STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING _____ B. WING _____	C 06/15/2023

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STAUNTON POST ACUTE & REHABILITATION	512 HOUSTON STREET STAUNTON, VA 24401

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 6/12/2023 through 6/14/2023. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 6/12/2023 through 6/14/2023. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code report will follow. Three complaints were investigated during the survey. Complaint VA00055938 was unsubstantiated. Complaint VA00057190 was substantiated with a deficiency cited as past non-compliance. Complaint VA00057401 was substantiated with a deficiency cited. The census in this 170 certified bed facility was 109 at the time of the survey. The survey sample consisted of twenty-two current record reviews and three closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or	F 578	Regarding F 578 Request/Refuse/Discontinue Treatment; Formulate Advance Directive 1. Resident 11 had an executed POA for medical decisions but a copy was missing from her medical record. A copy of the document was obtained on 6/14/23 and scanned into the medical record. 2. An audit was conducted by NHA/designee to ensure the profile tab is consistent with POA documentation. 3. The SW, Admissions Director and BOM will be educated regarding POAs and accuracy of the profile tab. 4. There will be audits monthly for 3 months to ensure compliance. Any variation or opportunities for improvement will be reviewed/discussed at QAPI monthly. 5. Complete by 7/28/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Jackson | TITLE: Administrator | (X6) DATE: 7/7/23

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 578	Continued From page 1 inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure Power of Attorney (POA) for healthcare document was located in the medical record for one sampled resident reviewed for advance directives (Resident (R)11). This failure had the potential for an unauthorized person to enter a Do Not Resuscitate (DNR) directive for	F 578		

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F 578	Continued From page 2 the resident. Findings include: Review of R11's POA dated 09/04/98 revealed R11's daughter (F11) and another individual appointed as attorneys-in-fact by R11. The document revealed in part the power to act on R11's behalf as follows: ". . .1.To demand, hold and generally deal with any monies, securities and other property which now or hereafter belongs to me, or in which I may have interest. 2. To sign any note, check, security or other instrument, negotiable or nonnegotiable, whether or not the check or other instrument is drawn to the order of my Attorney, for deposit, discount, collection or otherwise. 3. To write checks upon, or otherwise withdraw, all funds or account balances now or hereafter outstanding to my credit or to the credit of my Attorneys, and to open accounts of whatever nature in my name or my Attorneys' name. 4. To vote in person or by proxy, to sell or otherwise dispose of, to cause to be registered in the name of a nominee selected by my Attorneys, and to transfer, redeem, convert or exchange any security that now belongs to me or may belong to me in the future or in which I may have interest, and to make, execute and deliver any endorsement, assignment, certification, or other document in connection with any security. 5. To buy, acquire or in property, real or personal, or intangible, including without limitation any security, option or other type of investment. . ." Further review of the POA document failed to reveal any power to make healthcare decisions	F 578		

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F 578	Continued From page 3 on behalf of R11. Review of the Admission Agreement dated 09/17/21, signed by F11 revealed: "If the Patient is unable to make decisions for himself or herself, a Resident Representative should be available to make certain decisions on behalf of the Patient. Patient hereby agrees that the Resident Representative is the person selected by the Patient as the Patient's responsible person or as the person recognized under state law as having the authority to make health care and/or financial decisions for the Patient. If the Resident Representative has authority specifically conferred by a court of law or other document. Verification of such status must be provided to the Center at the time of admission. Such verification includes providing the Center with a copy of any court order, or a validly executed Power of Attorney or other legal document imbuing the representative to act on the resident's behalf. The Resident Representative authority will be limited to scope of the delegated authority by the resident, state law, or court mandated order. All rights not explicitly delegated by the Resident, state law, or the court will be reserved to the Resident." Review of the "Profile" tab of the electronic medical record (EMR) revealed R11's daughter was listed as "Daughter, Responsible Party, POA - Financial, POA - Care, and Care Conference Person." Review of R11's "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 04/20/23 revealed R11 was admitted to the facility on 09/17/21 with diagnoses that included	F 578		

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F 578	Continued From page 4 dementia, spinal stenosis, cerebral atherosclerosis, adult failure to thrive, and abnormal weight loss. R11 had a "Brief Interview for Mental Status (BIMS)" score of five out of 15, which indicated the resident was severely cognitively impaired. Interview with the Administrator on 06/14/23 at 1:27 PM revealed R11's medical POA was R11's father who was now deceased. The Administrator acknowledged that the family informed the facility upon admission that a POA for healthcare existed, but the facility failed to follow up with obtaining the document and was unaware the POA on record did not cover healthcare decisions.	F 578		
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 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.	F 584	Regarding F584: Safe/Clean/Comfortable Homelike Environment 1. Resident 84 had verbalized concerns about the shower rooms. DON/NHA followed up with resident to ensure his concerns were heard. A plan for updates to the area were shared with the resident. 2. The black stains within the shower rooms has been scrubbed. Missing drain covers have been replaced. Thresholds are under repair. The ceiling light has been repaired. The shower stall seat on 3NW will be addressed upon receipt of needed items. 3. An outside vendor will be sought to provide a deep cleaning and treatment to the areas. Bids for further updates will be sought. Cleaning schedules will be maintained. 4. Nursing staff will be educated on cleaning between housekeeping visits. Housekeeping will reeducated on cleaning procedures. All will be educated on the importance of/how to put in work orders when a problem is identified. Weekly rounding will occur by NHA/DON and compliance with this standard will be reviewed through the QAPI monthly meeting. 5. Complete by 7/28/23	

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F 584	Continued From page 5 §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, facility document review, resident interview and staff interview, the facility staff failed to provide a clean, homelike environment on three of four living units. The findings include: The shower rooms on 2 new west, 2 west side, and 3 new west had black stains along caulking lines on/around the shower stall seats, black stains under the stall floor mats, missing drain covers, and deteriorated flooring at the thresholds to the stalls. On 6/12/23 at 4:22 p.m., accompanied by licensed practical nurse (LPN) #1, the shower room on 2 new west unit was inspected. There	F 584		

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F 584	Continued From page 6	F 584		

were three shower stalls. The caulked area around the seat base, back, and flooring was black on each of the three seats. The entrances to the shower stalls had deteriorated flooring and black stains around the safety strips. The shower stall floors had black stains under and around the floor mats and safety strips. LPN #1 stated at this time that certified nurses' aides (CNAs) disinfected the shower stalls after each resident and housekeeping was responsible for daily cleaning of the shower rooms.

On 6/13/23 at 9:15 a.m., accompanied by CNA #2, the 2 west side unit shower room was inspected. The ceiling light was out near the entrance to the room. There were two shower stalls with black discoloration along the caulking lines around the base and back of the shower seats. There was no drain cover in the right stall and used/dirty towels were on the floor near the right stall and the sink.

On 6/13/23 at 9:23 a.m., accompanied by a housekeeper (other staff #13), the 3 new west unit shower room was inspected. There were three shower stalls with black stained caulking around the base and bottom of the shower seats. The shower seat on the left stall was cracked with missing caulking at the back of the seat. The housekeeper was interviewed at this time about cleaning of the shower rooms. The housekeeper stated showers were supposed to be cleaned daily or as requested. The housekeeper stated that the cleaners they had did not remove the black stains along the caulking and flooring.

On 6/13/23 at 9:33 a.m., Resident #84 was interviewed about quality of life in the facility. Resident #84 stated that the shower room on his

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F 584	Continued From page 7 unit "...had black mold around the seats and on the floors." Resident #84 stated that since admission to the facility for almost a year now, the shower room has been stained like that. On 6/13/23 at 10:43 a.m., the housekeeping supervisor (other staff #1) was interviewed about the above shower room observations. The housekeeping supervisor stated that housekeepers were expected to thoroughly clean/disinfect the showers at least once daily and as needed. The housekeeping supervisor stated that a bathroom cleaner was used for the shower stalls, a multi-surface cleaner for the counters, and a toilet cleaner for areas in/around the commodes. The housekeeping supervisor stated that there were "issues" where the shower seats were attached to the stalls/flooring, in that the caulked areas had become black and deteriorated in places. The housekeeping supervisor stated that the cleaning agents used did not remove the black stains along the caulking and if too much pressure was applied, the caulking came off. When questioned, the housekeeping supervisor stated that the shower rooms were not homelike, did not have a clean appearance, and needed a "remedy." The facility's housekeeping guidelines (undated) documented shower rooms were to be cleaned prior to 4:00 p.m. each day. These findings were reviewed with the administrator, director of nursing and unit managers during a meeting on 6/13/23 at 4:25 p.m. The administrator stated administration recognized that the shower rooms needed repair and upgrades. No further information was presented regarding the condition of the shower	F 584		

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F 584	Continued From page 8 rooms prior to the end of the survey.	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to ensure a significant change assessment was completed for one of 25 residents. Resident #61 did not have a significant change assessment completed, after a functional decline in ADL's (Activities of Daily Living). The Findings Include: Diagnoses for Resident #61 included: Dementia, schizophrenia, anxiety, Alzheimer's disease and malignant neoplasm. The most current MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 5/31/23. Resident #61 was assessed with short and long-term memory problems and as severely cognitively impaired. On 6/13/23, a comparison of Resident #61's	F 637	Regarding F637: Comprehensive Assessment After Significant Change 1. Resident 61 had a Significant Change Assessment created, submitted and accepted on 6/16/23. 2. A 30-day look back audit will be completed by the DON/designee on residents identified as having potential ADL changes to ensure compliance with significant change assessments. 3. The MDS Coordinators will be educated on identifying Significant Changes regarding ADL declines. Resident changes will be discussed at Stand-up meeting allowing the MDS coordinators/IDT to collect and follow up on changes. 4. Monthly audits will occur for the next three months with review/discussion at QAPI meetings regarding findings. 5. Complete by 7/28/23	

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F 637	Continued From page 9	F 637		

quarterly MDS dated 4/25/23 and an annual MDS dated 5/31/23 indicated (in section "G") Resident #61 had a decline in the following: Bed mobility from extensive with one person assist to total dependence with two person assist, dressing from extensive assist to total dependence one person assist, eating from extensive assist to total dependence with one person, toilet use from extensive assist one person to total dependence two person assist, and personal hygiene from extensive assist to total dependence one person assist.

Resident #61's ADL flow sheets were also reviewed for 5/1/23 through 6/14/23, which verified the decline in Resident #61's ADL abilities.

On 6/13/23 at 9:51 AM, MDS coordinator (registered nurse, RN #2) was interviewed and was asked what prompted a significant change assessment. RN #2 verbalized several things can prompt a significant change assessment including changes in two or more areas of ADL assistance. RN #2 then reviewed section "G" of both MDS's and agreed that there should have been a significant change assessment completed, but would look into the concern to make sure.

On 6/13/23 at 10:29 AM, RN #2 returned and verbalized that it would be appropriate to have done a significant change and that she would make the necessary changes.

On 6/13/23 at 4:22 PM the above information was provided to the administrator and director of nursing.

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F 637	Continued From page 10 No other information was provided prior to exit conference on 6/14/23.	F 637		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of facility policy, the facility failed to ensure the required Level II Preadmission Screening and Resident Review (PASRR) was completed for one of 24 residents (Resident (R) 4). Potentially, this impedes R4 from receiving the appropriate treatments/services for mental illness. Findings include: Review of facility's undated document titled "Virginia Long-Term Services and Supports	F 644	Regarding F644: Coordination of PASARR and Assessments 1. Resident 4 did not have the required Level II Pre-admission screening. It was identified during investigation that Resident 4's Level I at her admission in 2016 was incorrectly completed failing to identify a key diagnosis that would indicate a Level II was needed. The Social Worker is completing a new Level I and will be working with appropriate resources to seek a Level II. 2. SW will audit all resident records for accuracy of Level I's and supporting Level II's as indicated. 3. The Admissions Coordinator, SW and IDT will receive education on the PASARR screenings and the process. 4. An audit of Level I's will be completed for all new residents once a month for three months. Any identified variance will be followed up on immediately by SW and reviewed/discussed at the QAPI monthly meeting to ensure compliance. 5. Complete by 7/28/23	

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F 644	Continued From page 11	F 644		

(LTSS) Screening, Preadmission Screening and Resident Review (PASRR) Policy" reads in part, "Level 2 Referral When a resident has a positive Level I screening, the facility will initiate the Level II screening request by faxing (do not e-mail PHI [protected health information]) the following materials to the state-designated authority (Ascend): Level 1 Screening (DMAS-95), indicating if the resident has a serious mental illness, intellectual disability, or related condition . . ."

Review of R4's "Admission Record" revealed that R4 was admitted to the facility on 08/01/16 with diagnoses that included schizoaffective disorder, delusional disorders, major depressive disorders, anxiety disorders, unspecified mood affective disorders, and unspecified depression.

Review of R4's "Physicians Orders" for June 2023 revealed R4 was to receive:
"Vraylar [an atypical antipsychotic] three milligrams (mg.) for schizoaffective disorder;
Seroquel [an antipsychotic] 100 mg. for delusions;
Trintellix [an antidepressant] 20 mg for depression; melatonin three mg for insomnia;
Trazadone [an antidepressant and sedative] 150 mg for depression;
psychology and psychiatry as needed."

Review of R4's "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) 03/30/23 revealed R4 had a Brief Interview for Mental Status (BIMS) score of 15 out 15, indicating the resident's cognition was intact.

Review of R4's Level I PASRR dated 07/29/16 provided by the Social Services Director (SSD6)

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STAUNTON POST ACUTE & REHABILITATION	512 HOUSTON STREET STAUNTON, VA 24401

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F 644	Continued From page 12 revealed R4 resided in a long-term care facility (for psychosis) for approximately a year and was released to live in an apartment in the community. The Level I history included that in less than a month, R4 experienced a decline in self-care and taking the psychotropic medications. According to the Level 1 PASRR, R4 had a long history of chronic mental illness and would require a structured environment. The reviewer who completed this Level I assessment documented that R4 did not require a Level II assessment. During an interview on 06/14/23 at 12:08 PM, SSD6 stated that R4 was admitted to the facility some time ago, should have been admitted with the Level I PASRR, and believed that a Level II assessment should have also been completed. During an additional interview on 06/14/23 at 12:30 PM, SSD6 revealed she had reviewed R4's Level 1 PASRR and discovered that it was coded wrong. SSD6 stated that the reviewer should have completed the section in which R4 did require a Level II assessment. SSD6 stated given R4's history with mental illnesses and current diagnoses, R4 should have a Level II PASRR completed.	F 644	Regarding F657: Care Plan Timing and Revision as identified by the IDT. 1. Residents 89 and 54 had their individual care plans updated immediately. 2. An audit of care plans specific to weight loss and catheter securement devices will be completed by the DON/IDT to ensure no other residents have been missed. 3. The IDT/Care Plan Team will be educated on the care plan review process by the NHA/DON. 4. Monthly audits will occur over the next three months by the DON/NHA to ensure compliance with care plan updates for weight loss/catheter securement devices. Any identified improvement opportunities will be reviewed/discussed at the monthly QAPI meeting. 5. Complete by 7/28/23	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		

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F 657	Continued From page 13 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of facility policy, the facility failed to revise the comprehensive care plan to ensure accuracy for two of 21 residents (Resident (R) 89 and R54) reviewed for care plan revision. Specifically, the facility failed to revise R89's care plan to address weight loss and failed to revise R54's care plan to identify use of a catheter safety strap. Findings include: Review of the undated facility policy titled "Care Planning - Comprehensive Person-Centered," revealed, "A person centered comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing . . . needs shall be developed for each resident . . . comprehensive care plan means an	F 657		

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interdisciplinary communication tool developed after completion of a comprehensive MDS [Minimum Data Set] . . . The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: when the desired outcome is not met, when goals, needs and preferences change . . ."

1. Review of R89's "Face Sheet" revealed an admission date of 09/03/22 with medical diagnoses that included vascular dementia, depressive disorder, and cerebral infarction.

Review of R89's annual "MDS", dated 05/09/23, revealed a Brief Interview for Mental Status (BIMS) score of one out of 15, indicating R89 was severely cognitively impaired. The "MDS" revealed R89 required extensive physical assistance of one person for assistance with eating.

Review of R89's "Quarterly Dietician/Sig[significant] Wt [Weight] Change" note, dated 06/09/23, read in part: Wt: 106.8 lb [pound] 06/05/23, Sig wt change 5.3% loss in 30 days, 13.7% loss in 180 day[s] . . . BMI [Body Mass Index]: 19.5 -underweight for age . . . PO [by mouth] intake: Avg [average] 72% of meals in past 14 days . . . Recommendations: Continue current POC [plan of care], PO intake meeting increased estimated needs, significant weight loss in 30 days. RD [Registered Dietitian] to continue to monitor weight trends. Will reassess qrtly [quarterly]/PRN [as needed]."

Review of R89's "Care Plan" last updated 06/01/23 read in part, R89 ". . . has potential nutritional problem r/t [related to] hx [history] of alcohol dependence, dementia . . . advanced

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age." Interventions included, "Monitor/record/report to MD [Medical Director] s/sx [signs/symptoms] of malnutrition . . . muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, > 10% in 6 months." There was no additional information related to the actual weight loss or additional interventions to address this decline.

During an observation on 06/13/23 at 10:22 PM, R89 was observed sitting on the floor, scooting back and forth. R89 had a bed with a mattress next to the wall and a mattress on the floor. While scooting on the floor, R89's arms and legs appeared to be thin, bony, and without visible muscle. R89's ribs were visible through her shirt. Staff offered R89 water and held a washcloth to wipe her face. R89 was grabbing at the washcloth, attempting to put it into her mouth. Staff were encouraging R89 to get on the mattress and R89 was talking but could not be understood. R89 took a drink of water, staff did not offer anything else to eat or drink.

During an interview on 06/14/23 at 9:50 AM, the RD (Registered Dietician) stated R89 was currently on monthly weights. The RD stated that a review of residents included a look at their intake and that R89 was eating approximately 75% of all meals. The RD stated R89 should be on weekly weights because of her recent weight loss. The RD stated when R89's weight loss was first identified, the weight loss, goals, and interventions should have been added to the care plan.

During an interview with the ADON and the Director of Nursing (DON), on 6/14/23 at 10:25 AM, the ADON stated R89's first weight loss was

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in March 2023. The ADON stated R89 should have been discussed in the "Resident at Risk" meeting. The ADON and the DON stated the RD should have notified them of the weight loss, as they would have notified the doctor or nurse practitioner to implement interventions. The DON confirmed that the nutrition care plan should have been updated to indicate the weight loss and that new interventions should have been added. The DON confirmed the care plan had not been updated.

During an interview on 06/14/23 at 10:52 AM, the MDS Coordinator (MDSC) stated each department was responsible for updating their own care plans. The MDSC stated the RD triggered a Care Area Assessment (CAA) in the annual "MDS" for weight loss, so the Care Plan should have been updated to reflect the weight loss and any new interventions that had been implemented. The MDSC stated that as the signing Registered Nurse (RN), she should always verify the care plan reflects the MDS but confirmed she had not.

During an interview on 06/14/23 at 11:07 AM, Registered Nurse (RN) 4, who managed the secure unit, stated she was responsible for reviewing the care plans and making sure interventions were in place. RN4 stated she would monitor any changes in level of care and add to the care plan accordingly.

During an interview on 06/14/23 at 12:09 PM, the Administrator stated the RD, nursing, and the Physician and/or Nurse Practitioner should have done more. The Administrator stated, "As a facility we missed [R89]." Then Administrator stated that Quality Assurance Performance

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F 657	Continued From page 17 Improvement (QAPI) had reviewed weight loss but had not reviewed R89's weight loss. 2. Observation 06/14/23 at 11:05 AM of R54's catheter care revealed that the resident was not wearing a catheter strap to secure the tubing. Review of R54's "Admission Record" revealed R54 was admitted on 09/03/21 with diagnoses that included obstructive and reflux uropathy. Review of R54's current "Physician's Orders" revealed that R54's Foley drainage bag and catheter securement device were to be changed every seven days. Review of R54's significant change "MDS", with an ARD 02/28/23, revealed R54's Brief Interview for Mental Status (BIMS) score was 15 out of 15, indicating the resident's cognition was intact. The MDS also assessed R54 to have an indwelling urinary catheter. Review of R54's "Care Plan", dated 05/26/23, revealed that the interventions did not include the wearing of a securement device for the urinary catheter. During an interview on 06/14/23 at 11:05 AM, R54 revealed that he had never worn a catheter securement device. During an interview on 06/14/23 at 11:41 AM, the Minimum Data Set (MDS) Registered Nurse (RN)2 stated that she was responsible for developing and the revising of the nursing care plans. RN2 stated that she did not normally include wearing the securement devices as an intervention for residents wearing catheter. RN2	F 657		

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F 657	Continued From page 18 agreed that wearing the securement device was a means to prevent the catheter from becoming dislodged. During an interview on 06/14/23 12:10 PM, the Director of Nursing stated that it was an expectation for residents with indwelling catheters to wear a securement device and that it should be included in the care plan interventions.	F 657		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility failed to ensure a resident's room was free of an accident hazard for one of 25 residents, resulting in harm at past noncompliance. Resident #210 received a second degree burn from a heating element with a missing heat guard. The Findings Include: Diagnoses for Resident #210 included: Dementia, anemia, brain injury, and seizure disorder. The most current MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 9/28/22.	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 19 Resident #210 was assessed with moderate cognitive impairment. On 6/12/23 review of a facility synopsis dated 11/27/22 was reviewed and read in part that Resident #210 had 4 seizures back-to-back on 11/26/22 and during the seizures Resident #210's arm had flailed, causing the arm to drop over the side of the bed, landing on a baseboard heating system resulting in a burn. It was also noted that corrective action had taken place by repositioning the bed and placing a cover guard over the baseboard heater. Review of Resident #210's closed record documented via nursing progress notes that Resident #210 had several seizures on 11/26/23, 911 was called, and Resident #210 was sent to the emergency department due to the multiple seizures. The nursing notes did not describe Resident #210's burn to right arm. Review of Resident #210's hospital records documented that Resident #210 had a "Right forearm, second degree burn with partial thick skin loss and surrounding blisters. Small amount of serous drainage." Three individual statements (two nurses and one certified nursing assistant) were reviewed from the staff taking care of Resident #210 at the time of the incident. All statements indicated that Resident #210 received a burn and was being cared for but did not document condition of the baseboard heater. Only one of the staff members taking care of Resident #210 at the time of the incident, was currently working at the facility.	F 689		

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F 689	Continued From page 20 On 6/13/23 at 8:30 AM, license practical nurse (LPN #3, unit manager) was interviewed. LPN #3 said that although not working at the time of the incident and unable to speak to exactly what happened, but did say that as a result an inservice was done about uncovered baseboard heaters and all beds were moved away from the heating units and turned so that the bed is no longer parallel to the heating system. On 6/13/23 at 10:00 AM, the regional maintenance director (other staff, OS #8) was interviewed. OS #8 said that the heating guard was tore off and voiced uncertainty of how the guard had gotten torn off. Questioned further, OS #8 verbalized that Resident #210 had behaviors and could have torn the guard off or that the bed was against the heating system and the guard could have possibly been torn off while moving the bed. When asked if there was a repair order for the missing guard, OS #8 verbalized that there probably wasn't, as that would be something that would be repaired as soon as seen and reported. Questioned further, OS #8 expressed doubt that the guard had been off for very long, stating that the staff and maintenance review and observe rooms daily. OS #8 was asked the purpose off a heating guard. OS #8 verbalized the guard is in place to prevent direct access to the heating element to prevent possible burns. On 6/13/23 at 10:10 AM, LPN #4 was interviewed. Confirming being present in the room during Resident #210's seizure activity, LPN	F 689		

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F 689	Continued From page 21 #4 stated that Resident #210's right arm fell between the bed and wall, landing on the baseboard heater, burning Resident #210's arm. LPN #4 stated that the burn wound was cleaned, dressed, and ice applied, before sending Resident #210 to the hospital due to the multiple seizures. When asked about the guard to the baseboard heater, LPN #4 verbalized that the guard was neither seen on the heater or in the room. LPN #4 verbalized that since this incident all baseboard heaters have been reinforced with bigger guards and the beds have all been repositioned away from the heating system. On 6/13/23 at 4:35 PM, the above information was presented to the administrator and director of nursing. The administrator verbalized that although the incident happened prior to her employment and while under another company's ownership, the incident was somewhat familiar and agreed that it happened. The administrator stated that corrections had been put in place at the time and that employees were in-serviced about bed positioning, along with the baseboard guards, and that the incident continues to be part of the facility's quality assurance program and plan. On 6/14/23, a summary of the plan of correction, along with supporting evidence that the plan of correction was carried out was presented. The plan of correction included: - Facility wide audit of heaters completed to ensure bed is appropriate distance from heater. - Cover placed over Resident #210's heater. - maintenance staff, environmental staff and clinical staff to be educated on ensuring	F 689		

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F 689	Continued From page 22 appropriate distance between bed and heater. - Skin sweeps to be completed on everyone to ensure no burns to skin in rooms with baseboard heaters. - IDT will complete quality review weekly on bed/heater spacing and will address any issues immediately. - the plan of correction date of completion was 11/28/22. Observations of bed placement in regards to appropriate distance to baseboard heaters were completed by the survey team. Also, interviews of staff evidenced knowledge of appropriate distance from heaters, along with placement of the bed not being parallel with the heating systems. Review of Resident records, along with accident logs and interviews, did not evidence other residents with concerns regarding burns from baseboard heaters. On 6/14/23 at 10:45 AM, a maintenance staff person (OS #12) accompanied this surveyor to Resident #210's former room and explained the updated heating guards. The baseboard heaters were affixed to the wall at ground level and extended approximately 6 to 8 inches up the wall. The new guards surrounded the baseboard heaters completely. Resident rooms throughout the facility were also observed and had the same new guards placed. The plan of correction was accepted. This deficiency was cited as past non-compliance. No current deficiencies were cited under the concerned regulation during the survey. No other information was presented prior to exit conference on 6/14/23.	F 689		

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F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interview, record review,	F 690	Regarding F 690: Bowel/Bladder Incontinence, Catheter, UTI 1. Resident 54 has a catheter in place. DON/ADON followed up with resident regarding the use of a securement device. Resident declined the use of a securement device. His plan of care was updated to reflect his right/choice regarding the decision. 2. All residents with catheters were offered a securement device and their orders/care plan updated. 3. Educate the nurses on the use of catheter securement devices. 4. The ADON/designee will audit monthly for 3 months to ensure compliance. Any identified opportunities will be addressed immediately and reviewed in the monthly QAPI meeting. 5. Complete by 7/28/23	

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and review of facility policy, the facility failed to ensure one of one resident (Resident (R)54) reviewed for catheter care was wearing a securement device. This failure increased the potential for the catheter to become dislodged or cause injury.

Findings include:

Review of facility's undated policy titled "Urinary Catheter Care" read in part" Changing Catheters: indwelling catheters will be changed in accordance with physician/ nurse practitioner's orders by a licensed nurse. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.)"

During an observation on 06/14/23 at11:05 AM of R54's catheter care, it was noted R54's catheter was not secured to her upper thigh area. R54's catheter was draining yellow color urine with slight amount of sediment noted in the tubing.

Review of R54's "Admission Record" located in the resident's EMR under the "Profile" tab revealed R54 was admitted on 09/03/21 with diagnoses that obstructive and reflux uropathy.

Review of R54's current "Physician's Orders" located in the resident's EMR under the "Orders" tab revealed R54's foley drainage bag and catheter securement device were to be changed every seven days.

Review of R54's significant change "Minimum Data Set (MDS)" with an assessment reference date (ARD) of 02/28/23, located in the resident's

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STAUNTON POST ACUTE & REHABILITATION	512 HOUSTON STREET STAUNTON, VA 24401

(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 690	Continued From page 25 EMR under the "MDS" tab, revealed R54's Brief Interview for Mental Status (BIMS) score was 15 out of 15, indicating R54's cognition was intact. R54 was assessed to have an indwelling catheter. During an interview on 06/14/23 at 11:05 AM, Certified Nursing Assistant (CNA) 6 revealed R54 was not wearing a catheter securement device. CNA6 stated the facility had securement devices in the storeroom but was not aware R54 needed one. During an interview on 06/14/23 at 11:15 AM, the Unit Manager Registered Nurse (RN) 1 revealed residents with foley catheters should wear leg securement device to secure the catheter and avoid the catheter being pulled out. RN1 further stated she was unaware R54 did not have securement device in place. RN1 confirmed R54 was recently diagnosed with urinary tract infection. During an interview on 06/14/23 at 12:10 PM, the Director of Nursing revealed it was an expectation for residents with indwelling catheters to wear a securement device.	F 690		
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	F 812	Regarding F 812: Food Procurement, Storage/Prep Serve-Sanitary 1. As directed by the Regional Director: All identified items from the kitchen refrigerator, freezer or dry storage that were in question due to dating or loose coverage were removed and trashed; all areas have been cleaned. The cucumber on the floor was removed and the floor was cleaned. All nesting items were removed, rewashed and set to dry properly. All personal items were removed the area immediately. All staff donned hair nets immediately. The dishwasher has been cleaned and empty spray bottles removed. The hand sink has been scrubbed. All kitchen equipment was cleaned and added to a routine cleaning schedule. The 3-compartment sink area was scrubbed. Hand Sanitizer stations were filled/repaired. The Ice Machine exterior was cleaned. Plates, cups and utensils were audited for cleanliness and proper storage. Cleaning schedules were updated and posted. Nourishment refrigerators were cleaned on each unit.	

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F 812	Continued From page 26 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, facility document review, and staff interview, the facility staff failed to store, prepare and distribute food in a sanitary manner. The findings include: 1. Food preparation/service equipment and the overall kitchen environment were dirty. Undated, out of date, and unsealed food items were stored in the refrigerator and available for use. The dishwasher was dirty and operated by staff members not using hair restraints. Stainless steel serve pans were stored nested and wet. On 6/12/23 at 11:05 a.m., the initial tour of the main kitchen was conducted accompanied by the cook (other staff #2). Two dietary aides (other staff #14, #15) were observed operating the dishwasher with no hair restraints in use. The dishwasher had crumbs and food particles on the top surface of the machine along with streaks of a white/orange colored substance down the front of the dishwasher panels. There was an empty, broken spray bottle on top of the machine. The hand sink near the dishwashing area was dirty with brown stains in the sink bowl. The dry	F 812	F 812 Cont. 2. All Dietary staff will be educated including: Proper storage and labeling/dating General cleanliness/expectations/schedules Following policies and procedures Appropriate storage of kitchen items Personal hygiene and infection control Proper washing and drying of kitchen wares Other staff such as nurses will be educated on proper use and upkeep of nourishment refrigerators. 3. Daily checklists and cleaning schedules will promote compliance. Unit Managers will round daily to include nourishment refrigerators. 4. Walking rounds/audits will be completed 4 x a week for 2 weeks; 2 x a week for 4 weeks and 1 x a week six weeks. Any opportunities for improvement will be addressed immediately. Results of rounds and variances will be reviewed/discussed at the monthly QAPI meeting. 5. Complete by 7/28/23	

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F 812	Continued From page 27	F 812		

storage room had a five-gallon bucket of puffed wheat cereal that was not sealed/covered. The overall storage area had a messy/disorganized appearance with food wrappers, empty boxes, and paper debris on the shelves and on the floor. The kitchen's stove was dirty with heavy, black buildup on the stove eyes and grates, along with dried food particles. During the stove inspection, the cook stated that the evening cook was responsible for cleaning the stove, which included the grates being soaked and run through the dishwasher. The knobs on the stove, convection ovens, and tilt skillet were dirty with stains/food debris. The doors to the convection oven were dirty with brown stains. The tilt skillet had accumulated brown stains at the base and at the hinges. The floor under the steam table was covered with spilled puffed cereal that the cook stated was spilled that morning during breakfast preparation.

On 6/12/23 at 11:22 a.m., accompanied by OS #2, the walk-in refrigerator was inspected. The glass door to the reach-in portion of the refrigerator was dirty and covered with fingerprints/stains. A container of tuna salad was stored partially covered with loose plastic wrap. There was a 10-liter bucket of lemonade that had no label indicating a preparation or discard date. There was a quart container of whipped topping marked "4/10." The manufacturer's label for the topping read, "Keep frozen until ready to use." There was a cucumber laying on the floor under the front rack with a white, puffy substance on the surface. On 6/12/23 at 11:30 a.m., the walk-in freezer was then inspected. There was debris, trash, food wrappers on the floor. Frozen condensation was observed on the freezer ceiling and on the floor near the entrance. Condensation

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was dripping from the ceiling near the top door seal.

Further inspection during this initial tour included the 3-compartment sink area and pan storage. Fifteen large stainless steel serve pans were on the ready-to-use rack, stored nested and wet. Water was visible along the pan rims and moisture on the inside pan surfaces. On top of the pan rack were two opened bottles of lemon juice. A stainless prep bowl stored on the clean rack had food debris along the rim. The sanitizer dispenser at the 3-compartment sink area had the cover off. The cover, on a nearby shelf, was dirty with food debris/residue. The ice machine near the sink area had brown stains on the side panel and outside of the door.

On 6/12/23 at 12:42 p.m., the tray line/steam table service was observed. There was an opened Pepsi bottle, cell phone, and keys positioned in the prep area near the end of the steam table. There were several plastic glasses/cups observed with white looking residue giving the containers a cloudy appearance.

On 6/13/23 at 11:45 a.m., the regional dietary director (other staff #3) who was the interim kitchen manager, was interviewed about the kitchen observations. The regional dietary director stated that staff were supposed to clean the steamers, ovens, stove eyes/grates at least every other day. The dietary director stated that he looked at the stove eyes/grates and he agreed they had not been cleaned. The regional dietary director stated the kitchen was staffed from 5:00 a.m. until 8:00 p.m. each day and that staff were expected to provide daily generalized cleaning, with duties divided between two cooks and the

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remaining dietary aides. The dietary director stated that leftover food items were supposed to be dated when prepared, marked with a discard date, and discarded when expired.

The dietary director provided the following policies used by the facility for food safety, sanitation, storage, and service.

The facility's policy titled Food Safety and Sanitation (Chapter 4: Sanitation and Infection Control 4-2) documented, "Food stored in dry storage is placed on clean racks...The room should be clean, dry and cool...All time and temperature control for safety (TCS) foods (including leftovers) should be labeled, covered, and dated when stored...When a food package is opened, the food item should be marked to indicate the open date. This date is used to determine when to discard the food. Leftovers are used within 72 hours (or discarded)..."

The facility's policy titled Food Safety - Director of Dining Services' Responsibilities (Chapter 4: Sanitation and Infection Control 4-3) documented, "...The director of food and nutrition services will be responsible for providing safe foods to all individuals...The director of food and nutrition services assures all of the following..."Sanitary conditions will be maintained in the food storage, preparation, and serving areas...All refrigerated and frozen foods will be stored and handled properly...Employees will follow sanitary practices...The director of food and nutrition services or designee will conduct regular inspections to assure proper food handling...Cleaning schedules will be posted and followed..."

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F 812	Continued From page 30 The facility's policy titled Employee Sanitary Practices (Chapter 4: Sanitation and Infection Control 4-4) documented, "All food nutrition services employees will practice good personal hygiene and safe food handling procedures...All employees will...Wear hair restraints (hairnet, hat, and/or beard restraints) to prevent hair from contacting exposed food...Clean and sanitize equipment and work areas after use...Follow all federal, state and local requirements..." The facility's procedure PM5 - Daily Assignments (undated) documented, "...absoutley [absolutely] no cell phones allowed in the work areas. This is to include all kitchen and prep, storerooms..." (Sic) The 2022 Food Code in chapter 4 on page 28 documents, "...Clean equipment and utensils...shall be stored...in a self-draining position that allows air drying...Covered or inverted..." (1) 2. The nourishment refrigerators on the second floor units were dirty with leftover and opened food items that had no identification or discard/use by dates. On 6/12/23 at 11:43 a.m., the nourishment/snack refrigerator on the 2 west side unit was inspected. The inside of the freezer section was dirty with black buildup/debris and dried liquid spills on the rack/bottom of the freezer. Stored in the refrigerator was an opened bag of lettuce that was discolored (brown/yellow) with no discard date, an opened container of guacamole dip unsealed and undated, an opened container of spinach/artichoke dip with no date, an opened	F 812		

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container of humus spread with no date labels, and a sub-sandwich wrapped in paper. There was no name and/or date on the sandwich.

On 6/13/23 at 9:09 a.m., accompanied by certified nurses' aide (CNA) #2, the snack/nourishment refrigerator on 2 new west unit was inspected. There was a box of leftover pizza and a McDonald's meal labeled for a current resident but with no discard date. There were two pint jars of a white semi-liquid labeled for a current resident. The jars were not labeled to identify the food product and had no use-by or discard dates marked on them. There was an opened bottle of Pepsi and a Styrofoam cup containing liquid, neither were labled with a name and/or dates. CNA #2 was interviewed at this time about the food items. CNA #2 stated that the food was supposed to be dated when placed in the refrigerator and discarded when expired. CNA #2 was unsure what the white product was in the pint jars but thought it was mayonnaise.

On 6/13/23 at 3:00 p.m., the regional dietary director (other staff #3), serving as interim kitchen manager, was interviewed. The regional dietary director stated that kitchen staff placed snacks and juices in the unit refrigerators, but dietary staff were not responsible for resident food items. The regional dietary director stated, "We do not take care of the food or refrigerators [on units]. We only put snacks in them."

The facility's policy titled Food: Safe Handling for Foods from Visitors (9/2017) documented, "Residents will be assisted in properly storing and safely consuming food brought into the facility for residents...When food items are intended for later consumption, the responsible facility staff

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F 812	Continued From page 32 member will...Ensure that the food is stored separate or easily distinguishable from the facility food...Ensure that foods are in a sealed container to prevent cross contamination...Label foods with the resident name and the current date....Refrigerators/freezers for storage of foods brought in by visitors will be properly maintained and...Daily monitoring for refrigerated storage duration and discard of any food items that have been stored for [greater than or equal to] 7 days...Cleaned weekly...The unconsumed portion of foods that have been re-heated will be discarded..." These findings were reviewed with the administrator, director of nursing and unit managers during a meeting on 6/13/23 at 4:25 p.m. No further information was presented prior to the survey exit regarding food service concerns in the main kitchen and unit refrigerators. (1) Food Code 2022. U.S. Public Health Service. U.S. Food &Drug Administration. U.S. Department of Health and Human Services. January 18, 2023 version.	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review and staff interview, the facility staff failed to properly dispose of garbage/refuse. The findings include:	F 814	Regarding F814: Dispose Garbage and Refuse Properly 1. The dumpster area was cleaned immediately. 2. Director of Maintenance to pursue replacement of dumpster to address doors that will not close. 3. Education will be provided to Dietary staff, housekeeping and nursing staff regarding refuse disposal by the Regional Director/DON or NHA. 4. The Dumpster area will be added to daily walking rounds to promote compliance. Any variance or identified opportunity will be addressed immediately. Any variance will be reviewed/discussed at the monthly QAPI meetings. 5, Complete by 7/28/23	

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F 814	Continued From page 33 On 6/12/23 at 11:30 a.m., accompanied by the cook (other staff #2), the garbage disposal area/dumpsters were observed. The doors on the two dumpsters were open with visible/exposed refuse in both containers. On the ground around and in front of the dumpsters were several blue gloves, a plastic drink bottle, an empty trash bag, and small trash items/debris. The cook stated that garbage was supposed to be placed inside the dumpsters and the doors kept closed. On 6/13/23 at 11:45 a.m., the regional dietary director (other staff #3), serving as interim kitchen manager, was informed about the open dumpsters with trash/debris on the ground. The regional dietary director had no comment about the dumpsters but stated that kitchen staff were responsible for daily cleaning and disposal of waste. The facility's policy titled Food Safety - Director of Dinging Services' Responsibilities (Chapter 4: Sanitation and Infection Control 4-3) documented under procedures that the director of food and nutrition services would conduct regular inspections to ensure proper food handling. Procedures listed in this policy included, "Proper waste disposal methods will be used." During a meeting on 6/13/23 at 4:25 p.m., this finding was reviewed with the administrator, director of nursing, and unit managers, with no other information provided regarding garbage disposal.	F 814		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 34 §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 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,	F 880	Regarding F 880: Infection Prevention & Control 1. This was a process failure and did not impact a direct resident 2.The Water Management plan and Legionella Prevention plans were immediately updated to reflect best practices. 3. The NHA/Director of Maintenance/IP and DON have reviewed the Water Management plan/Legionella Prevention plans and supporting processes. Staff education regarding these will occur at the next Mandatory Staff Meetings. 4. The Water Management Plan and Legionella Prevention Plan including the supporting documentation, will be reviewed no less than annually and as changes occur. Staff will be provided education on the plans no less than annually. 5. Complete by 7/28/23	

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F 880	Continued From page 35 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 review of facility's records, interviews, and policy review, the facility failed to maintain a legionella prevention program to protect residents from contracting water-borne pathogens as part of the facility's infection prevention and control program. This failure had the potential to affect all residents residing in the facility. Additionally, the facility failed to ensure staff follow infection prevention practices for hand hygiene during dining observation. This has the potential for facility wide spread of infection and/or contamination.	F 880		

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F 880	Continued From page 36 Findings: 1. Review of the facility's policy revised July 2017 and titled "Legionella Water Management Program" revealed "...Facility is committed to the prevention, detection and control of water-borne contaminants, including legionella... 1. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. 2.The water management team will consist of at least the following personnel: The infection preventionist. The administrator. The medical director (or designee). The director of maintenance; and The director of environmental services. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. The water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE [American Society of Heating, Refrigerating and Air-Conditioning Engineers] recommendations for developing a Legionella water management program ..." Review of the CDC website titled "Legionella . . . Prevention and Control, dated 03/25/21, indicated ". . . The key to preventing Legionnaires' disease is to reduce the risk of Legionella growth and spread. Building owners and managers can do this by maintaining building water systems and implementing controls for Legionella . . . Key	F 880		

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F 880	Continued From page 37 Elements . . . Seven key elements of a Legionella water management program are to . . . Establish a water management program team . . . Describe the building water systems using text and flow diagrams . . . Identify areas where Legionella could grow and spread . . . Decide where control measures should be applied and how to monitor them . . . Establish ways to intervene when control limits are not met . . . Make sure the program is running as designed (verification) and is effective (validation) . . . Document and communicate all the activities . . . Principles . . . In general, the principles of effective water management include . . . Maintaining water temperatures outside the ideal range for Legionella growth . . . Preventing water stagnation . . . Ensuring adequate disinfection . . . Maintaining devices to prevent sediment, scale, corrosion, and biofilm, all of which provide a habitat and nutrients for Legionella . . . Once established, water management programs require regular monitoring of key areas for potentially hazardous conditions and the use of predetermined responses to respond when control measures are not met. . ." Review of website for ASHRAE titled "Risk Management For Legionellosis," dated 10/15, indicated ". . . The design engineer first needs to evaluate which requirements of the standard apply to their project. This evaluation determines if the project contains any of the following building risk factors . . . Health-care facility with patient stays over 24 hours . . . Facilities designated for housing occupants over age 65 . . . The risk of disease or illness from exposure to Legionella bacteria is not as simple as the bacteria being present in a water system. Other factors that contribute to the risk are environmental conditions	F 880		

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	495243	A. BUILDING _____ B. WING _____	C 06/15/2023

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F 880	Continued From page 38 that promote the growth and amplification of the bacteria in the system, a means of transmitting this bacteria (via water aerosols generated by the system), and the ultimate exposure of susceptible persons to the colonized water that is inhaled or aspirated by the host providing a pathway to the lungs. The bacteria are not transmitted person-to-person, or from normal ingestion of water. Susceptible persons at high risk for legionellosis include, among others, the elderly, dialysis patients, persons who smoke, and persons with medical conditions that weaken the immune system . . ." Review of the facility's legionella folder provided by the facility revealed documents titled "Water Temp Log" detailing monthly water temperature logs of multiple water sources in the facility dating back 2 years. The last document was titled "Water Temp Log 03/06/23---03/12/23". Further review of the Legionella binder failed to reveal any documentation of water temperatures beyond March 2023. No other documentation of a water program was provided. During an interview on 06/13/23 at 2:03 PM, the Infection Control Preventionist (ICP, Registered Nurse (RN) 3) stated she did not know the details of the facility's Legionella prevention program and would find out. During an interview on 06/14/23 at 1:55 pm, when asked about the legionella prevention program since March, the Administrator stated she did not have the latest documentation on the facility's legionella prevention program because the maintenance supervisor who performed the task was no longer with the facility. The Administrator did not have access to the previous maintenance	F 880		

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F 880	Continued From page 39 records. The Administrator further admitted that there were no records of the facility's ongoing legionella prevention program. 2. Review of the facility's undated document titled "Hand Hygiene" read in part "The facility promotes hand hygiene as a simple and effective method for preventing the spread of infection Glove use is not a substitute for hand hygiene. All staff are to perform hand hygiene during all care activities and while working in all locations within the facility." Review of the facility's undated document titled "Standard Precautions" reads in part "Hand hygiene is performed with ABHR [alcohol based hand rub] . . . before and after contact with the resident . . . after contact with items in the resident's room; before eating and after using the restroom." During the lunch meal observation on 06/13/23 at 12:40 PM on unit three North West, Certified Nursing Assistant (CNA) 7 pulled a meal tray from the cart without performing hand hygiene. CNA7 served the meal tray to R19 in his room. After arranging R19's meal tray CNA7 left R19's room and went to the meal cart and removed another meal tray without performing hand hygiene. CNA7 served this meal tray to R8 who was sitting in the dining room. CNA7 prepared R8's meal tray, opening the condiment packets for R8. CNA7 left the dining room to obtain a clothing protector and placed it around R8's neck. CNA7 returned to the meal cart without performing hand hygiene and pulled another meal tray. CNA7 took this tray to R46's room. CNA7 rolled up the head of R46's bed and positioned the overbed table within the R46's reach. CNA7 left R46's room and returned	F 880	F 880 Cont. 1. The CNA who failed to follow hand hygiene practices was educated immediately. 2. This was identified as a staff process failure. 3. The Infection Preventionist provided education to nursing staff as well. All staff will receive hand hygiene education at upcoming Mandatory Staff meetings. 4. 10% of nursing staff will be audited through Hand clinic checks each month for three months. The checks will include observation and education to all involved by the Infection Preventionist. Any identified opportunities will be discussed/reviewed at the monthly QAPI meeting. 5. Complete by 7/28/23	

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F 880	Continued From page 40 to the meal cart without performing hand hygiene. CNA7 obtained a milk carton from the meal cart and placed it on a meal tray for R54. CNA7 took the meal tray to R54 and set up the meal tray and positioned the overbed table so R54 could reach the tray. CNA7 returned to the meal cart and obtained another meal tray without performing hygiene. During an Interview on 06/13/23 at 12:43 PM, CNA8 revealed it was an expectation to either wash hands or use hand sanitizer between each resident contact either in the dining room or when taking resident trays. During an interview on 06/13/23 at 1:07 PM, the ICP/RN3 stated it was an expectation for staff to perform hand hygiene between each resident contact either in the dining room or resident's room during meal service. During an interview on 06/13/23 at 1:10 PM, CNA7 revealed that she had received training to perform hand hygiene between each resident contact during meal services. CNA7 acknowledged she had not performed hand hygiene and could not explain why she did not do it.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure proper function of the	F 908	Regarding F908: Essential Equpment, Safe Operating Condition 1. The freezer has been repaired including the compressors, the seal around the door and pressure hinge at top of the door. All ice and water have been removed. 2. The repair vendor has returned twice since the freezer was fixed to confirm no additional issues remain. 3. Education will be provided to the Dietary Manager regarding monitoring the freezer for ice and condensation. The freezer is checked at regular intervals for ice and condensation build up by the Dietary Manager or Regional Director. 4. The freezer will be checked as a part of walking rounds by the NHA for 2 times a week for 2 weeks and 1 times a week for 4 weeks and 1 x a month for 2 months. Any identified issues will be addressed immediately and reviewed/discussed at the monthly QAPI meeting. 5. Completed 7/7/28	

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F 908	Continued From page 41 freezer in the main kitchen. The findings include: On 6/12/23 at 11:30 a.m., accompanied by the cook (other staff #2), the walk-in freezer in the main kitchen was inspected. Upon opening the door, there was water and ice on the floor, at the threshold to the unit. Water was noted dripping along the top of the freezer door. There was frozen condensation visible on the entire ceiling of the freezer. The cook was interviewed at this time about the water/ice. The cook stated that the freezer had been worked on but not repaired and that the water/ice had been there for weeks. On 6/13/23 at 11:45 a.m., the maintenance director (other staff #4) was interviewed about the freezer with condensation/ice. The maintenance director stated that he thought the kitchen manager had contacted an outside vendor for repair. The maintenance director stated that he was not sure if the vendor worked on the freezer or the outcome of the repair. The maintenance director denied knowledge of a work order for his department to assess/repair the freezer. On 6/13/23 at 12:06 p.m., the regional dietary director (other staff #3) serving as interim kitchen manager, was interviewed about the freezer. The regional dietary director stated, "[Name of vendor] has been here a bunch of times." The dietary director denied knowing when the freezer was last looked at for repair. During a meeting on 6/13/23 at 4:25 p.m., this finding was reviewed with the administrator, director of nursing, and unit managers, with no other information provided regarding the freezer	F 908		

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F 908	Continued From page 42 condensation/ice.	F 908		