STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495178	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlottesville Health & Rehabilitation Center	505 West Rio Road Charlottesville, VA 22901

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 41449 Based on observation, resident interview, staff interviews, facility documentation review and clinical record review, the facility staff failed to assess and determine if a Resident was safe to self-administer medications that were at the bedside, for one Resident (Resident #28) in a survey sample of 26 Residents. The findings included: For Resident #28 (R28), who had multiple medications stored on the over bed table and bedside table, in their room, the facility staff failed to assess if the resident was safe to self-administer medications. On 7/8/24 at 12:42 p.m., observations were conducted in R28's room and an interview with R28 was conducted. During the interview, it was observed that R28 had prescription nasal spray which was Ipratropium Bromide and had a pharmacy label with an RX # and date of 4/16/24. Also at the bedside was sterile eye drops and a toothache cream on the over bed table which was positioned at the bedside. When asked, R28 said she is supposed to use the nasal spray 3 times a day, but most days only uses it twice. R28 also said, she uses the eye drops routinely and when asked about the toothache cream, she reported she had dentures but that she wipes her mouth a lot and gets sores in the corners of her mouth. R28 reported she used the cream on the corners of her mouth. Additional observations revealed a tube of Bengay on the over bed table. On 7/8/24 at 1:15 p.m., a clinical record review was conducted of R28's chart, which included physician orders. The orders included an active order that was started on 5/16/23, and read, Ipratropium Bromide Nasal Solution 0.03 % (Ipratropium Bromide (Nasal) 2 sprays in both nostrils three times a day for allergies . and an order dated 3/3/24, for Visine Dry Eye Relief Ophthalmic Solution 1 % (Polyethylene Glycol 400 (Ophth)) Instill 2 drop in both eyes in the morning for dry eyes. There were no orders for toothache cream, Bengay, or voltaren. During the clinical record review, R28's care plan was reviewed. There was no indication that R28 had been assessed for the ability to, nor had been approved by the interdisciplinary team that it was clinically appropriate for the resident to self-administer medications. Review of the assessment tab of the clinical record, revealed no evidence of an assessment having been conducted to assess the resident's ability to self-administer medication. (continued on next page)

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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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/08/24 at 03:27 p.m., observations revealed all the above noted medications still at the bedside. On 07/08/24 at 03:57 p.m., an interview was conducted with LPN #1 (licensed practical nurse), who was assigned to and routinely cares for R28. LPN #1 was asked about residents who are permitted to self-administer medications. LPN #1 explained that all medications are kept in the medication cart, which is maintained by the nurses and locked for safety. LPN #1 went on to say that if the resident is able, she will allow them to use inhalers and things of that nature while she is in the room and watching. LPN #1 went on to say at times families come and sneak stuff in. When asked what they do when this happens, LPN #1 said that they remove the items if they see them and tell the family. On 7/8/24, at approximately 4 p.m., following the above interview, LPN #1 accompanied the surveyor into R28's room. LPN #1 confirmed that the nasal spray was an item that had come from the facility's pharmacy. LPN #1 removed the nasal spray, Bengay, and voltaren gel that was also at the bedside. LPN #1 then asked the surveyor to accompany her to the medication cart and showed the surveyor where she had the prescription nasal spray for R28 in the medication cart that she said she administers. On 7/9/24 at 8:03 a.m., LPN #1 was observed performing medication administration with R28. Following the administration, R28 did not want to give LPN #1 the nasal spray back. LPN #1 had to engage the unit manager and said, We are going to get an order from the doctor, she is a strong woman. On 7/9/24 at 12:23 p.m., the facility conducted an assessment titled, Medication Self-Administration Safety Screen, to determine if R28 could self-administer the nasal spray and Voltaren Gel. According to the assessment it was determined that R28 could self-administer these two medications and store them at the bedside. On 7/9/24 at 2:38 p.m., the director of nursing (DON) was interviewed. The DON said that if a resident can self-administer medications, they can get them a lock box to keep the medications in. When asked why the medications are stored in a lock box, the DON said, so other residents can't access it. The DON confirmed that the facility does have residents that wander. When asked what the expectation is if families bring in over-the-counter medications, the DON said, if they see, they will take them and give to the nurse. The facility's policy regarding medication storage and self-administration of medications was requested. On 7/9/24, in the afternoon, it was noted that R28 had a box at the bedside that was locked for the medications to be stored in. It was also noted that the facility had obtained a physician order for the Voltaren which included unsupervised self-administration and updated the order for the nasal spray to include, . unsupervised self-administration. A review was conducted of the facility policy titled, Self-Administration of Medication at Bedside, which had an effective date of 1/29/24. Excerpts from the policy read, 1. The patient may request to keep medications at bedside for self-administration in a lock box. 2. Complete Medication Self-Administration Safety Screen Assessment. 3. The Interdisciplinary Team will review the assessment and together, use clinical judgement to determine if the patient is eligible. 4. If eligible, medications that are ordered by a provider to be self-administered will be identified in the medical record . On 7/9/24, in the late afternoon, during an end of day meeting, the facility Administrator and director of nursing were made aware of the above findings. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on family interview, staff interview, facility document review and clinical record review, the facility staff failed to provide advance written notice of a room change for one of twenty-six residents in the survey sample (Resident #77). The findings include: Resident #77 (R77) nor R77's responsible party were provided a written notice prior to a room change. R77 was admitted to the facility with diagnoses that included adult failure to thrive, deep vein thrombosis, insomnia, severe protein-calorie malnutrition, major depressive disorder, cancer, and gastroesophageal reflux disease. The minimum data set (MDS) dated [DATE] assessed R77 with moderately impaired cognitive skills. On 7/8/24 at 2:30 p.m., R77's family member (other #7) was interviewed. R77's family member stated the facility moved the resident to a different room on 7/1/24 and that there had been no advance notice of the room change. The family member stated she was not aware of any written notice provided about the room change. R77's clinical record documented the resident changed rooms on 7/1/24. A note written by the admissions coordinator documented verbal notification to the resident on the same day as the room change. The admissions coordinator note dated 7/1/24 at 2:49 p.m. documented, .[R77] notified of room change on 07/01/2024 12:00 AM. Family/Responsible party notified of change . R77's clinical record documented a room change notification form dated 7/1/24 listing the reason for R77's room change and indicated the resident and/or responsible party were provided with a copy of the room change notification. On 7/9/24 at 10:30 a.m., the admissions coordinator (other staff #5) was interviewed about any written, advance notice of R77's room change. The admissions coordinator stated she notified R77 verbally on the day of the room change. The admissions coordinator stated, We looked at her as her own responsible party. The admissions coordinator stated she called the resident's listed responsible party (RP) and left a voice message that the resident was moving rooms. The admissions coordinator stated the notifications were made on the same day as the room change and no written notice of the change was provided to the resident or the RP. When asked about the documentation on the room change notification form indicating that a copy had been provided, the admission coordinator stated that no actual copy was provided. The admissions coordinator stated, I just marked yes about the notification. The admissions coordinator stated she asked the resident about the move on 7/1/24 and left a voice message for the RP. The admissions coordinator stated, There was no piece of paper. The admission director stated the current protocol was to complete the room change form in the electronic health record and that the facility no longer provided paper copies of the room change notice. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's current admissions/business contract documented residents had a right to advance notice of room and/or roommate changes. This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 7/9/24 at 4:30 p.m. with no further information provided prior to the end of the survey.

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 41449 Based on staff interview and facility record review, the facility staff failed to have a surety bond to assure the security of all personal funds of residents deposited with the facility, which affected 72 residents who had funds deposited with the facility. The findings included: On 7/10/24 the facility staff provided a surety bond which was in the amount of $165,000. On 7/10/24, a review of the resident trust accounts revealed that there were 72 residents with funds deposited at the facility. The total balance was $180,783.50. The surety bond did not have sufficient coverage to cover the funds deposited with the facility. On 7/10/24, during an end of day meeting, the facility administrator was made aware of the above findings. Following the end of day meeting, the administrator came to the conference room and a list of residents that she said the business office said they needed to close the accounts for. The surveyor then went to the business office manager's (BOM) office. The BOM said she had just started at the facility and had identified several accounts that need to be closed, but that had not been done yet. No additional information was provided.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on facility staff interview, clinical record review and facility documentation review, the facility staff failed to obtain and incorporate the recommendations from a level II PASARR (preadmission screening and resident review) into the Resident's assessment and care plan for one Resident (Resident #46) in a survey sample of 26 Residents. The findings included: For Resident #46 (R46), who had a level II PASARR, the facility staff were unaware until requested by the survey team, that the Resident had a level II screening and failed to incorporate the recommendations into the Resident's assessment and care planning. On 7/8/24, a clinical record review was conducted of R46's electronic health record. The census tab of the clinical record revealed R46 was initially admitted to the facility on [DATE]. R46 did have several hospitalization s and the most recent readmission was on 10/7/23. R46's diagnosis included but were not limited to hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side, paranoid schizophrenia, schizoaffective disorder, bipolar type, major depressive disorder/recurrent/moderate, other symptoms, and signs involving cognitive functions and awareness, and generalized anxiety disorder. During the above review, the surveyor was unable to find a PASSAR. The care plan did not address that R46 had a level II PASARR, nor any recommendations contained within the assessment. According to the care plan, it read in part, The resident has signs and symptoms of depression and is at risk for adverse reactions secondary to major depressive disorder, recurrent, anxiety disorder and schizoaffective disorder, bipolar type. Another focus area read, The resident exhibits adverse behavioral symptoms such as restlessness (agitation), hitting, increase in complaints, delusions, hallucinations, psychosis, aggression, refusing care. According to the documents tab of R46's chart, a document with an upload date of 10/29/2018, that was titled, UAI (uniform assessment instrument) 102918, was a one-page document which contained the Medicaid Funded Long-Term Care Service Authorization Form. On this document it indicated that a level II PASARR was referred, active treatment not needed. On 7/10/24 at 11:44 a.m., an interview was conducted with Other Employee #8 (OE8), who was the discharge planner/social services director. OE 8 was asked about the PASARR for R46. OE8 provided the surveyor with a level I PASARR that was completed 10/8/2023, that indicated, No referral for Level II evaluation for active treatment needs required because individual: Has a severe physical illness (e.g. documented evidence of coma, functioning at brain-stem level, or other conditions which results in a level of impairment so severe that the individual could not be expected to benefit from specialized services.) OE 8 also said that R46 had been admitted from a sister facility and they did not have the PASARR either. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review was conducted of the discharge summary from the hospital dated 10/7/23. The document read in part, . Reason for Admission: . Suicidal ideation, schizoaffective disorder. Hospital Course: . Suicidal Ideation/Schizoaffective disorder. Patient has a history of SI [suicidal ideation] and schizoaffective disorder. Patient initially endorse SI but denies on day of discharge. Psychiatry consulted and has evaluated patient to be at low risk to act on SI and does not require suicide precautions at this time, in terms of his chronic mental illness, patient's home facility meds has been reconciled and restarted while admitted . Recommendations: Melatonin 10 mg nightly, Mirtazapine 7.5 mg nightly, Olanzapine 10 mg daily, Risperdal 2mg BID [twice daily], Buspirone 10 mg BID, Clonazepam 0.5 mg BID, Valproic acid 250 mg morning, 375mg nightly . On 7/10/24 at approximately 12 noon, OE 8 confirmed he had completed the PASARR form dated 10/8/23. When asked what severe physical illness the resident had that made him not qualify for a Level II? OE 8 stated, he is pretty low functioning and bed bound. The surveyor explained that R46 was alert and had been able to communicate with the surveyor and impaired physical functioning was not reason to not perform a PASARR. Review of the facility policy titled, Level II PASRR- Virginia was conducted. Excerpts from this policy read, 1. Prior to center admission, the admission director will review preadmission information to determine if a Level II PASRR has been triggered by a completed Level I PASRR. a. If a Level II PASRR was triggered, and results are included in preadmission documents, the patient can be admitted to the center. No later than five (5) days after admission confirm that the Level II PASRR is uploaded into PCC and ensure that any requirements outlined in the Level II determination are incorporated into the care plan for the patient. 2. If a Level II PASRR was triggered by the Level I PASRR provided by the transferring hospital and the patient was admitted without a completed Level II PASRR, the center Social Work and Discharge Planner will initiate the discharge planning process by contacting: [name of company that performs Level II PASRR assessments redacted and phone number redacted] . On 7/10/24, during an end of day meeting, the facility Administrator was made aware of the above findings. No further information was provided.

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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. 41449 Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to ensure that residents receive devices to prevent accidents for one resident (Resident #28-R28), in a survey sample of 26 residents. The findings included, For R28, who had a recent fall, the facility staff failed to ensure the resident had fall interventions in place to prevent further accidents. On 07/08/24 at 1:19 p.m., an interview was conducted with R28. R28 reported that she has had several falls while at the facility. When asked what interventions were put in place to prevent future falls, the resident said she didn't know. Observations revealed no fall mat within the room. On 7/8/24, a clinical record review was conducted of R28's chart. According to the Post Fall Investigation document in the assessment tab of the chart, it indicated that R28's most recent fall was on 6/16/24. There were also Post Fall Investigation assessments completed on 12/15/23, 10/26/23, 9/19/23, 9/18/23, and 9/14/23. According to the care plan R28 had a focus area initiated on 5/15/23, which was the day of admission that read, the resident is at risk for falls due to history of falls with injury with impaired gait and mobility. The care plan was last revised on 6/7/24. Interventions to prevent falls and injuries included but were not limited to: fall mats to side of bed (left), which was initiated 10/26/23, and concave mattress to help with bed parameters, which was initiated 9/14/23. On 07/08/24 at 12:42 p.m., and again at 3:27 p.m., observations were conducted in R28's room. It was observed that R28 had a regular mattress, not a concave mattress and there was no fall mat present. On 07/09/24 at approximately 8:00 a.m., R28 was visited in her room. R28 was in bed, lying on a regular mattress and there was no fall mat at the bedside. R28 was asked about the fall mat, and she reported they didn't put anything on the floor by the bed to prevent injury in the event of a fall. On 7/9/24 at 03:01 p.m., an interview was conducted with LPN #1 (licensed practical nurse), who routinely cares for R28. LPN #1 was asked about R28's fall history. LPN #1 reported R28 had been treated for pneumonia recently and had some confusion and during that time had a fall. LPN #1 was shown R28's care plan which indicated she was to have a fall mat and concave mattress. On 7/9/24 at 3:03 p.m., LPN #1 accompanied the surveyor into R28's room and confirmed there was no fall mat present in the room to be used. LPN #1 also confirmed that R28 did not have a concave mattress and went on to say that the resident had not had that since she moved to her current room. LPN #1 reported that R28 transfers in and out of bed independently and was concerned that a fall mat would post more of a risk to the resident and was not aware why that would have been a part of the resident's care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Fall Management Program, was conducted. The policy read in part, The center considers all patients to be at risk for falls and provides an environment as safe as practicable for all patients. The center utilizes a systematic approach to a falls management program that facilitates an interdisciplinary approach with evidence-based interventions to develop individual care strategies . Prevention: . 2. Discuss fall risks and interventions with patient and/or responsible party. 3. Incorporate any identified interventions into the care plan as applicable Fall Occurrence: 2. Complete the Post-Fall Investigation to determine, to the extent possible, the cause of patient fall . 3. A licensed nurse will review, revise, and implement interventions to the care plan . On 6/9/24, during the end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided.

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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** 49456 Based on observations, staff interviews, facility document review, and clinical record review, the facility staff failed to ensure that each resident received the necessary respiratory care, services, and failed to appropriately store respiratory equipment, in accordance with professional standards of practice for two residents (Resident #84 and Resident #28) in a survey sample of 26 residents. The findings included: 1. The facility staff failed to obtain a physician order prior to administering oxygen to Resident #84 (R84) and failed to label the oxygen tubing with the date. According to the clinical record, R84 was admitted to the facility on [DATE] and has diagnoses that include but are not limited to congestive heart failure, pressure ulcer of sacral region - Stage 3, pressure ulcer of the right buttocks - Stage 3, and cutaneous abscess of back. R84's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 6/18/24 coded R84 with no cognitive impairment with daily decision making. 07/09/24 08:30 a.m. a tour of unit one was conducted. During the tour, R84 was observed with oxygen being administered by nasal cannula at 3 liters per minute, without having any dated labels on the tubing or humidifier bottle. On 07/09/24 a clinical record review was conducted, which included R84's physician orders. This revealed that there was no order for oxygen to be administered to R84. On 07/09/24 a clinical record review was conducted. The daily skilled documentation dated 6/27/24, read in part, .Continues on 3L oxygen therapy R/T [related to] acute respiratory failure. A daily skilled note dated 7/7/24, read in part, . 2 l/min [liters per minute]via nasal cannula. A daily skilled note dated 7/8/24, read in part, .2 l/min via nasal cannula. On 07/09/24 at 1:30 p.m. LPN#5 (LPN5) was interviewed. LPN5 reviewed R84 physician orders and stated that R84 had no order for the oxygen that was in use. On 07/09/24 at 2:50 p.m. an interview was conducted with the director of nursing (DON). During the interview, the DON reviewed the physician orders for R84 and stated that there was no physician order for oxygen to be used. On 07/9/24 at 4:30 p.m. an end of day meeting was held with the administrator, director of nursing, and regional nurse consultant to discuss the above concerns. The facility policy was requested. On 07/10/24 a review of facility documentation was conducted. The policy titled, Patient Care Equipment, was reviewed and read in part, .Oxygen humidifier bottles, cannulas/mask, and tubing's are changed weekly. On 07/10/24 at 1:30 p.m. a exit conference was conducted with the administrator, director of nursing and regional nurse consultant and no more information was provided. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	41449 2. For Resident #28 (R28), the facility staff failed to ensure respiratory equipment was stored in a manner to prevent contamination while not in use and failed to change the tubing on a routine basis, in accordance with professional standards. On 7/8/24 at 3:25 p.m., during observations of R28's room, it was noted that the resident had a nebulizer machine on the bedside table. Observations revealed that the nebulizer mask and tubing was dated as having last been changed on 6/25/24. There was an oxygen concentrator at the bedside and the nasal cannula was hanging over the top of the concentrator, open to air. The oxygen tubing was dated 6/1/24. R28 was not in the room at the time. R28's roommate reported to the surveyor that R28 had pneumonia recently and used the oxygen at that time. On 7/9/24 at 2:13 p.m., observations were conducted in R28's room and revealed all the same findings as noted on 7/8/24 at 3:25 p.m. On 7/8/24-7/9/24, a clinical record review was conducted of R28's chart. This review included but was not limited to the physician orders, medication administration records (MAR), and treatment administration record (TAR). According to the physician order dated 6/13/24, the order for oxygen read, Administer 2 liters of oxygen via nasal cannula when 02 < 90% [oxygen saturation is less than 90 percent], as needed for 02 less than 90%. On 6/16/24, an order was written that read, Oxygen Therapy - Oxygen at 3 liters per minute via nasal cannula. Increase to 4 liter if oxygen btw [between] 89-90%. The physician order for the nebulizer treatments was dated 5/15/23, and read as, Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 1 puff inhale orally every 6 hours as needed for COPD wheezing/SOB [shortness of breath]. According to the TAR, on 4/26/24, an order was entered to change the nebulizer tubing setup weekly and as needed. This order was discontinued on 6/10/24. According to the TAR for June 2024, documentation indicated that this was only changed on 6/2/24. On 7/9/24 at 3:01 p.m., an interview was conducted with LPN #1. When asked about R28's use of oxygen and nebulizers, LPN #1 said, [R28] had pneumonia about a month ago and was really confused. When asked if R28 uses oxygen and the nebulizer, LPN #1 said, It is prn [as needed], she still has a cough, I think it is recurring. They said it happened on unit 2 too [referring to when the resident was living on a different unit in the facility]. Her O2 [oxygen] sats go down in the 80's, she is non-complaint with that too. LPN #1 explained that oxygen tubing and nebulizers are changed every Sunday, by the night shift. When asked why it is changed weekly, LPN #1 said, it's for germs and for protection. When asked how they are stored when not in use, LPN #1 said, they are supposed to always have a bag. On 7/9/24, following the above interview, LPN #1 accompanied the surveyor into R28's room. LPN #1 confirmed that the oxygen nasal cannula was open to air, was not stored in a bag, and had last been changed on 6/1/24. LPN #1 also confirmed that the nebulizer had last been changed on 6/25/24. According to the facility policy titled, Patient Care Equipment, section 4 read in part, . i. Oxygen humidifier bottles, cannulas/masks, and tubing are changed weekly. j. Nebulizer/aerosol masks and tubing are changed weekly . m. Tubing not in use should be kept in labeled, dated bag . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/24 at 4:45 p.m., during and end of day meeting, the facility administrator and director of nursing (DON) were made aware of the above findings. The DON confirmed that respiratory equipment tubing, and set-up is to be changed on a weekly basis. No additional information was provided.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on resident interviews, staff interviews, and facility documentation review, the facility staff failed to maintain sufficient nurse staffing to assure resident safety and highest practicable well-being of each resident, to meet their daily needs in accordance with the facility assessment, for 2 of 2 nursing units. The findings included: On 7/8/24, during initial tour of the facility and interviews with the residents, numerous residents expressed concerns about the facility staffing. The residents reported having to wait long periods of time, that they described as over an hour, for call bell responses. On 7/8/24 at 2:20 p.m., the Ombudsman met with the survey team. The Ombudsman reported, staffing is horrible. I think it is dangerous. Especially on weekends, people feel like they can just call out, it is like a revolving door. I worry, they don't have an intercom system, if they put their call light on, it is on for an hour. If someone has fallen, this is dangerous. On 7/8/24 at 3:07 p.m., a group meeting was held with the resident council and survey team. Five residents were in attendance. They reported concern with call bell responses and said, sometimes we have to wait a long time, up to an hour. When asked if this was specific times of the day, they said, it's just anytime . I need help with bathroom and can't hold it. The resident council went on to say, some days there are only 2 aides on the floor [unit]. On 7/8/24-7/10/24, interviews were conducted with various staff, which included: CNA #11 (certified nursing assistant). CNA #11 reported that staffing was not good, that people call out all the time. CNA #9 reported staffing was horrible and said she can't provide the care Residents need. CNA #9 reported that 95% of the time I have over 20 residents to take care of, they are supposed to get showers twice a week but 95% of the time we don't have enough staff to do them. CNA #10 reported, staffing is very short, especially on weekends, a few weeks ago there was only 2 CNAs for the entire unit. It's not always that bad, but it is hard to get everything done. CNA #7 confirmed staffing was challenging and reported she can't provide all the care residents needs due to lack of staff. LPN #2 described the staff as, rachet and went on to say, do they get the care they need and deserve, no. When asked if there are times there is only one CNA for the entire unit, LPN #2 said, yes, the weekends are really bad. On 7/10/24, a review was conducted of the resident council minutes from November 2023-June 2024. The minutes revealed the following complaints directly related to nursing staffing and lack of care/services due to staffing: November 2023, concerns were shared regarding call bell response times. December 2023, concerns were shared regarding lack of showers. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	January 2024, staffing and staff leaving at 3 p.m., and leaving the unit short. CNA's complaining to residents about being short staffed, long call bell wait times, not seeing staff for a 4-hour period, and rounds not being conducted. February 2024- call lights not being answered in a timely manner. March 2024, long call bell wait time, staff turning off light [call bell], especially bad at night, 2 CNAs per unit, . beds not made, and sheets not changed. April 2024, staffing being an issue . Under the section G. titled, Administration is read, Asking for more staff and what can we do to keep the staff we have. May 2024, read in part, The weekdays staffing has increased. However, weekends are still bad . June 2024, read in part, . Nursing: back to call light being on long [sic]. Some residents not getting there showers [sic]. Staff on the weekend is really bad . Administration: Residents wanting to know about the staffing shortage . On 7/10/24, the facility assessment was reviewed. According to that document, the facility needed 34.2 FTE's (full time equivalents) for nurse aides, per day. Which would equate to 16 CNAs per unit, per 24-hour period. Also noted as 5 nursing assistants per shift, per unit. The document went on to say, department heads are responsible for staff review. Needs are discussed daily . On 7/10/24, the facility staffing/nursing assignment sheets were reviewed from June 1, 2024-July 8, 2024. This review revealed on multiple instances there were only 3 CNAs to care for all residents on one of the two units. Those dates included, but were not limited to: 6/1/24, 6/2/24, 6/3/24, 6/4/24, 6/6/24, 6/8/24, 6/9/24, 6/10/24, 6/11/24, 6/12/24, 6/13/24, 6/14/24, 6/17/24, 6/20/24, 6/21/24, 6/24/24, 6/27/24, 6/29/24, 7/1/24, 7/3/24, 7/6/24, 7/7/24, 7/8/24, and 7/9/24. Additional details according to the staffing assignment sheets included: On 6/1/24, units 1 and 2, each only had 2 CNA's from 7 pm-7 am. On 6/2/24, unit 2 only had 2 CNA's from 7 pm-7am. On 6/8/24, unit 2 only had 2 CNAs on the over-night shift. On 6/13/24, on unit 2 after 3 p.m., there was only 1 CNA until 7 pm. On 6/14/24, unit 2 from 3-7 p.m., there was only 2 CNAs for the unit. On 6/15/24, unit 1 only had two CNA's from 7 am-7pm. On 6/19/24, unit 2 only had 2 CNAs for the 7am-7pm shift. On 6/21/21, unit 2 only had 2 CNA's from 7am until 5 pm, and from 7pm-7am, there was only 2 CNA's. On 6/22/24, both units only had 2 CNA's from 7am-3pm. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/23/24 unit 2 only had 2 CNAs for first shift, 7am-3pm. On 6/24/24, unit 2 only had 2 CNAs for the 12-hour shift from 7am-7pm. On 6/29/24, unit 2 had a nurse work the floor as a CNA to make 2 staff to provide for all resident needs on the unit from 7am-7pm. On 6/30/24 there were 4 total CNAs for the entire facility from 7am-3pm and 7pm-7am. On 7/5/24, unit 2 only had 2 CNA's from 7am-7pm. On 7/6/24, unit 1 only had 2 CNA's. On 7/10/24 at 10:28 a.m., an interview was conducted with the Director of Nursing (DON). The DON was asked about nurse staffing of each nursing unit. The DON confirmed that standard staffing is 4 CNAs on each side during day shift, we come as close to that as we can with the staffing, we have available. We would rather over staff than under staff, not to mention call outs, when we can, go up to 5 and 5 [5 CNAs per unit]. During the above interview, the DON was asked about agency staffing and how they manage when people call out for their scheduled shift. The DON explained that they have been using agency since 2019. The company will only allow them to use one staffing agency, which is also owned by the same company, so they are limited in agency staff available. He went on to say, they are unreliable, they are just no shows [do not call or show up for their scheduled shift], but it all we have, and I can't do anything to hold them accountable. As for call outs, the DON said, It is difficult, I did some research recently and found that majority of the time when people call out, they had worked the previous 6 days because we are so low on staffing. I have a really hard time writing them up when they bailed me out in the week and picked up 12-hour shifts. I [NAME] these CNA's they bail us out and bail us out, but then call out because they are tired. The DON went on to say, Staffing has got me, that's the enemy in this place. When asked if there are times there are only 2 CNAs for a unit, he said, Oh yeah, it's happening but that's my worst days, I will come in and help do what I can, my unit manager comes in. We lost a unit manager recently because she got sick of coming in. I agree with you, staffing is bad. The DON further confirmed that the facility's average census runs around 100, which equates to 60 on one unit, and 40 on another. He explained that unit 2, where 40 residents are, is skilled, with families, the families more involved, they are scared, the residents are more needy and are more demanding, the residents more complicated and a higher acuity, so they need just as many staff as the other unit. On 7/10/24, during an end of day, pre-decision making meeting, the above findings were discussed. No further information was provided.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 41449 Based on resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to ensure prn (as needed) orders for psychotropic medication was limited to 14 days, affecting 1 resident (Resident #82- R82), in a survey sample of 26 residents. The findings included: For R82, the facility staff failed to ensure that a prn order for lorazepam was limited to 14 days. On 7/8/24 at 2:33 p.m., R82 was visited in her room. R82 was able to communicate with the surveyor but confusion was evident. R82 appeared calm and not anxious during the interview. On 7/8/24, a clinical record review was conducted of R82's chart. This review included a review of the physician orders, progress notes and medication administration records (MARs). It was noted that R82 had a physician order dated 5/1/24, that read, Lorazepam oral concentrate 2 mg/ml (Lorazepam) give 1 ml by mouth every 1 hours as needed of end-of-life anxiety. The order had no end date and remained an active and current order. According to the MAR, R82 received the lorazepam on 5/3/24, 6/30/24, and 7/2/24. According to the nursing progress notes, the following entries were made with regards to why the lorazepam had been given. There were no nursing notes to indicate why the lorazepam was administered on 5/3/24. The nursing note dated 6/30/24, read, Resident was agitation [sic], give resident 1 ml of lorazepam to help with agitation md aware. The note dated 7/2/24, read, Resident showing anxiety and taking off clothes. give resident 1 ml of lorazepam to help with anxiety md [medical doctor] aware. According to the physician notes R82 was seen on 5/2/24. The note made no reference to R82's medications or order for lorazepam as needed. On 5/15/24, R82 was seen by the physician, the note did indicate that R82 had been admitted to hospice services but made no reference to the residents' medications or the order for the lorazepam ordered as needed. R82's last visit with the physician was on 6/2/24, according to the progress notes and the note from the doctor did not reference the resident's medication orders or rational for having a prn order for lorazepam that was not being used routinely. On 7/10/24 at 8:15 a.m., the corporate nursing consultant confirmed that prn orders for psychotropics are not to exceed 14 days. She stated that the facility did not have a policy regarding this. On 7/10/24 at approximately 11:30 a.m., the facility administrator and director of nursing were made aware of the above findings. No additional information was provided.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 41449 Based on observation, resident interview, staff interview, and facility documentation review, the facility staff failed to provide meal substitutions in accordance with resident preferences for one resident (Resident #32-R32), in a survey sample of 26 residents. The findings included: On 7/8/24 at approximately 12:30 p.m., R32 was observed being served her lunch meal in the dining room by a dietary aide, (Other Employee #9-OE9). R32 asked OE9 for a grilled cheese sandwich and OE9 was heard to say to the resident, That's what you ordered, and walked away. A few minutes later OE9 served another resident their plate and as OE9 walked by R32, R32 again asked for a grilled cheese sandwich. OE9 told R32 again, That's what you ordered, it's not pork. When the surveyor then walked over to R32, OE9 said to the the surveyor, That's what she ordered. R32 then said to the surveyor, I don't want that. I want a grilled cheese sandwich. On 7/8/24 at 12:45 p.m., R32 was observed in the dining room, eating a cold turkey and cheese sandwich. When asked about the sandwich, R32 said, It wasn't what I wanted, but I guess I have to eat it. On the afternoon of 7/8/24 at approximately 3 p.m., an interview was conducted with the dietary manager. When asked what she expects to be done when a resident doesn't want what is served and requests a grilled cheese, the dietary manager said, I expect them to make the grilled cheese. When told of the above interactions with R32, the dietary manager said, That should never happen. I had 3 cooks here and myself. We could have made the grilled cheese. On 7/9/24 at approximately 9 a.m., the dietary manager told the surveyor that she had talked to OE9. The dietary manager said that OE9 had told her that she didn't notify the cook of the request for the grilled cheese sandwich because OE9 didn't think the cook would want to make it. The dietary manager again said, That's not right, I would have made it. On 7/9/24, during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. A facility policy regarding food preferences was requested. No further information was received prior to conclusion of the survey.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 41449 Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to provide a therapeutic diet in accordance with physician orders for one resident (Resident #82-R82) in a survey sample of 26 residents. The findings included: For R82, who had a physician order for nectar thickened liquids (NTL), the facility staff failed to provide thickened liquids. On 7/8/24 at approximately 12:30 p.m., observations were conducted of R82 during the lunch meal. R82 was served a beverage with her lunch meal that was an amber color, which appeared to be apple juice. There was ice in the cup, and it was noted to be a thin consistency. R82 also had a water pitcher that when picked up you could tell there was a liquid with ice that was able to be swirled around in the pitcher. According to the meal ticket that was on the lunch tray, R82 was noted to have been on NTL. On 7/8/24 at 12:47 p.m., LPN #6 accompanied the surveyor to the room of R82. LPN #6 confirmed that the resident was served thin liquids, and she opened the water pitcher and confirmed it was a thin consistency. LPN #6 said, she is not supposed to have a water pitcher, and removed both items from the room. When LPN #6 was asked what the risk to the resident is, LPN #6 said the resident could aspirate. On 7/9/24 at 08:01 a.m., R82 was observed again to have a water pitcher on the over bed table which had thin water consistency with ice in it. On 7/9/24 at 08:20 a.m., during the breakfast meal service, it was observed that the CNA's were delivering beverages to the residents prior to the meal trays being delivered to the unit. CNA #9 delivered regular consistency cranberry juice to R82 and sat it on the over bed table, in front of the resident. On 7/9/24 at 8:30 a.m., an interview was conducted with CNA #10. CNA #10 was asked how they know if a resident gets thickened liquids? CNA #10 said, it's on their ticket [referring to the meal ticket], but I've been here long enough, I know them. CNA #10 was asked about R82 and said, She prefers thin liquids and she's ok, she can drink it. On 7/9/24 at 8:35 a.m., when R82 was delivered her meal tray, an interview was conducted with CNA #9. They surveyor asked CNA #9 about the meal ticket on the tray indicating R82 was to have nectar thick liquids. CNA #9 said, her family wanted her on regular food. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/24, a clinical record review was conducted of R82's chart. This review revealed a physician order dated 5/15/24, that read, Regular diet Regular texture, Nectar Thick Liquid consistency. Review of the discharge summary from the hospital immediately preceding the resident's admission to this facility read in part, .She did pass for a diet consisting of pureed foods with thickened liquids on post-trauma day 5, but subsequently refused most PO [by mouth] intake. SLP [speech language pathology] made numerous attempts to work with her but patient refused to participate with subsequent therapy sessions. TF [tube feeding] via NGT [nasogastric tube] were continued to provide adequate caloric intake. Several appetite stimulants were started without any improvement in PO intake . On 7/9/24 at 2:07 p.m., an interview was conducted with the therapy director (Other Employee #6- OE6). When asked about R82, OE6 accessed his computer system and confirmed that R82 had not been on speech therapy caseload while a resident of the facility. OE6 confirmed that the speech therapist was not at the facility for an interview. When asked about thickened liquids and a resident being served thin liquids, he confirmed that the risk to the resident is aspiration. OE6 said he was accustomed that nursing could advance a resident's diet to a higher level, such as someone on thin liquids, nursing could change them to thickened liquids until speech therapy could evaluate the resident, but not downgrade from thickened liquids to thin. OE6 did say, I don't know how hospice works, they may have a different set of rules. On 7/9/24 at 3:30 p.m., an interview was conducted with LPN #1. LPN #1 was asked about R82's diet and liquids. LPN #1 said, family wanted her to have regular food. LPN #1 went on to say that R82 had NTL in the water pitcher yesterday, but it had thinned down. The nurse said that she had removed the water pitcher and the resident now had thickened liquids at the bedside. On 7/9/24 at 4:45 p.m., during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided.

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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. 41449 Based on observation, staff interview, and facility documentation review, the facility staff failed to store, prepare, and serve food accordance with professional standards for food safety in the main kitchen, which has the potential to affect multiple residents on 2 of 2 nursing units. The findings included: 1. The facility staff failed to store food at an appropriate temperature in the walk-in refrigerator. On 7/8/24 at 11 a.m., a tour of the kitchen was conducted with a dietary aide and cook (other employee #11-OE11), in the absence of the dietary manager. On 7/8/24 at 11 a.m., upon entry into the walk-in cooler, it was noted that the temperature did not feel cool enough to ensure food safety. The internal thermometer located within the fridge was observed to be reading 55 degrees Fahrenheit. OE11 was asked about the cooler, and he reported, It feels cold enough to me. When asked about the temperature readings and records, OE11 said, maintenance checks that, and said the logs should be hanging on the wall. There were no temperature logs available for any of the food storage areas, to include the walk-in cooler, walk-in freezer, the stand alone cooler or stand-alone freezer. The following items were noted to be in the cooler: approximately 12 cartons of milk, sliced sandwich ham, boiled eggs, ground beef, macaroni salad, cups of sliced watermelon, tossed garden salad, sandwiches, and macaroni salad, cases of margarine, cheese, whipped topping, various items of produce to include fruits and vegetables. The cook (other employee #10- OE10) was asked about temperature logs and he also said, maintenance checks them daily. On 7/8/24 at 11:47 a.m., OE11 was asked to take the temperature of foods on the steam table. OE11 went to the dietary manager's office to obtain a thermometer, the surveyor followed him. While in the dietary manager's office, it was observed that other employee #12 (OE12) was sitting at a desk filling in the temperature logs. When asked, OE12 said, I am catching them up. When the surveyor asked how she knew what the temperatures were on those days, no response was given. On 7/8/24 at 11:55 a.m., the dietary manager arrived in the kitchen. The dietary manager was asked about the walk-in cooler and reported they had been having problems with the cooler for a few weeks. When notified that they surveyor wanted the temperature of the milk taken, the dietary manager and surveyor walked into the walk-in cooler. When asked if she felt it was cool enough, the manager said, yes. The thermometer was pointed out that it was reading 56 degrees. The dietary manager did take the temperature of the milk stored in the walk-in cooler and the temperature was 52 degrees. The dietary manager said, that's not good, it should be way lower than that. When asked about temperatures of the food storage areas, she said that the dietary staff take temperatures twice daily. She was notified that each of the dietary employees had reported maintenance did this and there were no logs of temperature monitoring. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/8/24 at 2:44 p.m., the dietary manager accompanied the surveyor into the walk-in cooler. It was noted that there was a rack containing 3 shelves of fruit cups and tuna stored in the walk-in cooler, in addition to the previously identified items. The dietary manager replaced the thermometer in the walk-in cooler, and it was now reading 55 degrees. On 7/8/24 at 2:50 p.m., the surveyor observed the even cook preparing a ground beef dish that was to be served as a taco salad. The cook was asked where she got the ground beef being prepared from and responded that it was in the walk-in cooler and had come on the truck delivery that morning. The dietary manager was asked what was going to be done with the remaining ground beef, she said it had just been delivered that morning and she was sure it was ok. The surveyor asked the ground beef, which was still stored in the walk-in cooler to have the temperature taken. The dietary manager took the temperature of the ground beef, and it was 47 degrees. On 7/9/24 at 8:55 a.m., an interview was conducted with the maintenance director. The maintenance director reported that his department checked the temperature of the walk-in cooler and freezer daily, but dietary staff were to do it twice daily. The maintenance director went on to say that their department doesn't work on weekends, and therefore no temperatures are taken those days. When asked about the walk-in cooler, the maintenance director reported that when they check the temperature in the mornings the temperature is in the 30's. He accompanied the surveyor into the walk-in cooler and confirmed the thermometer was reading 53 degrees. The maintenance director then used a laser thermometer to check the temperature of the air coming from the cooling fans, it registered 50-degree air coming from the left fan and 48-degree air from the right fan. Review of the facility policy titled, Food Storage: Cold, was conducted. That policy read in part, . 2. The dining services director/cook(s) ensure that all perishable foods will be maintained at temperature of 41 degrees F [farenheight] or below except during necessary periods of preparation and service . 4. The dining services director/cook(s) ensures that an accurate thermometer will be kept in each refrigerator and freezer. A written record of daily temperatures is recorded . On 7/9/24 at 4:45 p.m., during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. 2. The facility staff failed to label and date foods that had been opened and failed to store food in a manner to prevent contamination. On 7/8/24 at 11 a.m., a tour of the kitchen was conducted with a dietary aide and cook (other employee #11-OE11), in the absence of the dietary manager. On 7/8/24 at 11 a.m., upon entry into the walk-in cooler, it was noted that a bag of onions was sitting on the floor of the walk-in cooler. There were multiple items that were not labeled with the date of when they were prepared, or when to be used by, which included but were not limited to: left over pureed eggs in a bag tied closed, boiled eggs in a liquid appearing to be water, covered with saran wrap, which had no date. There was a garden salad on a plate, which had no date(s). There was a zip lock bag, which was open and not closed and contained sliced sandwich ham. There was a container of macaroni salad, container of what appeared to be stewed tomatoes, macaroni and cheese, and multiple sandwiches all of which had no label or date of when they were prepared or to be used by. Additionally there were approximately 50 cups of cut watermelon that were open to air, not covered and had no date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Under one of the food preparation tables in the kitchen was a box of hotdog buns on the floor. OE11 was asked if this is where bread is normally stored and he said, when in a rush we put it there and put it up later. In the walk-in freezer there was a case of diced carrots and a case of green peas, that were open to air and not secured or dated of when opened. In the stand-alone cooler there was a container of egg salad that was covered with saran wrap and had no date of when it was prepared. There were multiple bottles of apple and cranberry juices that had been opened and not dated. On 7/8/24 at approximately 11:55 a.m., the dietary manager arrived and was asked about food storage. The dietary manager said, everything is to be labeled and dated. When asked why, the dietary manager said, we don't want anyone getting food poison. On 7/8/24 at 2:44 p.m., during a follow up visit to the kitchen, it was noted that in the walk-in cooler tuna salad was stored without any date. There were 3 racks of bowls of fruit cocktail. The dietary manager said they had just made them and would make a label for them. The walk-in freezer had a case of bacon that was not secured, was open to air and had no date as to when it was opened. There were also rolls and green peas that were observed to not be secured and were stored open to air and had no date of when opened. On 7/9/24 at 4:20 p.m., during a follow-up visit to the kitchen, observations were conducted with the dietary manager. In the walk-in cooler, the bag of onions remained stored on the floor of the cooler. The stand-alone cooler had 3 pitchers of juice that had no label of contents or date of when prepared. A review was conducted of the facility policy titled, Food Storage: Cold. The policy read in part, . 1. The dining services director is responsible for storing all items 6 inches above the floor and 18 inches below the sprinkler unit . 5. The dining services director/cook(s) ensures that all food items are stored properly in covered containers, labeled and dated and arranged in a manner to prevent cross contamination. The CFR [Federal code] read, 3-305.11 Food Storage .D. A date marking system that meets the criteria . (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded . According to the 2017 Food Code published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 3, section 3-302.15, page 64 stated: Package Integrity. Food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants. On 7/9/24 at 4:45 p.m., during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The facility staff failed to wash dishes in a manner to prevent micro-organism growth, by wet nesting dishes. On 7/8/24 at approximately 11:15 a.m., observations were conducted of the facility staff washing dishes. It was noted that a dietary aide, (other employee #9-OE9) was observed removing dishes from the dish washer and immediately stacking them, while wet. This included tulip bowls and plates. When asked about the silverware that was wet, OE9 said she was going to get a towel and dry them. A few minutes later, OE9 was observed to have one towel that she was using to dry the eating utensils. On 7/8/24 at 2:50 p.m., OE9 was again observed to be stacking dishes directly out of the dishwasher that were still wet. This included trays and plate warmer bottoms. Another dietary aide, OE11 was observed taking silverware directly from the rack that go through the dishwasher on and putting them into a container where the spoons were stacked in a manner that they could not air dry. Joining this surveyor, the dietary manager observed the items and confirmed that water was in them. The dietary manager stated that this was wet nesting, which could allow the growth of bacteria. The dietary manager said that all items are to be air dried. Review of the facility policy titled, Ware Washing read in part, . 4. The dining services director ensure that all dishware is air dried and properly stored. According to the 2017 Food Code published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 4, section 4-901.11, titled Equipment and Utensils, Air-Drying Required pages 151-152 stated: After cleaning and sanitizing, equipment, and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food; and (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry. On 7/9/24 at 4:45 p.m., during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided. 4. The facility staff failed to sanitize food preparation areas and dishes washed in the 3-compartment sink. On 7/8/24 at 11 a.m., during the initial tour of the kitchen, the following was observed. OE11, who was a dietary aide was at the food preparation table preparing a rice pudding for the meal. Following the completion, OE11 used a rag from a green bucket to wipe down the food prep table. Sanitizer strips were used, and the solution had no sanitizer in it and registered a reading of 0 ppm [parts per million]. On 7/8/24, during the above observation in the initial kitchen tour, the cook was observed removing dishes from the 3 compartment sink and putting them on storage racks to dry and be available for use. It was noted that the gallon jug of sanitizer solution was empty, and the hose and plunger were hanging on the outside of the container. The cook was asked about the sanitizer, and he stated he didn't know where it was kept and did not know how long it had been empty. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Sanitizer Dispenser Log which was posted on the wall to the left of the 3-compartment sink had not been filled out since 6/4/24 at 7:30 a.m. On 7/8/24 at 11:55 a.m., when the dietary manager arrived, she was made aware of the above findings. The dietary manager confirmed that the green buckets are used for soapy water to clean food prep area and then a red bucket is used to have sanitizer which is used to sanitize the food prep areas. The dietary manager was made aware that there were no red buckets nor any sanitizer available for use in the kitchen. Review of the facility policy titled, Ware Washing read in part, . It is the center policy that all dishware and service ware will be cleaned and sanitized after each use . 3. The dining services director is responsible for insuring appropriate completion of temperature and/or sanitizer concentration logs as appropriate . On 7/9/24 at 4:45 p.m., during an end of day meeting the facility administrator and director of nursing were made aware of the above findings. No further information was provided. 5. The facility staff failed to monitor and record the temperature of foods to ensure they were cooked to appropriate internal temperatures and failed to monitor and record the temperatures foods were held at, on the steam table, to ensure temperatures prevent the growth of food-borne illness causing bacteria. On 7/8/24 at approximately 11:30 a.m., during initial tour of the kitchen, the cook (OE10) had prepared the food for the lunch meal and had it on the steam table. OE10 was asked about temperatures and OE10 reported that he had already taken temperatures of the food. OE10 was asked where the record of food temperatures was located and OE10 went to the dietary managers office and started shuffling through papers and reported he could not find where he had written it. On 7/8/24 at approximately 11:45 a.m., the surveyor was provided a 3-ring binder that had food temperature logs. Review of this log revealed that food temperatures were recorded May 1-17, and June 2-June 6, 2024. Additionally temperatures were recorded for the breakfast meal on 6/7/24. There was no evidence of food temperatures cooked temperature or holding temperatures being monitored since 6/7/24. On 7/8/24 at approximately 12 noon, when the dietary manager arrived, she was made aware of the above findings and reported facility staff are to record food temperatures at every meal on the log. Review of the policy titled, Food: Preparation was conducted. This policy read in part, . 9. The cook(s) will prepare all cooked food items, in a fashion that permits rapid heating to appropriate minimum internal temperature. 10. Time/Temperature control for safety (TCS) hot food items will be heated according to the following guidelines: poultry and stuffed foods 165 degrees, ground meat 155 degrees, fish, and other meats 145 degrees for 15 seconds, . 11. The cook(s) ensure that all foods are held at appropriate temperatures, greater than 135 degrees (or as state regulation requires) for hot holding and less than 41 degrees for cold food holding. 12. Temperature for Time/Temperature Control for Safety (TCS) foods recorded at time of service, and monitored periodically during meal service periods as indicated . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/9/24 at 4:45 p.m., during an end of day meeting, the facility administrator was made aware of the above findings. No further information was provided. 6. The facility staff failed to ensure that dietary staff wore proper hair restraints while in the kitchen. On 7/8/24 at 11:05 a.m., upon the surveyor's entry to the kitchen, a dietary aide/other employee #11- OE11, was observed in the kitchen/food preparation area without a hair net on. OE11 was observed to walk to the back of the kitchen and obtained a hair net and put on. On 7/8/24 at approximately 12 noon, a nursing employee was observed to enter the kitchen and start to put juice into a pitcher from the juice machine and did not put on a hair net. The employee was advised by kitchen staff and then returned to the doorway to put on a hair net. On 7/8/24 at approximately 12:15 p.m., a dietary aide- other employee #13 (OE13) was observed to enter the kitchen through the back door and walk through the food service area without a hair net or beard guard. On 7/8/24 at 2:44 p.m., on a follow-up visit to the kitchen, two dietary staff (OE11 and OE13) were observed in the kitchen without any hair net on. During the above observation of OE11 and OE13, the dietary manager was asked about hair nets. The dietary manager was asked about hair restraints. The dietary manager stated that all staff are to put on hairnets before entering the kitchen. The dietary manager observed OE11 and OE13 and directed them to put on a hair nets. On 7/9/24, during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. 7. The facility staff failed to maintain the kitchen and kitchen equipment in a clean and sanitary manner. On 7/8/24 at approximately 11:15 a.m., during an initial tour of the kitchen the following was observed: Under the food steamer was a black pan approximately 8 inches deep that was filled with a liquid that had a grease film across the top. A dietary aide/other employee 11 (OE11), who was touring with the surveyor in the absence of the dietary manager, confirmed it was grease. OE11 stated that it is supposed to be dumped each day but could not answer why it had not been dumped from the previous day. There was a blender canister that was observed on the shelf beside the hand washing sink. The blender canister had a liquid in it, that was clear in color. When the cook, OE10 was asked about it and the contents, OE10 said, honey, I don't know. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was a metal 2 shelf cart beside a food prep table near the oven that had a hammer on the shelf that had left a brown, rust colored area of the claw hammer. There was significant debris on the cart, and it was observed that food service utensils/scoops and other food storage containers were stored on the cart. On 7/8/24 at 2:50 p.m., during a follow-up visit to the kitchen, observations revealed the pan of grease under the food steamer was still in place. The metal cart with the hammer, containing a rust stain and debris remained. Under the oven was a disposable fork. Under the 3-compartment sink was a copious amount of debris and dirt build-up that was black in color around the wall. The front of the oven had food spills down the front doors. On 7/9/24 at 4:20 p.m., during a return visit to the kitchen, the cart with the claw hammer was still present. The dietary manager was asked about it and shown the brown rust stain and she said maintenance must have left it there. She was asked about the cleaning of equipment and said her manager was going to get her a check list, but that equipment and floors are to be cleaned daily. When it was pointed out that the disposable fork under the oven had been observed yesterday and was still present, she confirmed the observation but made no comment. She was shown that under the 3 compartment sink it was significant debris build-up, and the oven had food spills down the front. The dietary manager said they are to clean the ovens every 2 months but are to wipe them down daily. A review was conducted of the facility policy titled, Equipment. This policy read in part, 1. The dining services director will ensure that all equipment is routinely cleaned and maintained in accordance with manufacturer directions and training materials. 2. The dining services director will ensure that all staff members are properly trained in the cleaning and maintenance of all equipment. 3. The dining services director ensure that all food contact equipment is cleaned and sanitized after every use. 4. The dining services director ensures that all non-foods contact equipment is clean . On 7/9/24 at 4:45 p.m., during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No further information was provided.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 provide a complete and accurate clinical record for one of twenty-six residents in the survey sample (Resident #77). The findings include: Resident #77's clinical record did not include recent hospice notes/documentation. Resident #77 (R77) was admitted to the facility with diagnoses that included adult failure to thrive, deep vein thrombosis, insomnia, severe protein-calorie malnutrition, major depressive disorder, cancer, and gastroesophageal reflux disease. The minimum data set (MDS) dated [DATE] assessed R77 with moderately impaired cognitive skills. R77's clinical record documented the resident had been receiving hospice care/services since 1/19/24. R77's clinical record documented no hospice notes or record of provided hospice services since mid-April 2024. On 7/10/24 at 8:35 a.m., the director of nursing (DON) was interviewed about R77's hospice notes. The DON stated hospice was required to provide notes after visits and notes were then uploaded to the clinical record by the medical records coordinator. The DON stated he was not sure why R77 had no hospice notes since April 2024. On 7/10/24 at 8:50 a.m., the medical records coordinator (other staff #3) was interviewed. The medical records coordinator stated hospice nurses and providers were supposed to leave their notes in a binder located on the unit. The medical records coordinator stated that she was not made aware of when the notes were placed in the binder and that at times the notes were not provided timely by hospice. The medical records coordinator reviewed R77's record and stated hospice notes had not been updated since mid-April (2024). The medical records coordinator stated the system to upload hospice notes was not clear and there were times when hospice provided a stack of notes at one time instead of providing after each visit. The medical records coordinator obtained the most recent hospice notes prior to the end of the survey. There were nineteen notes by hospice nurses, social workers and a spiritual counselor dated from 4/15/24 through 6/21/24, that were missing from R77's clinical record. This finding was reviewed with the administrator, DON and regional nurse consultant during a meeting on 7/10/24 at 12:25 p.m. with no further information provided prior to the end of the survey.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49456 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to follow infection control practices for one of 26 residents. The findings include: For Resident #84 (R84), who was on enhanced barrier precautions, the facility staff failed to wear PPE (personal protective equipment) while providing direct care. According to the clinical record, R84 was admitted to the facility on [DATE]. Diagnoses for R84 included but are not limited to pressure ulcer of sacral region - Stage 3, pressure ulcer of the right buttocks - Stage 3, and cutaneous abscess of back. R84's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 6/18/24 coded R84 with no cognitive impairment with daily decision making. On 7/9/24 at 8:15 a.m. a tour of unit one was conducted. During the tour, R84 observed residing in the A bed, which was closest to the door. The room had a sign outside the room, above the resident's name that indicated enhanced barrier precautions were in place and that facility staff were to wear PPE when providing direct resident care, such as bathing, dressing, wound care, etc. Observations were made of two certified nursing assistants, CNA#3 (CNA3) and CNA#1 (CNA1) in R84's room, providing direct care without following the enhanced barrier precautions. CNA1 and CNA3 assisted R84 with bathing, dressing, transferring from the bed to the wheelchair, and changing the bed linen, but were not wearing the required PPE. On 07/09/24 at 08:21 a.m. an interview was conducted with CNA3. CNA3 said that if the sign is above the name, it's for the A- bed resident and if below the names, it is for B- bed resident. CNA3 said that wearing the protective clothing depends on the color of the sign and stated, I don't know if I need to wear the protective gown when taking care of the patient. I haven't been here that long, and I always wondered that myself. On 07/09/24 at 08:34 a.m. a interview was conducted with CNA4. When asked about the signage, CNA4 said, We don't know which patient the sign is for so when we enter, we just put on gown and gloves when we go into the room. It is mainly for catheters but neither of these residents have catheters. So I don't know why the sign is up but we keep carts on all the units with the PPE. On 07/09/24 at 08:39 a.m. an interview was conducted with licensed practical nurse, LPN#5 (LPN5). LPN5 stated, Enhanced barrier precautions was on the care plan and we give report to the CNA's. When the aides are giving direct contact, they have to wear gloves and gowns but non direct care they don't have to gown up. On 07/09/24 at 09:11 a.m. an interview with CNA1 was conducted. When asked about the signage, CNA1 said that if the sign is above the room names it is for A- bed resident and if below the names it is for the B-bed resident. CNA1 stated, I would wear my PPE for direct care and take it off and place in the red can prior to leaving room. The PPE is on the cart in the hallway on each unit. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/09/24 at 11:02 a.m. CNA4 approached the surveyor and stated that she went and checked on how to know who is on enhanced precautions and said, The sign is by the name of the one on it, and top is A- bed and bottom is B- bed. On 7/9/24 at 4:30 p.m. an end of day meeting was held with the administrator, director of nursing, and regional nurse consultant to discuss the above concerns. On 7/10/24, a clinical record review was conducted. R84 was noted to have a care plan dated 7/8/24 which documented enhanced barrier precautions to be followed by all staff. The clinical record also revealed that R84 has a physician's order dated 6/28/24 for enhanced barrier precautions, which remained on active order at the time of the survey. On 7/10/24, observations conducted during morning care noted that CNA1 and CNA3 were again providing direct care to R84, without wearing any PPE. The Director of Nursing was present, confirmed the observation, and asked the staff to step out of the room for him to speak to them. On 7/10/24, a facility document was reviewed. The facility document titled, Enhanced Barrier Precautions (EBP's), read in part, .EBP's require the use of gown and gloves by staff during high-contact patient care activities as defined below: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy, etc.) and wound care for chronic wounds. The Centers for Disease Control and Prevention has guidance titled, Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), which reads in part, .Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing [11-15]. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs [3,5,6]. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization . On 7/10/24 at 1:30 p.m. an exit conference was conducted with the administrator, director of nursing and. regional nurse consultant. No more information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495178	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlottesville Health & Rehabilitation Center	505 West Rio Road Charlottesville, VA 22901

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41449 Based on staff interview and facility documentation review the facility staff failed to ensure CNA's (certified nursing assistant) received 12 hours of in-service training per year for one CNA (CNA #8), in a survey sample of two CNA's reviewed. The findings included: For CNA #8, the facility staff failed to ensure that a minimum of 12 hours of in-service training per year was provided. On 7/9/24, a sample of two CNA's was selected for review of annual education. CNA #8, who was hired 8/30/22, was selected for review. The facility administrator was asked to provide all of CNA #8's training from 8/30/22-8/30/23, for review. Review of the Relias Official Transcript provided, revealed CNA #8 only had 4.75 hours of training during the timeframe reviewed, none of which included dementia management or care of the cognitively impaired. Also provided was the transcript for CNA #8 for 2024, which included 1.5 hours of training, which consisted of: HIPAA (privacy and confidentiality), Infection Control and Bloodborne Pathogens. According to the facility assessment, in part 2 titled, Services and Care/Offered Based on Resident Needs, it indicated that the facility provides .care of someone with cognitive impairment . In section 3 of the facility assessment section 3.4 read, Staff training/education and competencies . Required in-service training for nurse aides. In-service training must: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. Include dementia management training and resident abuse prevention training . For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired . Review Relias Annual Calendar for a list of all staff training . On 7/10/24 at 8:10 a.m., the above findings were reviewed with the facility administrator and corporate nurse consultant. No additional information was provided.