASKI, VA 24301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 12 discussed (a) the observations of improperly label resident food items in one (1) of the resident refrigerators on the nursing unit and (b) the observations of the ice machine drainage pipe being incorrectly positioned and noted to have a black substance on the drainage pipe.	F 812		