STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495171	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goodwin House Bailey's Crossroads	3440 S Jefferson Street Falls Church, VA 22041

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 31753 Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure a resident was safe to self-administer a medication for one of 28 residents in the survey sample, Resident #169. The findings include: For Resident #169 (R169), the facility staff failed to complete an assessment to determine if the resident was safe to self-administer a nebulizer medication. A review of R169's clinical record revealed a physician's order dated 8/13/24 for ipratropium 0.5 mg (milligrams)-albuterol (1) 3 mg- 3 ml (milliliters) via nebulization two times per day for aspiration pneumonia. On 8/20/24 at 8:56 a.m., R169 was observed holding a mask to his face and self-administering a nebulizer medication. On 8/21/24 at 10:27 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the nurses complete a self-assessment form for residents who self-administer medications. RN #1 stated the self-assessment consists of determining if the resident is alert and oriented, and determining if it is safe for the resident to self-administer medications. On 8/21/24 at 1:22 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Self-Administered Medications--HCC (Health Care Center) documented, It is the responsibility of the Interdisciplinary Team to determine that it is safe for a resident residing in HCC to self-administer medications before the resident may exercise that right. Assessment will be documented on the EHR (Electronic Health Record). No further information was presented prior to exit. Reference: (1) Ipratropium-albuterol inhalation solution is used to treat lung diseases. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000006.htm.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 31753 Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to implement the baseline care plan for one of 28 residents in the survey sample, Resident #169. The findings include: For Resident #169, the facility staff failed to implement the resident's baseline care plan for a fall mat. R169's baseline care plan dated 8/9/24 documented, (R169) will remain safe during treatments and care while in the facility. (A) (R169) needs these safety measures: Floor Mat x1 . A review of R169's clinical record revealed a physician's order dated 8/9/24 that documented, Fall mat x1. On 8/20/24 at 8:56 a.m., 8/20/24 at 3:39 p.m., and 8/21/24 at 8:47 a.m., R169 was observed lying in bed. There was no fall mat down on either side of the bed. A fall mat was observed folded up, against the wall. On 8/21/24 at 10:27 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the purpose of the care plan is to track treatments, so residents have better care. RN #1 stated any nurse has access to the care plan to make sure it is being implemented. RN #1 stated fall mats are used because if a resident falls, the impact is going to be less. RN #1 stated a resident's need for fall mats is communicated to nurses via physicians' orders and also shows up in the CNAs' (certified nursing assistants') computer system too. On 8/21/24 at 1:22 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Care Plans- Baseline documented, A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. No further information was presented prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 42183 Based on observations, staff/resident interviews facility document review and clinical record review, it was determined the facility staff failed to implement the care plan for two of 28 residents in the survey sample, Resident #53 and Resident #319. The findings include: 1. The facility staff failed to implement the comprehensive care plan for anticoagulation monitoring for Resident #53. Resident #53 was admitted to the facility on [DATE] with diagnosis that included but were not limited to toxic hyponatremia, CHF (congestive heart failure), CKD (chronic kidney disease and atrial fibrillation. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/25/24, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bathing/transfer/dressing/toileting and eating. A review of the comprehensive care plan dated 6/7/24 revealed, FOCUS: Resident is at risk for complications from blood thinning medication: Eliquis for atrial fibrillation. INTERVENTSIONS: Monitor for presence or absence of signs of hemorrhage under the skin, oral mucosa, and/or conjunctiva, active bleeding, bloody stools, declining hemoglobin and hematocrit. Notify physician if side effects noted. A review of the physician orders dated 5/20/24 revealed, Eliquis 5 milligram twice a day. A review of the MAR (medication administration record) for June, July and August revealed that Eliquis 5 milligram twice a day was administered. No evidence of anticoagulation side effect monitoring was found. An interview was conducted on 8/21/24 at 10:00 AM with Resident #53, when asked if they are monitoring her for bleeding/bruising, Resident #53, stated, no, not that I know of. An interview was conducted on 8/21/24 at 10:25 AM with LPN (licensed practical nurse) #2. When asked where evidence of anticoagulation side effect monitoring was located, LPN #2 stated, we look for the side effects, but there is nowhere to document it in this system. When asked if the care plan had been implemented, LPN #2 stated, no, it was not. On 8/21/24 at 1:05 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and LPN (licensed practical nurse) #1, the infection prevention nurse was made aware of the finding. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Care Plan, Comprehensive Person Centered policy revealed the following, The comprehensive, person-centered care plan includes measurable objectives and timeframes; reflects currently recognized standards of practice for problem areas and conditions. No further information was provided prior to exit. 2. The facility staff failed to implement the comprehensive care plan for anticoagulation monitoring for Resident #319. Resident #319 was admitted to the facility on [DATE] with diagnosis that included but were not limited to venous thrombosis, hypertension and gout. The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 8/5/24, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bathing/toileting and supervision for bed mobility, transfer, dressing and eating. A review of the comprehensive care plan dated 8/16/24 revealed, FOCUS: Resident is at risk for complications from blood thinning medication: Eliquis for post-surgery, fracture of femur and history of venous thrombosis. INTERVENTSIONS: Monitor for presence or absence of signs of hemorrhage under the skin, oral mucosa, and/or conjunctiva, active bleeding, bloody stools, declining hemoglobin and hematocrit. Notify physician if side effects noted. A review of the physician orders dated 7/29/24 revealed, Eliquis 2.5 milligram twice a day for deep vein thrombosis. A review of the MAR (medication administration record) for July and August revealed that Eliquis 2.5 milligram twice a day was administered. No evidence of anticoagulation side effect monitoring was found. An interview was conducted on 8/21/24 at 10:10 AM with Resident #319, when asked if they are monitoring him for bleeding/bruising, Resident #319, stated, they may be. I do not really know and do not have much healthcare knowledge. An interview was conducted on 8/21/24 at 10:25 AM with LPN (licensed practical nurse) #2. When asked where evidence of anticoagulation side effect monitoring was located, LPN #2 stated, we look for the side effects, but there is nowhere to document it in this system. When asked if the care plan had been implemented, LPN #2 stated, no, it was not. On 8/21/24 at 1:05 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and LPN (licensed practical nurse) #1, the infection prevention nurse was made aware of the finding. The facility's Care Plan, Comprehensive Person Centered policy revealed the following, The comprehensive, person-centered care plan includes measurable objectives and timeframes; reflects currently recognized standards of practice for problem areas and conditions. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 31753 Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to implement a fall intervention for one of 28 residents in the survey sample, Resident #169. The findings include: For Resident #169 (R169), the facility staff failed to implement a physician ordered floor mat. A review of R169's clinical record revealed a physician's order dated 8/9/24 that documented, Fall mat x1. On 8/20/24 at 8:56 a.m., 8/20/24 at 3:39 p.m., and 8/21/24 at 8:47 a.m., R169 was observed lying in bed. There was no fall mat down on either side of the bed. A fall mat was observed folded up, against the wall. On 8/21/24 at 10:27 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated fall mats are an intervention used in the facility. RN #1 stated fall mats are used because if a resident falls, the impact is going to be less. RN #1 stated a resident's need for fall mats is communicated to nurses via physicians' orders and also shows up in the CNAs' (certified nursing assistants') computer system too. On 8/21/24 at 1:22 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Fall Protocol documented, It is the policy of (name of facility) to provide an environment that is free from fall and accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents and injuries . Implementation includes communicating the interventions to all relevant staff, assigning responsibility, providing training as needed, documenting interventions and ensuring the interventions are put into place. No further information was presented prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to provide monitoring for fluid restriction and intake for one of 28 residents, Resident #53. The findings include: The facility failed to provide monitoring for fluid restriction and intake for Resident #53. Resident #53 was admitted to the facility on [DATE] with diagnosis that included but were not limited to toxic hyponatremia, CHF (congestive heart failure), CKD (chronic kidney disease and atrial fibrillation. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/25/24, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bathing/transfer/dressing/toileting and eating. A review of the comprehensive care plan dated 6/7/24 revealed, FOCUS: Resident has a potential for fluid imbalance related to CHF. INTERVENTIONS: Administer medications per orders, assess for edema, abnormal breath sounds and advise physician as needed. A review of the physician orders dated 6/27/24 revealed, 1500 milliliter fluid restriction daily. A review of the June, July and August MAR-TAR (medication administration record-treatment administration record) revealed 1500 milliliter fluid restriction at 7:00 AM, 3:00 PM and 12:00 AM, with initials by each shift. There was no specification of amounts of fluids designated for each shift, nor any specific allocation of amount to dietary. An interview was conducted on 8/21/24 at 10:25 AM with LPN (licensed practical nurse) #2. When asked where evidence of fluid restriction/intake monitoring was located, LPN #2 stated, we have taken her water pitcher out of her room and give her multiple medications with applesauce. We do not have any specific documentation place for amounts. On 8/21/24 at 1:05 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and LPN (licensed practical nurse) #1, the infection prevention nurse was made aware of the finding. On 8/21/24 at approximately 1:55 PM, ASM #1 stated, we do not have fluid restriction amounts documented, but we do weigh her daily. ASM #2 stated, we started working on this yesterday 8/20/24. The facility's Intake/Output policy revealed the following, It is the facility policy to maintain accurate fluid intake and output amounts on a resident who is on fluid restriction or as a nursing measure for assessing hydration. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 31753 Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide respiratory care and services for one of 28 residents in the survey sample, Resident #169. The findings include: For Resident #169 (R169), the facility staff failed to store an incentive spirometer in a sanitary manner. A review of R169's clinical record revealed an admission nursing assessment dated [DATE] that documented the resident was oriented. Further review of R169's clinical record revealed a physician's order dated 8/15/24 for an incentive spirometer three times a day. On 8/20/24 at 8:56 a.m., an uncovered incentive spirometer with the mouthpiece exposed to air was observed sitting on R169's overbed table. On 8/20/24 at 3:39 p.m., an incentive spirometer with the mouthpiece exposed to air was observed sitting on R169's bed. R169 stated he uses the incentive spirometer whenever he can, and he has not been offered a bag or covering for it. On 8/21/24 at 8:47 a.m., an uncovered incentive spirometer with the mouthpiece exposed to air was observed sitting on R169's overbed table. On 8/21/24 at 10:27 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated an incentive spirometer should be stored in a Ziplock bag to avoid any microbes and protect it, so it's not exposed to germs. On 8/21/24 at 1:22 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Oxygen Administration, Storage, & Safety documented, 11. Incentive Spirometer. b. After each use, clean the mouthpiece and place the spirometer and mouthpiece in a plastic bag within the resident's reach. No further information was presented prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to ensure residents were free of unnecessary medications for two of 28 residents in the survey sample, Resident #53 and Resident #319. The findings include: The facility staff failed to ensure Resident #53 and Resident #319 were free from unnecessary meds by providing monitoring for anticoagulation side effects. 1. Resident #53 was admitted to the facility on [DATE] with diagnosis that included but were not limited to toxic hyponatremia, CHF (congestive heart failure), CKD (chronic kidney disease and atrial fibrillation. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/25/24, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bathing/transfer/dressing/toileting and eating. A review of the comprehensive care plan dated 6/7/24 revealed, FOCUS: Resident is at risk for complications from blood thinning medication: Eliquis for atrial fibrillation. INTERVENTSIONS: Monitor for presence or absence of signs of hemorrhage under the skin, oral mucosa, and/or conjunctiva, active bleeding, bloody stools, declining hemoglobin and hematocrit. Notify physician if side effects noted. A review of the physician orders dated 5/20/24 revealed, Eliquis 5 milligram twice a day. A review of the MAR (medication administration record) for June, July and August revealed that Eliquis 5 milligram twice a day was administered. No evidence of anticoagulation side effect monitoring was found. An interview was conducted on 8/21/24 at 10:00 AM with Resident #53, when asked if they are monitoring her for bleeding/bruising, Resident #53, stated, no, not that I know of. An interview was conducted on 8/21/24 at 10:25 AM with LPN (licensed practical nurse) #2. When asked where evidence of anticoagulation side effect monitoring was located, LPN #2 stated, we look for the side effects, but there is nowhere to document it in this system. On 8/21/24 at 1:05 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and LPN (licensed practical nurse) #1, the infection prevention nurse was made aware of the finding. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Anticoagulation-Clinical Protocol policy revealed the following, The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. No further information was provided prior to exit. 2. Resident #319 was admitted to the facility on [DATE] with diagnosis that included but were not limited to venous thrombosis, hypertension and gout. The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 8/5/24, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bathing/toileting and supervision for bed mobility, transfer, dressing and eating. A review of the comprehensive care plan dated 8/16/24 revealed, FOCUS: Resident is at risk for complications from blood thinning medication: Eliquis for post-surgery, fracture of femur and history of venous thrombosis. INTERVENTSIONS: Monitor for presence or absence of signs of hemorrhage under the skin, oral mucosa, and/or conjunctiva, active bleeding, bloody stools, declining hemoglobin and hematocrit. Notify physician if side effects noted. A review of the physician orders dated 7/29/24 revealed, Eliquis 2.5 milligram twice a day for deep vein thrombosis. A review of the MAR (medication administration record) for July and August revealed that Eliquis 2.5 milligram twice a day was administered. No evidence of anticoagulation side effect monitoring was found. An interview was conducted on 8/21/24 at 10:10 AM with Resident #319, when asked if they are monitoring him for bleeding/bruising, Resident #319, stated, they may be. I do not really know and do not have much healthcare knowledge. An interview was conducted on 8/21/24 at 10:25 AM with LPN (licensed practical nurse) #2. When asked where evidence of anticoagulation side effect monitoring was located, LPN #2 stated, we look for the side effects, but there is nowhere to document it in this system. On 8/21/24 at 1:05 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and LPN (licensed practical nurse) #1, the infection prevention nurse was made aware of the finding. The facility's Anticoagulation-Clinical Protocol policy revealed the following, The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.

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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 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. 42183 Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to maintain one of one kitchen in a sanitary manner. The findings include: On 8/20/24 at 7:25 AM, an observation was conducted in the main kitchen. Two employees were observed coming from the kitchen without hair nets, OSM (other staff member) #3, the cook and OSM #5, dining services. When told I was there for the kitchen inspection and requested a hair net, OSM #3, the cook, went back into the kitchen to obtain a hair net. OSM #3 put a hairnet on at this time. Hair nets were located inside the kitchen and around a corner near another entrance, but not outside of the kitchen area. During the inspection of the dry storage room, OSM #4, dining services, came into the dry storage room. When asked about her hair covering, OSM #4 stated, I do not work in the kitchen. When asked if you are in the kitchen are you to wear a hair net, she stated, yes, I should have one on. OSM #5 was observed back in the kitchen without hair net and at 7:45 AM, OSM #5 was coming back into the kitchen and when asked if there were any items she was to wear in the kitchen, OSM #5 stated, yes, a hair net. I am going to go get one now. I just got to work. On 8/20/24 at 7:40 AM, flowers were observed in the 'dessert' refrigerator. On 8/20/24 at 10:20 AM, on second trip to the kitchen, OSM #7, the executive staff introduced herself. I asked her to come with me to the 'dessert' refrigerator and asked her about the flowers stored with the food. OSM #7 stated, they just are there for a short while, they are for the table vases. I informed OSM #7, that I had observed them at 7:40 AM in the refrigerator, OSM #7 stated, I will have them moved now. On 8/21/24 at 1:05 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and LPN (licensed practical nurse) #1, the infection prevention nurse was made aware of the finding. The facility's Dining Services-Personal Appearance and Personal Hygiene policy revealed the following, Hair coverings will be worn at all times while working in the kitchen. No further information was provided prior to exit.