STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. Building B. Wing	05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Appomattox Health & Rehabilitation Center	235 Evergreen Ave Appomattox, VA 24522

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview and clinical record review, the facility staff failed to maintain floor mats and positioning cushions in clean/intact condition for one of sixteen residents in the survey sample (Resident #4). The findings include: Resident #4's floor mats were dirty, and the surfaces were heavily torn with frayed edges. The coverings on the bolster cushions in Resident #4's bed had torn corners with exposed foam visible. Resident #4 was admitted to the facility with diagnoses that included congestive heart failure, chronic kidney disease, hypertension, anemia, aphasia, cardiomyopathy, adult failure to thrive, dementia, psychotic/mood disturbance and anxiety. The minimum data set (MDS) dated [DATE] assessed Resident #4 with severely impaired cognitive skills and as requiring the extensive assistance of two people for bed mobility. On 5/9/23 at 10:02 a.m., floor mats were observed on Resident #4's side of the room. One mat was observed rolled up by the bedside table and the other mat was under the resident's bed. The covers of both mats were dirty and worn with visible cracks over the entire mat surface. The edges of both mats were tattered and frayed. On 5/9/23 at 2:18 p.m., the licensed practical nurse (LPN #6) caring for Resident #4 was interviewed about the condition of the floor mats. LPN #6 stated, They [mats] are in pretty bad shape. LPN #6 stated that she was not sure if new mats were kept in the supply room. On 5/9/23 at 2:29 p.m., accompanied by LPN #6, two bolster cushions on Resident #4's bed were observed. The coverings on both cushions were torn on the corners with exposed foam visible. LPN #6 stated at this time that the floor mats were ragged and the torn cushion covers needed replacing. On 5/9/23 at 2:45 p.m., the unit manager (LPN #2) was interviewed about the floor mats and bolster cushions being in poor condition. LPN #2 stated any mats and/or cushions with hole or rips were supposed to be immediately replaced. LPN #2 stated that it was not sanitary to use cushions with torn coverings. LPN #2 stated Resident #4's mats and the bolster cushions needed to be discarded and replaced. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 5/9/23 at 4:15 p.m. The facility provided no further information about the torn/tattered mats/cushions prior to the end of the survey.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 29123 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to identify and report an injury of unknown origin to the appropriate facility staff for one of 16 residents, Resident #258. Findings were: Resident #258 was admitted to the facility with the following diagnoses, including but not limited to, Atrial fibrillation, dementia, psychotic disturbance, mood disturbance, anxiety, and urinary tract infection. Due to her recent admission, no MDS (minimum data set) information was available. Upon attempted interview with Resident #258, her speech was nonsensical and she was unable to answer questions. On 05/08/2023 at approximately 12:15 p.m., the initial tour of the facility was conducted. Resident #258 was observed sitting in a wheelchair outside of her room. An elongated area was observed on the right side of her head, from her scalp, down her forehead, running parallel to her hair line. The area was bluish/purple in color. When asked what had happened to her head, Resident #258 answered, I don't know it's [Name redacted]'s choir .they know. CNA (certified nursing assistant) #3 was in the hallway with Resident #258 and was asked about the bruise. CNA #3 stated that Resident #258 was a fall risk and that she falls. When asked if she had hit her head during a fall, Resident #258 again answered the question with a reference to [Name redacted]'s choir. The clinical record was reviewed on 05/09/2023 at approximately 11:00 a.m. There was no documentation observed regarding the discolored area on Resident #258's forehead. The admission assessment completed on 05/01/2023 was reviewed. The section Skin Observations assessed Resident #258 as having no skin issues. At approximately 3:00 p.m., LPN (licensed practical nurse) #1 was interviewed regarding the area of discoloration on Resident #258's forehead. LPN #1 stated that she had done the admission assessment and documentation for Resident #258 and had not seen the area at that time. LPN #1 and this surveyor went to Resident #258's room. Resident #258 was lying supine on her bed. The area on her forehead was observed with more green coloring with the same elongated shape described above. LPN #1 stated, I haven't seen that before .it wasn't there when she came in. At approximately 3:15 p.m., the DON (director of nursing), the administrator, and the regional nurse consultant were all in the DON's office. They were asked if anyone had reported the area on Resident #258's forehead to them. The administrator and the DON both stated that they had not been made aware of any discoloration. During an end of the day meeting with the DON, the administrator, and the regional nurse consultant the above information was discussed. The DON stated they were still investigating to see if they could find out what had happened. When asked if the area should have been reported to him by they facility staff, the Administrator stated, Yes. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/10/2023 at approximately 8:50 a.m., CNA #3 was interviewed regarding the area on Resident #258's forehead. When asked if he had noticed the area when he was taking care of her, CNA#3 stated, Yes, I saw it. When asked if he had reported it to his charge nurse when he first noticed it, CNA #3 stated, No, I thought it looked old, so I thought they already knew about it. At approximately 9:00 a.m. the DON and the regional nurse consultant were interviewed regarding Resident #258. The regional nurse consultant stated, We are still looking into it .the therapist said he noticed it last Friday .her son said he noticed it on Saturday .she had a fall here on May 5th .the documentation is that she fell on her bottom . When asked if the therapist or the resident's son had told any one about the area, the regional nurse consultant stated, No. At approximately 10:25 a.m., a skin observation tool completed on 05/09/2023 at 6:21 p.m. was presented by the unit manager, LPN #2. The skin observation tool contained the following: Top of Scalp: Bruising Left hand (back): Bruising Right knee (front): Bruising Left knee (front): Bruising Right top foot: Bruising Notes: Head to toe Skin sweep Resident noted to have a bruise to her right temple area blue, yellow greenish in color. Yellowish bruise noted to left wrist, yellowish bruise noted to left shin area, blue bruise noted to right knee and a reddened area noted to the top of her right foot under metatarsals no open area noted, nor drainage noted. Dr [name redacted] called and notified at this time of head-to-toe skin sweep and finding. LPN #2 stated, I did the skin sweep last night, I called the doctor to let him know about the bruises that I saw the staff should have reported what they were seeing. The facility policy, Injuries of Unknown Origin contained the following: Injuries of unknown origin will be handled the same as an allegation of mistreatment, neglect, or abuse and must be reported to the center Administrator. Procedure: Injuries of unknown origin to a patient are to be reported to a licensed nurse. The staff educator, RN (registered nurse) #3 was interviewed at approximately 10:30 a.m. regarding staff education about injuries of unknown origin. RN#3 presented an Inservice/Educational Record that education had occurred on 03/09/2023 with nursing staff and included information regarding injuries of unknown origin. The above information was discussed with the DON, the administrator, and the regional nurse consultant during a meeting at approximately 11:30 a.m. No further information was presented prior to the exit conference on 05/10/2023.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 09404 Based on complaint investigation, closed clinical record review, and staff interview, the facility staff failed for one of 16 residents in the survey sample, Resident # 107, to forward a notice of discharge to the local Ombudsman. Resident # 107 was transferred to the hospital without a notice of discharge being sent to the local Ombudsman. The findings were: Resident # 107, who was her own Responsible Party, was admitted to the facility with diagnoses that included status post left femur fracture, history of malignant neoplasm of the breast, hypothyroidism, depression, hypertension, difficulty walking, generalized muscle weakness, anxiety disorder, peripheral vertigo, chronic obstructive pulmonary disease, right hip pain, chronic respiratory failure with hypoxia, and COVID-19. The Progress Notes in the resident's Electronic Health Record included the following entries: 12/30/2022 - 1930 (7:30 p.m.) - O2 (oxygen) sat (saturation) reported @ 75% on 5L/M (5 liters per minute). Resident positioned sitting up, alert and oriented. Administered prn (as needed) Duoneb treatment and titrated oxygen to 8L/M via nasal cannula. O2 sat increased to 88%. TC (Telephone Call) to on call MD, (name), and received order to transfer Resident to ED. Resident left facility via EMS transport to Lynchburg General @ 2020 (8:20 p.m.). Daughter notified of Resident's change in condition approx(imately) 2000 (8:00 p.m.). 12/31/2022 - 0431 (4:31 a.m.) - Spoke with (name) at Centra Lynchburg ER resident being admitted for Acute respiratory failure. Resident # 107 did not return to the facility. At approximately 2:30 p.m. on 5/9/2023, the facility Administrator was asked for a copy of the resident's transfer notice sent to the local Ombudsman. The Administrator stated that the Discharge Planner/Social Worker who handles that process was no longer employed at the facility, but that he would try to locate the notice. At 10:50 a.m. on 5/10/2023, the Administrator reported that he was unable to find the transfer notice sent to the local Ombudsman. The lack of a transfer notice was discussed at a 10:30 a.m. meeting on 5/10/2023 that included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. 29123 Based on observation, staff interview, and clinical record review, the facility staff failed to ensure admission orders were in place for the care of suprapubic catheter for one of 16 residents, Resident #257. Findings were: Resident #257 was admitted to the facility with the following diagnoses including but not limited to: hypertension, pulmonary edema, protein-calorie malnutrition, anemia, pneumonia, urethral stricture, and pseudomonas pneumonia. Due to his recent admission, no MDS (minimum data set) information was available. When interviewed, regarding his care at the facility Resident #257 answered questions appropriately. During initial tour of the facility on 05/08/2023 at approximately 12:15 .pm., Resident #257 was observed lying supine on his bed. His pajama top was not pulled all the way down and a suprapubic catheter was observed. The clinical record was reviewed on 05/08/2023 at approximately 2:30 p.m. The physician order section contained the following order for the care of the suprapubic catheter: Cleanse and apply split sponge to suprapubic site daily . The care plan was reviewed. A focus area, The resident requires an urinary suprapubic catheter related to : Obstructive uropathy. The interventions listed was to provide catheter care each shift. An end of day meeting was held on 05/09/2023 at approximately 4:00 p.m. with the DON (Director of Nursing), the administrator, and the regional nurse consultant. The DON was asked if the facility was changing Resident #257's catheter or was he going out of the facility. The DON stated that she didn't know but would check. Concerns were voiced that there were no immediate care orders on the clinical record that addressed what to do if the catheter became clogged or dislodged, nor were there interventions on the care plan to address these concerns. The DON stated that she would find out what was supposed to be done. On 05/10/2023 the facility staff presented an updated care plan that included care of the catheter, and physician orders that included, Nursing staff not to change suprapubic catheter, urology will manage. No further information was obtained prior to the exit conference on 05/10/2023.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 29123 Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a baseline care plan for the care of suprapubic catheter was in place for one of 16 residents, Resident #257. Findings were: Resident #257 was admitted to the facility with the following diagnoses including but not limited to: hypertension, pulmonary edema, protein-calorie malnutrition, anemia, pneumonia, urethral stricture, and pseudomonas pneumonia. Due to his recent admission, no MDS (minimum data set) information was available. When interviewed, regarding his care at the facility Resident #257 answered questions appropriately. During initial tour of the facility on 05/08/2023 at approximately 12:15 p.m., Resident #257 was observed lying supine on his bed. His pajama top was not pulled all the way down and a suprapubic catheter was observed. The clinical record was reviewed on 05/08/2023 at approximately 2:30 p.m. The physician order section contained the following orders for the care of the suprapubic catheter: Cleanse and apply split sponge to suprapubic site daily . The care plan was reviewed. A focus area, The resident requires an urinary suprapubic catheter related to : Obstructive uropathy. Interventions listed were to provide catheter care each shift. An end of day meeting was held on 05/09/2023 at approximately 4:00 p.m. with the DON (Director of Nursing), the administrator, and the regional nurse consultant. The DON was asked if the facility was changing Resident #257's catheter or was he going out of the facility. She stated she didn't know but would check. Concerns were voiced that there were no immediate care orders on the clinical record regarding the care of the catheter nor were there any interventions regarding replacement listed on the care plan. The DON stated that she would find out what was supposed to be done. On 05/10/2023 the facility staff presented an updated care plan that included care of the catheter, and physician orders that included, Nursing staff not to change suprapubic catheter, urology will manage. No further information was obtained prior to the exit conference on 05/10/2023.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for one of sixteen residents in the survey sample (Resident #4). The findings include: Resident #4 was admitted to the facility with diagnoses that included congestive heart failure, chronic kidney disease, hypertension, anemia, aphasia, cardiomyopathy, adult failure to thrive, dementia, psychotic/mood disturbance and anxiety. The minimum data set (MDS) dated [DATE] assessed Resident #4 with severely impaired cognitive skills and as requiring the extensive assistance of two people for bed mobility. On 5/9/23 at 2:34 p.m., Resident #4 was observed seated in a wheelchair in his room. The resident had a pommel seat cushion in use with the wheelchair. Review of Resident #4's clinical record revealed an occupational therapy (OT) discharge summary dated 4/3/23 recommending use of the pommel cushion to assist with proper positioning and fall prevention when in the wheelchair. Resident #4's plan of care (revised 4/5/23) listed, Pommel cushion for positioning PRN [as needed], reposition as needed as an intervention related to maintaining activities of daily living. The plan of care included no problems, goals and/or interventions regarding use of the pommel cushion and the pommel cushion was not included among interventions regarding fall/injury prevention. On 5/9/23 at 3:13 p.m., the director of nursing (DON) was interviewed about a plan of care for Resident #4's pommel cushion use. The DON stated the device required a plan of care. The DON stated the pommel cushion was a recommendation from OT for fall prevention due to the resident's improper positioning when seated in the wheelchair. This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 5/9/23 at 4:15 p.m. The facility provided no further information about a care plan regarding the pommel cushion prior to the end of the survey.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on resident interview, staff interview and clinical record review, the facility staff failed to revise the comprehensive care plan for one of sixteen residents in the survey sample (Resident #41). The findings include: Resident #41's plan of care was not revised regarding discontinued use of a Foley urinary catheter. Resident #41 was admitted to the facility with diagnoses that included vertebra compression fractures, atrial fibrillation, sepsis, pneumonitis, urinary tract infection, atherosclerotic heart disease, anxiety, asthma, congestive heart failure, urine retention and kidney failure. The minimum data set (MDS) dated [DATE] assessed Resident #41 as cognitively intact. Resident #41's plan of care (revised 4/19/23) documented the resident required a urinary catheter due to retention and diagnosed bladder infection. Interventions to prevent catheter complications and resolve infection included changing catheter as ordered, anchoring catheter, provision of privacy bag, monitoring urine for dark or cloudy appearance, and catheter care every shift and per orders. Review of Resident #41's clinical record revealed no current order for a Foley urinary catheter. On 5/8/23 at 3:00 p.m., Resident #41 was interviewed about the urinary catheter. Resident #41 stated she previously had a catheter due to retention problems, but the catheter had been discontinued and she was voiding without problem. Resident #41 stated the catheter had been taken out over a month ago. On 5/8/23 at 3:15 p.m., the licensed practical nurse unit manager (LPN #2) was interviewed about the Foley catheter. LPN #2 stated the resident no longer had a catheter. LPN #2 looked at the clinical record and stated the catheter was discontinued on 3/22/23. On 5/10/23 at 8:21 a.m., the registered nurse MDS coordinator (RN #6) responsible for care plans was interviewed. RN #6 stated the last care plan meeting for Resident #41 was on 4/26/23. RN #6 stated the care plan items about the catheter should have been removed when the device was discontinued. This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 5/10/23 at 11:25 a.m. No further information was provided about Resident #41's care plan prior to end of the survey.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09404 Based on complaint investigation, closed clinical record review, staff interview, and review of facility documents, the facility staff failed for one of 16 residents in the survey sample, Resident # 107, to administer medications in a timely manner. Six medications, administered by two different nurses, were given between 2 hours and 43 minutes, and 4 hours and 45 minutes late. The findings were: Resident # 107, who was her own Responsible Party, was admitted to the facility with diagnoses that included status post left femur fracture, history of malignant neoplasm of the breast, hypothyroidism, depression, hypertension, difficulty walking, generalized muscle weakness, anxiety disorder, peripheral vertigo, chronic obstructive pulmonary disease, right hip pain, chronic respiratory failure with hypoxia, and COVID-19. As a part of the complaint investigation process, the Medication Admin Audit Report was reviewed. Review of the report revealed the following medications were administered late. Docusate Sodium Capsule 100 mg (milligrams) - Give 1 capsule by mouth two times a day for constipation. Scheduled Administration time - 4:00 p.m. Administration Time - 8:44 p.m. Time Documented - 8:45 p.m. Time late - 4 hours, 44 minutes Carvedilol Tablet 3.125 mg - Give 1 tablet by mouth two times a day for Hypertension. Scheduled Administration time - 4:00 p.m. Administration Time - 8:44 p.m. Time Documented - 8:45 p.m. Time late - 4 hours, 44 minutes Aspirin 81 Tablet Chewable 81 mg - Give 1 tablet by mouth two times a day for supplement for 30 days. Scheduled Administration time - 4:00 p.m. Administration Time - 8:45 p.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Time Documented - 8:45 p.m. Time late - 4 hours, 45 minutes Donepezil HCl Tablet 5 mg - Give 1 tablet by mouth two times a day for dementia. Scheduled Administration time - 4:00 p.m. Administration Time - 8:45 p.m. Time Documented - 8:46 p.m. Time late - 4 hours, 45 minutes Calcium Carbonate-Vitamin D3 Tablet 600-400 mg - Give 1 tablet by mouth with meals for supplement. Scheduled Administration time - 5:00 p.m. Administration Time - 8:45 p.m. Time Documented - 8:45 p.m. Time late - 3 hours, 45 minutes At approximately 6:00 p.m. on 5/9/2023, LPN # 3 (Licensed Practical Nurse) was interviewed by telephone. LPN # 3 was identified on the Audit Report as the staff member who administered the five medications. Review of the Medication Administration Report (MAR) for the month of December 2022 revealed LPN # 3's initials were on the MAR as having administered the medications. Asked if she remembered Resident # 107, :LPN # 3 said, I have no recollection. When asked why the medications were administered late, LPN # 3 said, I'm usually pretty good about giving meds (medications) on time. Maybe it was a computer problem. Further review of the Medication Admin Audit Report revealed the following medication was administered late: Hydrocodone-Acetaminophen Tablet 5-325 mg - Give 1 tablet by mouth every 8 hours for pain for 7 days. Scheduled Administration time - 4:00 p.m. Administration Time - 6:43 p.m. Time Documented - 6:44 p.m. Time late - 2 hours, 43 minutes (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the MAR, Resident # 107's pain level at the time of administration was 9 on a scale of 0 to 10. At approximately 11:00 a.m. on 5/10/2023, LPN # 7 was interviewed by telephone. LPN # 7 was identified on the Audit Report as the staff member who administered the pain medication. Review of the Medication Administration Report (MAR) for the month of December 2022 revealed LPN # 7's initials were on the MAR as having administered the pain medication. Asked about Resident # 107, LPN #7 said she did not remember her. When asked why the pain medication was administered late, LPN # 7 said, I don't recall. I know it was very busy. I might have given it but didn't document it until later. The six rights of medication administration include the following: 1. The right medication. 2. The right dose. 3. The right client. 4. The right route. 5. The right time. 6. The right documentation. (Ref.: Fundamentals of Nursing, [NAME]-[NAME], 7th Edition, Chapter 35, page 707,) The findings were discussed at a 10:30 a.m. meeting on 5/10/2023 that included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28106 Based on observation, staff interview and clinical record review, the facility failed to follow physician orders for the treatment of a pressure ulcer for one of 23 resident's. Resident #6 did not have physician ordered elbow protector in place. The Findings Include: Diagnoses for Resident #6 included; Hemiplegia, contractures, bursa right elbow, dementia, and pressure ulcers. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/30/23. Resident #6 was assessed with long and short-term memory problems and severely cognitively impaired. On 5/8/23 Resident #6's clinical record was reviewed. An active physician's order read: Right Elbow: Cleanse with wound cleanser, pat dry, Apply Silver Alginate, Collagen Particles, cover with kerlix and elbow protector. Review of Resident #6's most recent skin assessment dated [DATE] documented Resident #6 had a stage 4 pressure ulcer to the right elbow. On 5/8/23 at 2:25 PM Resident #6 was observed lying in bed with a dressing to the right elbow but did not have an elbow protector in place. On 5/09/23 at 10:31 AM during observation of a dressing change to Resident #6's right foot, Resident #6 was again observed without an the elbow protector and the dressing to the elbow had started to come loose. At this time license practical nurse (LPN #4) and certified nursing assistant (CNA #1) was asked about the elbow protector. LPN #4 verbalized unawareness that the protector was not in place. CNA #1 verbalized Resident #6 rubs against the pillow and causes the dressing to come off and also verbalized, she wasn't currently assigned to Resident #6, but said the elbow protector was hard to apply. LPN #4 and CNA #1 was asked to locate the elbow protector. After looking around Resident #6's room the protector could not be located. On 5/09/23 at 10:58 AM CNA #2 (CNA assigned to Resident #6) was asked to look for elbow protector but could not find it. CNA #2 said that she has not seen the protector and has had a hard time putting the protector on in the past. CNA #2 was asked if the nurse had been notified that the aides were having a hard time applying the protector. CNA #2 verbalized she had not reported it. On 5/09/23 at 4:18 PM the above information was presented to the administrator, director of nursing, and regional nurse. No other information was provided prior to exit conference on 5/10/23.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to implement safety interventions consistent with the individualized needs and standards of practice for one of sixteen residents (Resident #4). Staff failed to appropriately position the safety interventions (bilateral floor mats) identified in Resident #4's care plan. In addition to the ongoing monitoring of effectiveness, Staff failed to perform a risk/safety assessment prior to implementing devices. The findings include: Resident #4 was observed in bed without protective floor mats being positioned properly as required in the plan of care for injury prevention. Resident #4 had bed bolster cushions in use for over six weeks without having a safety assessment prior to implementation. Resident #4 was admitted to the facility with diagnoses that included congestive heart failure, chronic kidney disease, hypertension, anemia, aphasia, cardiomyopathy, adult failure to thrive, dementia, psychotic/mood disturbance and anxiety. The minimum data set (MDS) dated [DATE] assessed Resident #4 with severely impaired cognitive skills and as requiring the extensive assistance of two people for bed mobility. On 5/8/23 at 2:05 p.m., Resident #4 was observed in bed. There were cushioned bolsters on each side of the resident positioned between the resident and bed rails. No floor mats were positioned on the floor on either side of the bed. One mat was observed rolled up by the bedside table and the other mat was under the resident's bed. Resident #4 was observed again in bed on 5/8/23 at 2:50 p.m. and 3:43 p.m. with the bolster cushions in use and no floor mats on either side of the bed. Resident #4's clinical record documented a history of falls from the bed. Nursing notes documented the following falls. 1/07/23 - .Resident experienced a witnessed fall .located in resident room. No injuries noted . 1/23/23 - .Resident rolled out of bed on to floor in room. No injury noted . 2/19/23 - .found resident lying on the left side of the bed on his right side (on the side of the fall mat) .booster [bolster] to right side of bed in place, booter [bolster] to left side of bed in floor. grip socks in place . unwitnessed fall to right side, c/o [complained of] hip pain and was sent to hospital . 3/10/23 - .Roommate of resident was yelling that resident had fallen out of the bed. Resident was found in room .w/ [with] upper half of body outside of the bed and on the floor, w/ feet remaining in the bed. His head was off of the floor .no injuries . 3/12/23 - .residnet [resident] was found lying next to bed on the floor, no injuries noted and no pain noted . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/20/23 - Resident experienced witnessed fall . no apparent injuries . 5/02/23 - .Nurse went to check on this Resident, He was noted to be on the Fall Mat laying on His Left Side . Resident #4's plan of care (revised 5/5/23) documented the resident was at risk for falls related to cognitive impairment, had a fall history, assistance required for transfers and poor safety awareness. Interventions listed to prevent falls/injuries included, .fall mats to side of bed .place bed in lowest position while resident is in bed .place common items within reach of the resident .remind the resident to use their call light .Bed bolsters PRN [as needed] .Ensure positioning in middle of bed after ADL care . Resident #4's clinical record documented the bed bolster cushions were added to the care plan on 3/21/23. The clinical record documented no device assessment for use of the bolster cushions. On 5/9/23 at 2:13 p.m., CNA #5 caring for Resident #4 was interviewed about the floor mats and bolster cushions. CNA #5 stated that the protective mats were supposed to be on the floor, on each side of the bed, when Resident #4 was in bed. On 5/9/23 at 2:16 p.m., CNA #3 that cared for Resident #4 during the day shift on 5/8/23 was interviewed. CNA #3 stated that the floor mats were supposed to be by Resident #4's bed because the resident had frequent falls. CNA #3 stated that he did not place the mats by the bed yesterday (5/8/23) because there was lots of coming and going in his room. When asked to explain, CNA #3 stated staff were in and out of the resident's room and he had not placed the mats by the bed. On 5/9/23 at 2:18 p.m., licensed practical nurse (LPN #6) caring for Resident #4 on 5/8/23 was interviewed. LPN #6 stated that she did not notice that the mats were not in place yesterday (5/8/23). LPN #6 stated that the mats were used for injury prevention because the resident had experienced multiple falls from the bed. LPN #6 stated the bolsters were used to help prevent the resident from rolling out of bed, but she was not sure how long they had been in use. On 5/9/23 at 2:45 p.m., the unit manager (LPN #2) stated the bolster cushions were a nursing intervention added in attempt to prevent falls from the bed. LPN #2 stated the mats were supposed to be in place when the resident was in bed for injury prevention in case of a fall. On 5/9/23 at 3:47 the director of nursing (DON) was interviewed about an assessment for the bolsters. After investigating, the DON stated the bolster cushions were added for fall prevention and no assessment had been completed for the resident's use of the cushions. The facility's policy titled Device Assessment/Bed Safety (effective 11/1/19) documented, The Device Assessment will be completed to provide documentation of the needs, and risk factors involved in the use of a restraint or device used by the patient .The assessment is to be completed by a licensed nurse before initiation of any restraint or device. The assessment will be reviewed and revised quarterly, annually, and with any significant changes .The specific type and reason for use of the device or restraint will be documented on the Device Assessment . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 5/9/23 at 4:15 p.m. The facility provided no further information regarding the out of place mats or a bolster cushion assessment.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 29123 Based on observation , resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to ensure adequate nutritional needs for the prevention of weight loss for one of 16 residents, Resident #1. Findings were: Resident #1 was admitted to the facility with the following diagnoses, including but not limited to: encephalopathy, diabetes mellitus, COPD (chronic obstructive pulmonary disease), major depressive disorder, vascular dementia, hypertension, and hypothyroidism. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 04/26/2023, assessed Resident #1 as moderately impaired with a cognitive summary score of 09 out of 15. 05/08/2023, Resident #1 was observed while finishing lunch in his room. Resident #1 had eaten 100% of the meal tray. When was asked about still being hungry, Resident #1 stated that he would like some milk. Resident #1 added, I like milk, but they don't give it to me. The clinical record was reviewed on 05/08/2023 at approximately 3:00 p.m. The weight section was reviewed and contained the following: 12/01/2022: 204.3 12/06/2022: 205.1 12/26/2022: 192.6 01/04/2023: 195 01/16/2023: 196.2 01/23/2023: 181.3 01/23/2023: 180.9 01/30/2023: 180.6 02/01/2023: 182.6 03/31/2023: 183.5 04/03/2023: 183.5 05/01/2023: 183.5 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1's weight on 12/01/2022 was listed as 204.3 pounds. His most recent weight was 183.5 pounds on 05/01/2023, a loss of 20.8 pounds or 10.18% in six months. The physician order section was reviewed and contained a diet order for Heart Healthy Diet, dysphagia, mechanically altered texture, Regular liquids consistency, weighted utensils. Also observed was an order for House supplement two times a day for prevention of malnutrition and history or weight loss, dated 01/26/2023. On 05/09/2023 at approximately 8:15 a.m., Resident #1 was observed with his breakfast tray. His tray contained pureed eggs and oatmeal. He had a small Styrofoam cup of orange juice. His tray card was observed and contained the following: Heart Healthy Dysphagia Diet Mechanically Altered Orange Juice: 4 oz Scrambled Egg Substitute: 2 ounces Slivered [NAME] Onions: 1 tablespoon Grits: 8 oz 2% Milk: 8 ounces Hot Coffee or Hot Tea: 6 ounces When asked if the coffee, tea, or milk had been on his tray, Resident #1 stated, No. When asked what he would like, Resident #1 stated, Milk. CNA (certified nursing assistant) #4 was in the hallway and was asked if she knew why Resident #1 didn't have any milk. CNA #4 stated, The drinks come on a separate cart. When asked if she had looked at Resident #1's tray card, CNA #4 stated, No, I just get them what they tell me they want. When asked to provide Resident #1 with some milk per his request, CNA #4 returned to the room with a Styrofoam cup containing milk. There was no lid on the cup. Attempting to drink, Resident #1 was observed with marked shaking of both his right and left hands, spilling more than half of his milk in his lap as he tried to drink it. Resident #1 stated, I'm making a mess, I am sorry. On 05/09/2023 at approximately 11:00 a.m., the RD (registered dietitian) was interviewed When asked about Resident #1's weight loss, the RD stated that Resident #1 had broken his hip in December and was hospitalized for surgical repair. The RD stated that Resident #1 had also had pneumonia in January that required a couple of days in the hospital. The RD stated, I put him on supplements in January when he got back and his weight came up some he has stabilized. When asked what was the ordered diet, the RD stated, Heart healthy, mechanically altered. Meats should be ground with gravy on them .bread and and bread products should be pureed. Asked if that should include the pureed eggs served that morning, the RD stated, No, he can have scrambled eggs. When asked why the diet specified 2% milk following the apparent weight loss, the RD stated, I didn't intend for that .I will liberalize his diet and get him whole milk, large portions, and a regular dysphagia mechanically altered diet. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An end of the day meeting was held on 05/09/2023 at approximately 4:00 p.m Concerns were voiced regarding Resident #1's weight loss and lack of additional interventions since January. On 05/10/2023 Resident #1 was observed eating breakfast, while the occupational therapist was in the room. the occupational therapist stated, I am recommending cups with lids for him .I also think he might benefit from a plate guard to help him eat. The breakfast tray card was observed and contained the following: Regular Dysphagia Mechanically Altered Diet Orange Juice: 4 ounces Scrambled eggs: 3 ounces Slivered [NAME] Onions: 1 tablespoon Pureed Buttered Biscuit Grits: 9 ounces Whole Milk: 8 ounces Hot Coffee or Hot Tea: 6 ounces Sausage Gravy: 4 ounces It was observed that Resident #1 had eaten 100% of his breakfast, but did not have any milk on the tray. When asked if he was full, Resident #1 stated. I don't want to be a pig but I would like a cake or something sweet. Resident #1's CNA was notified and stated that she would get something. At approximately 8:35 a.m., the CNA came and reported that Resident #1 had eaten 2 cups of ice cream after breakfast. At approximately 8:40 a.m., the nurse practitioner caring for Resident #1 was interviewed. When asked if she was aware of Resident#1's weight loss, the nurse practitioner stated, I was made aware of that yesterday .I ordered labs on him, a TSH, Free T4, CBC, and CMP he hasn't labs since January. They were fine then, but in light of his weight loss, I will repeat them and see where we need to go from there. When asked what she would have done if she had known about the weight loss sooner, the nurse practitioner stated, I would have ordered the labs sooner .I can't address what I don't know about. When asked if the residents weights when rounding, the nurse practitioner stated,No, I don't have time to review every patient's weights when I come in . I rely on the nurses and the RD to tell me if there is a problem with those .no one mentioned anything about him to me until yesterday. The above information was discussed during an end of the day meeting on 05/10/2023. No further information was provided prior to the exit conference on 05/10/2023.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview and clinical record review, the facility staff failed to administer oxygen as ordered by the physician for one of sixteen residents in the survey sample (Resident #24). The findings include: Oxygen was administered to Resident #24 at 4 lpm (liters per minute) when the physician's order required a rate of 2 lpm. Resident #24 was admitted to the facility with diagnoses that included chronic kidney disease, atrial fibrillation, atherosclerotic heart disease, hypertension, diabetes, COPD (chronic obstructive pulmonary disease), and anemia. The minimum data set (MDS) dated [DATE] assessed Resident #24 as cognitively intact. On 5/9/23 at 10:20 a.m., Resident #24 was observed in bed with oxygen being administered at 4 lpm via a nasal cannula. Resident #24's oxygen was observed again on 5/9/23 at 2:11 p.m. running at 4 lpm. Resident #24's clinical record documented a physician's order dated 4/12/23 for oxygen at 2 lpm via nasal cannula. On 5/9/23 at 2:20 p.m., the licensed practical nurse (LPN #6) caring for Resident #24 was interviewed about the oxygen rate. LPN #6 stated, I think it is supposed to be at 2 lpm. LPN #6 reviewed the clinical record and stated the order called for 2 lpm rate. LPN #6 stated that she had not checked the Resident #24's oxygen rate today. On 5/9/23 at 2:28 p.m., accompanied by LPN #6, Resident #24's oxygen was observed running at 4 lpm. LPN #6 stated that she had not adjusted the oxygen rate to 4 lpm and that she did not know who increased the rate or when. On 5/9/23 at 2:51 p.m., the unit manager (LPN #2) was interviewed about Resident #24's oxygen flow rate. LPN #2 stated that nurses were expected to check oxygen rates each shift and set the rate as ordered. This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 5/9/23 at 4:15 p.m. No other information was presented prior to exit about the oxygen rate.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to assess one of sixteen residents (Resident #4) for entrapment risks, attempt alternatives, or obtain informed consent prior to use of bed rails. The findings include: Resident #4, with multiple falls from the bed, had no assessment for bed rails, which were in use with bolster cushions, no documented attempts at alternatives to the rails and no informed consent from the resident's responsible party about risks/benefits of the bed rails. Resident #4 was admitted to the facility with diagnoses that included congestive heart failure, chronic kidney disease, hypertension, anemia, aphasia, cardiomyopathy, adult failure to thrive, dementia, psychotic/mood disturbance and anxiety. The minimum data set (MDS) dated [DATE] assessed Resident #4 with severely impaired cognitive skills and as requiring the extensive assistance of two people for bed mobility. On 5/8/23 at 2:05 p.m., Resident #4 was observed in bed, noting cushioned bolsters on each side of the resident, positioned between the resident and the bed rails, which were in the raised position. The bed rails were approximately ten inches in length. Resident #4 was observed again in bed on 5/8/23 at 2:50 p.m. and 3:43 p.m. with the bed rails in the raised position and bolster cushions on each side against the rails. Resident #4's clinical record documented a physician's order dated 2/9/23 for Bilateral 1/8 Assist Bars for Bed Mobility. Resident #4's plan of care (revised 5/5/23) documented use of Assist bars to bed to aide in turning and positioning. The assist bars had been on the care plan since 3/7/22. Added to the care plan on 3/21/23 was, Bed bolsters PRN [as needed] to assist with activities of daily living and fall prevention. Resident #4's clinical record documented no current assessment of the bed rails for safety. The most recent bed rail safety assessment was dated 3/7/22 and documented that the rails were non-restrictive and aided the resident with turning and positioning in bed. The record documented no attempted alternatives to the rails and no informed consent from the Resident #4's responsible party regarding risks/benefits of bed rail use. The record documented no safety assessment of the bed rails with use of the bolster cushions. Resident #4's clinical record documented falls from the bed on 1/7/23, 1/23/23, 2/19/23, 3/10/23, 3/12/23 3/20/23 and 5/2/23. In response to these falls, there had been no re-assessment of the Resident #4's bed rail use, no review of alternative interventions, and no assessment for safety of the bed rails used in combination with the bolster cushions. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/9/23 at 2:45 p.m., the licensed practical nurse unit manager (LPN #2) was interviewed about the bed rails and bolster cushions. LPN #2 stated, There was supposed to be a physician's order for positioning devices. On 5/9/23 at 3:35 p.m., the maintenance director (other staff #9) was interviewed about Resident #4's bed/rails. The maintenance director stated he performed a safety assessment of all beds, mattresses and bed rails during April 2023. The maintenance director stated nursing was responsible for assessing residents and any positioning devices. On 5/9/23 at 3:47 p.m., the director of nursing (DON) was interviewed about a recent assessment of Resident #4's bed rail use or an assessment of the bed rails with the bolsters. The DON stated there was no recent bed rail assessment for Resident #4 with the last one completed on 3/7/22. The DON stated there was no assessment regarding the use of the bolsters with the bed rails. The facility's policy titled Device Assessment/Bed Safety (effective 11/1/19) documented, The Device Assessment will be completed to provide documentation of the needs, and risk factors involved in the use of a restraint or device used by the patient .The assessment will also help to determine that all alternatives have been considered and that the least restrictive restraint or device is being used .The Device Assessment is used to provide documentation that the patient/responsible party has been informed of the purpose, benefits, and potential complications associated with the use of a device .The assessment is to be completed by a licensed nurse before initiation of any restraint or device. The assessment will be reviewed and revised quarterly, annually, and with any significant change .The specific type and reason for use of the device or restraint will be documented on the Device Assessment . This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 5/9/23 at 4:15 p.m. The facility provided no further information regarding assessment of Resident #4's bed rails use.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 09404 Based on observation, staff interview, and review of facility policy and procedure, the facility failed to ensure medications were properly dated on two of two medication carts. Undated multi-dose medication bottles were observed in the East Unit medication cart and the Central Unit medication cart. The findings include: 1. At 3:20 p.m. on 5/9/2023, an observation of the East Unit medication cart was conducted in the presence of RN # 2 (Registered Nurse). The medication cart included the following medications: A 32 oz (ounce) bottle of Milk of Magnesia (MOM) appeared to be nearly empty, but had no open date. A 16oz bottle of Geri Tussin Guaifenessin oral solution, with a punctured inner seal, but had no open date. A 16 oz bottle of Pro Stat, Wild Cherry flavor, that appeared to be nearly empty, but had no open date. Asked about expiration dates for the multi-use bottles of pills, RN # 2 said, I'm not sure. RN # 2 then turned to LPN # 2 (Licensed Practical Nurse), who was standing nearby, and asked what the open date meant on the multi-use bottles of pills. Oh, that's just the date we opened it. Everything has to have an open date, LPN # 2 said. Calling her attention to the open and nearly empty bottle of MOM, LPN # 2 said, Oh, this has to be discarded. No date. LPN # 2 then discarded the bottle in the trash. When asked what the expiration date would be for the mediction bottles, LPN # 2 said, I guess we just use the expiration date already on the bottle. Wait, I don't want to tell you the wrong thing. LPN # 2 walked away but did not return to offer any further explanation or clarification. Pointing to the bottle of Pro Sat, RN #2 was asked when it had been opened. Picking up the bottle and turning it around to examine all surfaces, RN #2 shrugged and stated, I don't know. There's no open date on it. I guess I have to throw it in the trash. RN #2 also threw away the bottle of Geri Tussin when she was unable to find an open date. 2. At 3:50 p.m. on 5/9/2023, an observation of the Central Unit medication cart was conducted in the presence of LPN # 5. The medication cart included the following medications: A 16 oz bottle of Lactulose was half-full and open, but had no open date or expiration sticker A 414 ml (milliliter) bottle of Sucralfate was open, half full, but had no open date or expiration sticker. A 16 oz bottle of MOM, that was nearly empty, but had no open date or beyond use date sticker. (continued on next page)

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	495188	A. Building B. Wing	05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Appomattox Health & Rehabilitation Center	235 Evergreen Ave Appomattox, VA 24522

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A bottle of Vitamin B12 500mg 100 tab bottle had an open date of 8/24/22, but no expiration sticker. The remaining medications in the cart had an open date, as well as an expiration sticker with a Beyond Use Date. Asked what the Beyond Use Date meant, LPN # 5 said, I'm not sure. I guess it means that you throw it away after that date. Concerning the undated bottle of MOM, LPN # 5 said, Yes, it should have been dated when it was opened, but I'll throw that away now. Anything without an open date should be thrown away. After confirming that the bottles of MOM and Sucralfate were also opened and undated, LPN #5 discarded them. At 10:00 a.m. on 5/10/2023, LPN # 4 was asked her understanding of the Beyond Use Date. Meds [Medications] should be discarded on this date. I mean, it's ok to use it on that date, but you can't use it afterwards, LPN # 4 said. When asked how the discard date is identified if there is no Beyond Use Date, LPN #4 stated, You go by the manufacturer's date. LPN #4 pointed to the manufacturer's expiration date of 4/24 on the Vitamin B12 bottle. At 10:22 a.m. on 5/10/2023, the Director of Nursing (DON) was shown the open bottle of Prostat from the East Unit medication cart. When asked what should be done with the bottle, the DON said, I would throw it away. It wasn't dated. You don't know when it was opened. Review of the facility's Storage of Medications policy noted the following: III. Expiration Dating (Beyond-Use Dating) 5. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. a. The nurse shall place a 'date opened' sticker on the medication and record the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days from opening, unless the manufacturer recommends another date or regulations/guidelines require different dating. The findings were discussed at a 10:30 a.m. meeting on 5/10/2023 that included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. 29123 Based on observation, staff interview, and clinical record review, the facility staff failed to provide dental services to one of 16 residents, Resident #1. Findings were: Resident #1 was admitted to the facility with the following diagnoses, including but not limited to: encephalopathy, diabetes mellitus, COPD (chronic obstructive pulmonary disease), major depressive disorder, vascular dementia, hypertension, and hypothyroidism. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 04/26/2023, assessed Resident #1 as moderately impaired with a cognitive summary score of 09 out of 15. During initial tour of the facility on 05/08/2023 at approximately 12:15 p.m., Resident #1 was observed in his room. While speaking, Resident #1's mouth was observed with no front upper or lower teeth. On 05/09/2023 at approximately 11:00 a.m., Resident #1 was about having a partial plate or dentures at the facility. Resident #1 stated, When I grew up, we didn't have much money, I still don't. These are all the teeth I have. Resident #1 opened to reveal approximately four teeth on the top row, two on each side, and four teeth on the bottom row, two on each side. When asked about the presence of pain with eating, Resident #1 stated, No, I guess you just get use to it. When asked about desire to see a dentist, Resident #1stated, I don't think I have the money for that, but teeth would be good. The clinical record was reviewed at approximately 11:15 a.m. The physician order section contained an order for Dental Consult PRN (as needed). There were no progress notes or office visit notes observed in the record from a dentist. At approximately 11:30 a.m., the administrator was asked if the social worker was available for interview. The Administrtor stated, We don't have one right now, we are dividing up the duties. When asked who would be responsible for referring residents to a dentist, the Administrator stated, We have a dentist that comes here .I believe he was here last month. When asked if Resident #1 had been seen by a dentist, the Administrator stated he didn't know but would check. The above information was discussed during an end of the day meeting with the DON (director of nursing), the administrator, and the regional nurse consultant on 05/09/2023 at approximately 4:00 p.m. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/10/2023 the unit manager, LPN (Licensed practical nurse) #2 brought information to the conference room and stated, We ordered a dental consult .here are his oral assessments that we have done. The documentation presented three Oral Assessments completed on 12/28/2022, 01/24/2023, 04/26/2023. All three assessments documented that there were no issues with Resident #1's oral health. When asked if she thought the assessments were accurate, LPN #2 stated, I would have marked either 'no natural teeth or tooth fragments' or 'Obvious or likely cavity or broken natural teeth' .I did a dental exam on [Resident #1] last night .[Resident #1] doesn't have very many teeth, but said the only thing that bothers him when eating is the tremors he has in his hands. [Resident #1] did agree to a dental consult, so we have him on the list. No further information was obtained prior to the exit conference on 05/10/2023.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 29123 Based on observation, and staff interview, the facility staff failed to store, serve, and prepare food in a sanitary manner in the main kitchen. Findings were: Initial tour of the facility kitchen was conducted on 05/08/2023 at approximately 11:15 a.m., with the DM (dietary manager-other staff #1). Observed in the refrigerator next to the tray line was a plastic bag. When asked what was in the bag, the DM stated, Her lunch, nodding towards the staff member plating food on the tray line. Also observed in the refrigerator were canned sodas. When asked if those belonged to residents, the DM stated, No, employees .they shouldn't be in here and the lunch shouldn't be either. The bins storing flour, sugar, and thickening were observed. Scoops for each bin were to be stored inside the bin, affixed to the top, away from the food ingredients. The scoop for the sugar was observed out of place and laying down in the stored sugar. The can opener which was affixed to a table in the kitchen, was observed with dark, dried debris on the blade area that punctures the cans. When asked how often the can opener was washed, the DM stated, About three times a week or as needed. A rack in the kitchen was identified as containing stacked, dried, and clean pans, with a smaller rack of bowls stationed beside it. The DM was asked to separate the pans to ascertain if they were clean on the inside. Two quarter-sized pans and one full-size pan were observed to be wet nested with water droplets on the interiors of the pans. Three white bowls were observed with dried debris on the inside. All of the dishes identified as compromised were removed from the area by the DM, as she stated, They are suppose to be clean and dry before they are put over here. The above information was discussed with the DON (director of nursing), the administrator, and the regional nurse consultant during an end of the day meeting on 05/09/2023 at approximately 4:00 p.m. No further information was obtained prior to the exit conference on 05/10/2023.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview and clinical record review, the facility staff failed to ensure an accurate clinical record for three of sixteen residents in the survey sample (Residents #24, #30 and #41). The findings include: 1. Resident #24's clinical record inaccurately documented a physician's order for enhanced barrier precautions when the precautions had been discontinued since 4/20/23. Resident #24 was admitted to the facility with diagnoses that included chronic kidney disease, atrial fibrillation, atherosclerotic heart disease, hypertension, diabetes, COPD (chronic obstructive pulmonary disease), and anemia. The minimum data set (MDS) dated [DATE] assessed Resident #24 as cognitively intact. Resident #24's clinical record documented a current physician's order dated 3/29/23 for Enhanced Barrier Precautions for infection control. The clinical record documented the precautions were implemented due to the resident's PICC (peripherally inserted central catheter). The clinical record documented the PICC was discontinued on 4/20/23. On 5/9/23 at 2:52 p.m., the licensed practical nurse unit manager (LPN #2) was interviewed about Resident #24. LPN #2 stated Resident #24 was on enhanced barrier precautions because of the PICC. LPN #2 stated no order had been entered to discontinue the precautions. LPN #2 stated the precautions should have been discontinued when the PICC was removed. 2. Resident #30's clinical record inaccurately documented a physician's order for enhanced barrier precautions when the precautions had been discontinued since 4/26/23. Resident #30 was admitted to the facility with diagnoses that included dislocated hip, femur fracture, atherosclerotic heart disease, major depressive disorder, atrial fibrillation, and Alzheimer's dementia. The minimum data set (MDS) dated [DATE] assessed Resident #30 with severely impaired cognitive skills. Resident #30's clinical record documented a current physician's order dated 3/7/23 for Enhanced Barrier Precautions for infection control. The clinical record documented the infection precautions were ordered due to a diagnosed urinary tract infection. On 5/9/23 at 2:32 p.m., the licensed practical nurse (LPN #6) caring for Resident #30 was interviewed about any precautions. LPN #6 stated that Resident #30 was not currently on any type of infection control precautions. LPN #6 stated it was possible the order was not discontinued timely. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/9/23 at 3:55 p.m., the unit manager (LPN #2) was interviewed about Resident #30. LPN #2 stated Resident #30 had a urinary tract infection and the infection precautions should have been discontinued when the infection cleared. LPN #2 stated the infection cleared on 4/16/23 and the precautions should have been removed ten days after that on 4/26/23. LPN #2 stated that no order was entered to discontinue the precautions after the infection cleared. 3. Resident #41's clinical record inaccurately documented a current physician's order for enhanced barrier precautions when the catheter for which is was ordered had been discontinued since 3/22/23. Resident #41 was admitted to the facility with diagnoses that included vertebra compression fractures, atrial fibrillation, sepsis, pneumonitis, urinary tract infection, atherosclerotic heart disease, anxiety, asthma, congestive heart failure, urine retention, and kidney failure. The minimum data set (MDS) dated [DATE] assessed Resident #41 as cognitively intact. Resident #41's clinical record documented a current physician's order dated 3/7/23 for Enhanced Barrier Precautions for infection control. The clinical record documented the resident previously had a Foley urinary catheter and had been placed on enhanced barrier precautions when providing catheter care. The clinical record documented the catheter was discontinued on 3/22/23. On 5/8/23 at 3:14 p.m., the registered nurse (RN #5) caring for Resident #41 was interviewed about infection control precautions. RN #5 stated Resident #41 did not currently require any type of infection control precautions and had not recently been on enhanced barrier precautions. On 5/8/23 at 3:20 p.m., the licensed practical nurse unit manager (LPN #2) was interviewed about order for enhanced barrier precautions. LPN #2 stated that Resident #41 was ordered precautions due to a urinary catheter. LPN #2 reviewed the clinical record and stated the catheter was discontinued on 3/22/23 but no order was entered to discontinue the infection control precautions. LPN #2 stated that an order should have been entered to discontinue the precautions when the catheter was discontinued. On 5/9/23 at 9:45 a.m., the registered nurse infection preventionist (RN #3) was interviewed about current orders for Residents #24, #30 and #41 for infection precautions. RN #3 stated she expected nursing to obtain an order to discontinue the precautions when the devices and/or infections were discontinued and/or cleared. These findings were reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 5/9/23 at 4:15 p.m. No further information was presented prior to exit about the inaccurate physician orders.