STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495318	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berry Hill Nursing Home	621 Berry Hill Road South Boston, VA 24592

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 41449 Based on staff interview and facility documentation review, the facility staff failed to implement the abuse policy with regards to the pre-screening of employees for 15 employees in a survey sample of 25 employee records reviewed. The findings included: For fifteen employees, the facility staff failed to obtain a sworn statement, criminal background within 30 days of employment and conduct verification with the board of nursing for nursing staff prior to allowing staff to work. On 8/21/24, a sample of twenty-five employees who had been hired within the last two years was identified and their employee files were requested. On 8/21/24, a review of the employee files was conducted and revealed the following. Three employees, a licensed practical nurse (LPN #4) and two certified nursing assistants (CNA #2 and CNA #7) did not have signed sworn statements on file. LPN #4 had no sworn statement in the file and CNA #2 and #7 had a sworn statement that was not signed by the employees. One employee, who was a licensed practical nurse (LPN #4), was hired 6/23/23. The criminal background check from the Virginia State Police was not requested by the facility until 11/13/23. Eleven employees who were nursing department employees, did not have their professional nursing license or certification verified until after the survey had commenced on 8/20/24. Therefore, the facility did not know if the staff had active and unencumbered licenses to practice or if they had any adverse actions reported against their license. They included registered nurses (RN #3 and RN #4), a licensed practical nurse (LPN #5), and certified nursing assistants (CNA #1, CNA #2, CNA #3, CNA #4, CNA #5, CNA #6, CNA #8, and CNA #9). Two of the nursing department employees did not have their professional license verified until after then had been permitted to work with residents. CNA #12 was hired 3/8/23, and her nurse aide certification was not checked until 2/19/24, and CNA #10 was hired 9/12/23, and her certification was not verified with the board of nursing until 11/13/23, to see if they had an active and unencumbered certification to practice as a certified nursing assistant. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/21/24 at 4:07 p.m., an interview was conducted with the payroll/human resources manager (HRM). The HRM stated that upon hire she is responsible for verifying the applicant/employee's professional license. When the surveyor asked about so many of the employees' license having been verified the day before or that day, the HRM said, we don't have an SDC [staff development coordinator] person and I don't know where they kept their information at. When asked if this information should have been part of the employees file, the HRM said yes. During the above interview the HRM further stated that the sworn statements are to be completed at the time the employee completes their application for employment and the criminal background check is to be obtained within 30 days of hire. The HRM confirmed that each of these items are done for the safety of the residents and a way to verify who they have working with residents. A review was conducted of the facility's policy titled, Abuse, Neglect, or Misappropriation of Resident Property Policy. This policy read in part, .The facility will do whatever is in its control to prevent mistreatment, neglect, exploitation, and abuse of our residents or misappropriation of their property . The facility will not employ individuals that have been found guilty of abusing, neglecting, exploiting, or mistreating residents by a court of law or who have had a finding entered into the state's Nurse Aide Registry concerning abuse, neglect, or misappropriation of their property . Screening of Employees: Potential employees (including contracted, temporary agency, and volunteers) will be screened by the facility for abuse, neglect, exploitation, or misappropriation of property. This screening process will include requesting of information from previous and/or current employers and checking with the appropriate licensing boards and/or registries . On 8/21/24 at 4:30 p.m., during an end of day meeting with the facility administrator, the above findings were discussed. On 8/22/24 at 10:01 a.m., the facility administrator stopped the surveyor in the hallway and provided a document that was titled, pre hire action with regards to LPN #4. The administrator pointed out on the second page a comment that was dated 6/20/23 at 2:56 p.m., that read, This person has passed all our background checks. When asked if he had evidence that the check was conducted with the Virginia State Police, he did not answer. On 8/22/24 at 10:30 a.m., an interview was conducted with the facility administrator. When asked what the purpose of the sworn statement and criminal background checks are for, the administrator said, so I don't have an employee who could be barred from employment due to a barrier crime working. When asked about the purpose of verifying the employee's license or certification with the board of nursing was for, the administrator said to ensure that staff hold an active license without any adverse actions for the position they are being hired for. No additional information was provided.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to complete an accurate minimum data set (MDS) for three of twenty-one residents in the survey sample (Residents #3, #5 and #21). The findings include: 1. Section L. of Resident #3's significant change MDS dated [DATE] did not accurately reflect the resident's oral/dental status. Resident #3 (R3) was admitted to the facility with diagnoses that included atrial fibrillation, gastroesophageal reflux disease, diabetes, osteoporosis, psychosis with delusions, depression and dementia. The MDS dated [DATE] assessed R3 with moderately impaired cognitive skills. On 8/20/24 at 2:30 p.m., R3 was observed. During conversation with R3, the resident's lower, front teeth were observed missing. The lower, front teeth were broken and/or decayed at the gum with the dark/black tooth fragments visible. R3's clinical record documented a denture consultation dated 5/14/24. This consultation documented R3 had dental caries, residual teeth roots and large dental [NAME] (bony growths). R3's significant change MDS dated [DATE] documented the resident with no oral/dental concerns. Items under section L. indicated the resident had no tooth fragments, no broken natural teeth and no teeth with likely decay. There was no indication on this MDS of an inability to exam R3's oral/dental status. On 8/21/24 at 1:51 p.m., the registered nurse MDS coordinator (RN #1) was interviewed about the accuracy of R3's dental MDS. RN #1 stated it was not obvious to her that R3 had broken, missing or decayed teeth. RN #1 stated she did not think that R3 had any of the items in section L. On 8/21/24 at 3:24 p.m., RN #2 caring for R3 was interviewed about the resident's teeth. RN #2 stated the resident had an appointment with an oral surgeon for teeth removal in preparation for dentures. RN #2 stated the resident's front, lower teeth were missing and looked decayed. 2. Section L. of Resident #5's annual MDS dated [DATE] did not accurately reflect the resident's oral/dental status. Resident #5 (R5) was admitted to the facility with diagnoses that included multiple sclerosis, hypertension, diabetes, depression, osteopenia, neurogenic bladder and cognitive communication deficit. The MDS dated [DATE] assessed R5 as cognitively intact. On 8/20/24 at 2:22 p.m., R5 was interviewed about quality of life/care in the facility. R5 was observed during this interview with multiple missing teeth. The resident's visible teeth had broken, uneven edges and dark areas of likely decay. When asked about dental problems, R5 stated she was missing most of her teeth and the teeth she had were not in good condition. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's plan of care (initiated 4/6/23) documented the resident had poor oral/dental health due to poor dentition related to aging and multiple comorbidities. R5's annual MDS dated [DATE] documented the resident with no oral/dental concerns. Items under section L. indicated the resident had no broken natural teeth and no teeth with likely decay. There was no indication on this MDS of an inability to exam R5's oral/dental status. On 8/21/24 at 1:50 p.m., the registered nurse MDS coordinator (RN #1) was interviewed about the accuracy of R5's dental MDS. RN #1 stated R5 was missing most of her teeth with only a few, sparse teeth intact. RN #1 stated she was not sure if the resident's remaining teeth were likely decayed. 3. Section L. of Resident #21's annual MDS dated [DATE] did not accurately reflect the resident's oral/dental status. Resident #21 (R21) was admitted to the facility with diagnoses that included psychosis, mood disorder, anxiety, depression, stroke, vascular dementia, colitis, aphasia, dysphagia, chronic obstructive pulmonary disease, and heart failure. The MDS dated [DATE] assessed R21 with moderately impaired cognitive skills. On 8/21/24 at 1:21 p.m., R21 was observed. R21's top, front teeth were missing and the resident had several visible teeth with dark, likely decayed areas. R21's clinical record documented an oral surgeon consultation on 4/25/23. This assessment listed the resident had cavities, mobile teeth and needed multiple teeth extractions prior to proceeding with a dental plan. R21's plan of care (initiated 12/5/22, revised 9/14/23) documented the resident had oral/dental problems and needed extractions. R21's annual MDS dated [DATE] documented the resident with no oral/dental concerns. Items under section L. documented the resident had no broken natural teeth, no loose teeth and no teeth with likely decay. There was no indication on this MDS of an inability to exam R5's oral/dental status. On 8/21/24 at 1:55 p.m., the registered nurse MDS coordinator (RN #1) was interviewed about the accuracy of R21's dental MDS assessment. RN #1 stated R21 was missing teeth but she did not see any broken teeth at the time of the assessment. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (October 2023) documents on page L-1 concerning oral/dental status, This item is intended to record any dental problems present in the 7-day look-back period. Page L-2 of this manual documents in steps for assessment, .Conduct exam of the resident's lips and oral cavity with dentures or partials removed .Visually observe and feel all oral surfaces including lips, gums, tongue, palate, mouth floor, and cheek lining .The assessor should use their gloved fingers to adequately feel for masses or loose teeth .Check L0200D, obvious or likely cavity or broken natural teeth: if any cavity or broken tooth is seen . (1) These findings were reviewed with the administrator and nurse consultant during a meeting on 8/21/24 at 4:30 p.m. with no further information presented prior to the end of the survey. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18.11, Centers for Medicare & Medicaid Services, Revised October 2023.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 49456 Based on staff interviews and clinical record reviews, the facility staff failed to complete the pre-admission screening and resident review (PASARR) for three out of 21 residents in the survey, Resident #17 (R17), Resident #21 (R21) and Resident #46 (R46). The findings included: 1. The facility staff failed to complete a PASARR on R46, who had a diagnosis of schizoaffective disorder and anxiety disorder. On 8/20/24 at 3:00 p.m. a clinical record review was conducted of R46's chart. There was no evidence of a PASARR being completed prior to R46's admission on 7/28/21. On 8/21/24 at 9:00 a.m. an interview was conducted with the social worker. She reviewed R46's chart and stated, he doesn't have one in his chart. On 8/21/24 at 11:09 a.m. the social worker presented a PASARR for R46 that was completed on 8/21/24. The social worker was interviewed and stated, I filled out one today because the resident did not have one from admission on 7/28/21. On 8/21/24 at approximately 4:10 p.m. an end of day meeting was held with the administrator and the nurse consultant to discuss the above concerns. No additional information was provided 21875 2. The facility failed to perform a PASARR (preadmission screening and resident review) for Resident #21. Resident #21 (R21) was admitted to the facility with diagnoses that included psychosis, mood disorder, anxiety, depression, stroke, vascular dementia, colitis, aphasia, dysphagia, chronic obstructive pulmonary disease, and heart failure. Review of R21's clinical record revealed no evidence that a PASARR screening was completed prior to or after admission to the facility. R21 was routinely evaluated and treated by psychiatry for mental health disorders and related behaviors. On 8/21/24 at 11:46 a.m., the social worker (other staff #1) was interviewed about a PASARR for R21. The social worker reviewed R21's clinical record and stated, He [R21] does not have one. The social worker stated R21 was admitted prior to her employment at the facility. The social worker stated prior to her employment, she was not sure who was completing or performing the PASARR screenings. This finding was reviewed with the administrator and nurse consultant during a meeting on 8/21/24 at 4:30 p. m. with no further information presented prior to the end of the survey. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28106 3. Resident #17 (R17) did not have a PASARR level 1 completed upon admission. Diagnoses for R17 included; Schizoaffective disorder, depression, and dementia. The most current MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 7/26/2024. R17 was assessed with a cognitive score of 10 indicating moderately cognitively intact. R17 was triggered for 'No PASARR level II with a diagnosis' on the LTCSP. Review of Section A1510. titled Preadmission Screening and Resident Review (PASARR). of the current MDS was blank. On 8/20/24 R17's clinical records were reviewed. R17 had an active diagnosis of depression, schizoaffective disorder, and dementia and was receiving medication for the diagnoses. Resident #17's clinical record did not evidence documentation that a level 1 PASRR had been completed. On 8/20/24 at 3:17 p.m. the social worker (Other staff, OS #1) was interviewed regarding a PASARR for R17. OS #1 reviewed the clinical record and the PASARR log book and did not find a PASARR for R17. OS #1 said, normally when a resident is admitted she will do the PASARR and place it in the log book and her or the business manager would scan into the clinical record. OS #1 verbalized not being employed at the facility when R17 was admitted but would look into the concern and see if the PASARR may have been misplaced. On 8/21/24 at 11:09 a.m. OS #1 presented a completed PASARR with the completion date of 8/21/24. When asked about the completion date, OS #1 verbalized she had completed the form today because the form had not been completed when R17 was admitted . On 8/21/24 at 4:30 p.m. the above finding was presented to the administrator and nurse consultant. The facility presented a PASARR policy that read in part '[.] A PASRR must be completed for all new residents prior to Admission. Residents should be admitted with an assigned PASSR Number that indicates the Level 1 Screening was completed. If the screening identifies a disability then the individual is referred for a Level 11 evaluation. No other information was presented prior to exit conference on 8/22/24.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 28106 Based on observation, staff interview and clinical record review, the facility failed to develop a care plan for one of twenty one residents. Resident #39 (R39) did not have a care plan developed for oxygen therapy. The Findings Include: Diagnoses for R39 included; Congestive heart failure, and shortness of breath. The most current MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 7/30/2024. R39 was assessed with a cognitive score of 6 indicating moderately cognitively intact. On 8/20/24 at 11:37 a.m. R39 was observed using oxygen at 2 liters per minute (LPM). R 39 was unable to verbalized the reason for the oxygen. R39's clinical record was reviewed, an order for oxygen continuously at 2 LPM was documented but did not indicate a start date. R39's care plan was then reviewed and did not evidence a care plan for oxygen therapy. On 8/21/24 at 11:48 a.m. registered nurse (RN #1, MDS coordinator) was interviewed regarding a missing care plan for oxygen. RN #1 said she would review the clinical record and find out. On 8/21/24 at 1:30 p.m. RN #1 verbalized the order originated on 11/13/23 when R39 had a diagnoses of COVID and also has congestive heart failure along with shortness of breath. RN #1 verbalized a care plan should have been developed at that time but was overlooked. On 8/21/24 at 4:30 p.m. the above finding was presented to the administrator and nurse consultant. No other information was presented prior to exit conference on 8/22/24.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on staff interview, clinical record review and facility documentation review, the facility staff failed to review and revise the care plan for two residents (Resident #35- R35, and Resident #61-R61) in a survey sample of 21 residents. The findings included: 1. For R35, the facility staff failed to review and revise the care plan to reflect a fall and significant weight changes the resident had experienced. On [DATE]-[DATE], a clinical record review was conducted of R35's chart. According to the weight records, on [DATE], the resident weighed 124.3 pounds. On [DATE], a weight of 116.5 was recorded and on [DATE] a weight of 110 pounds was noted. Then on [DATE] R35 was noted to weigh 120.2 pounds and on [DATE], R35 weighed 113 pounds. R35 had several instances of significant weight loss. According to R35's nutritional care plan which was initiated on [DATE], the goal had a revision date of [DATE]. The focus area read, State of nourishment; less than body requirement characterized by weight loss, inadequate intake, decreased appetite related to: Being on mechanically altered diet, Decreased Appetite, illness, Leaves 25% or more of food uneaten at most meals. The most recent revision to any of the interventions was performed on [DATE]. According to multiple progress notes written by the registered dietician (RD), R35's significant weight changes were noted. On [DATE], the RD noted, . has significant weight loss of 12.8% x 180 days ., on [DATE], the note read, . shows a 5% G [gain] this month ., then [DATE] the note indicated, -5.0% change over 30 days . The RD continued to make routine notes indicating the significant weight changes R35 was experiencing, but the care plan was not reviewed or revised to reflect such changes and the interventions being implemented. According to a nursing note dated [DATE], R35 had a fall. The note read, Called to residents' room by staff. Entered room to find resident laying on floor mat beside bed with both legs on the bed. Resident denies pain or discomfort at thit time. No injuries or markings noted from fall. Roommate stated resident slid from bed on to floor. VS: 98.3, 20, 78, ,d+[DATE], O2 98% on RA. Resident assisted back to bed and positioned by staff. ROM within normal limits for resident. MD/RP made aware. Call bell and safety measures in place. According to R35's care plan, the focus area which was last revised on [DATE], read, .is at Risk for falls characterized by history of falls and multiple risk factors related to: impaired self-mobility, impaired cognition, CVA with Left hemiplegia. The goal for this focus area was revised on [DATE] and the most recent revision to the interventions to prevent falls was dated [DATE]. There was no indication within the care plan that R35's care plan was reviewed or revised following the fall on [DATE]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:08 p.m., an interview was conducted with the registered nurse (RN #1), who was the care plan coordinator. RN #1 accessed R35's care plan and noted the last revision date of [DATE], and said, it doesn't look like I updated since [DATE]. When asked about the process for updating care plans RN #1 said, usually I do them as we go, as they come up, we discuss them in our morning meetings and if there is a new fall I will update it with the preventative intervention we come up with. It is supposed to be updated on the floor but that doesn't always work. You are correct, I don't see anything for the 28th and I believe at that time I was out with gallbladder surgery and that may be why it was missed. Review of the facility policy titled, Interdisciplinary Teams, was conducted. This policy read in part, . The care plan team meets on a regular basis to develop and review the residents' care plans . On [DATE] at 4:30 p.m., during an end of day meeting, the facility administrator was made aware of the above concerns. No additional information was provided. 49456 2. The facility staff failed to revise R61's care plan when her code status changed from do not resuscitate (DNR) to a full code. On [DATE] at approximately 2:00 p.m. a clinical record review was performed. R61's care plan had her as a DNR. R61 had a physician's order in her chart dated [DATE] for DNR code status. On [DATE] there was a physician's order in the chart for being a full code status. There was no evidence of a DDNR (durable do not resuscitate) signed by R61 in the clinical record. On [DATE] at 9:00 a.m. an interview was conducted with R61 about her code status. R61 stated, I want to be a full code, I want CPR. On [DATE] at 10:03 a.m. an interview was conducted with LPN#6 (LPN6). LPN6 was asked how she would know a resident's code status and she stated, I go by the paper on the MAR [medication administration record] for the code status. It's at the front of every resident. On [DATE] at 10:05 an observation was made of the sheets in front of the residents MAR that had residents code status. R61's code status was a full code on the sheet. On [DATE] a clinical record review was performed. R61's code status on the care plan was DNR code status dated [DATE] with only one revision date in this section of the care plan of [DATE]. On [DATE] at approximately 4:10 p.m. an end of day meeting was held with the administrator and the nurse consultant to discuss the above concerns. On [DATE] at 8:55 a.m. an interview was conducted with a registered nurse, RN#1 (RN1). RN1 was the MDS (minimum data set) coordinator and stated, I don't know why this wasn't done, she was a DNR, and I didn't realize she changed code status. I will have to investigate this. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] a review of a facility policy was performed. A policy titled, Interdisciplinary Teams, read in part, . the care plan team meets on a regular basis to develop and review the residents care plans. No additional information was provided.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 21875 Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of care during medication administration on one of two units (unit two). The findings include: During a medication pass observation, the medication Breo Ellipta was administered with no prompt or instruction for the resident to rinse after administration as recommended by the manufacturer and per a physician's order. A medication pass observation was conducted on 8/21/24 at 8:05 a.m. with licensed practical nurse (LPN) #3 administering medications to Resident #20 (R20). Among the medications administered was Breo Ellipta 100 mcg - 25 mcg. LPN #3 activated the Breo Ellipta inhaler device and instructed Resident #20 to inhale the medication. After R20 inhaled the medication, the resident did not rinse her mouth. LPN #3 provided no prompt or instruction to the resident to rinse after the administration of the medication. R20's clinical record documented a physician's order dated 7/19/21 for Breo Ellipta inhaler 100-25 mcg (micrograms), inhale one puff daily for treatment of COPD (chronic obstructive pulmonary disease). The physician's order included instructions, Rinse mouth after use . On 8/21/24 at 9:00 a.m., registered nurse (RN #2) caring for R20 was interviewed about the Breo Ellipta administration observed with no rinsing. RN #2 stated nurses were supposed to ask and assist the resident to rinse/spit after the administration of inhaled medications like Breo Ellipta. On 8/21/24 at 9:45 a.m., the director of nursing (DON) was interviewed about the Breo Ellipta administration. The DON stated that mouth rinsing was required after the administration of Breo Ellipta. The DON stated nurses were expected to prompt and ensure residents rinsed after taking Breo Ellipta. The Breo Ellipta manufacturer's instruction/prescribing information sheet documented under warnings and precautions, .Candida albicans infection of the mouth and pharynx may occur .Advise the patient to rinse his/her mouth with water without swallowing after inhalation to help reduce the risk . The information sheet documented under instructions for administration, .After inhalation, the patient should rinse his/her mouth with water without swallowing to help reduce the risk of oropharyngeal candidiasis . This finding was reviewed with the administrator and nurse consultant during a meeting on 8/21/24 at 4:30 p. m. with no further information presented prior to the end of the survey.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berry Hill Nursing Home	621 Berry Hill Road South Boston, VA 24592

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to develop a discharge plan of care and recapitulation of the residents stay for one resident (resident #43- R43) in a survey sample of 3 discharged residents reviewed. The findings included: For R43, the facility staff failed to prepare a post-discharge plan of care with instructions and failed to prepare a discharge summary and recapitulation of stay that included the required information. On 8/21/24, a closed clinical record review was performed of R43's chart. This review revealed that R43 discharged from the facility on 8/10/24. According to a nursing progress note written on 8/10/24 at 1:09 p.m., it read, Writer went over medication list and upcoming appointments with RR [resident representative]. No distress noted upon discharge. Treatment to leg was done before resident discharged from the facility. According to a nursing progress note dated 8/2/24, regarding the leg it read, . one open area to left lateral lower leg, cleansed with wound cleanser, padded dry, xeroform, 4x4 and kling applied to area On 8/21/24 at 2:00 p.m., an interview was conducted with the social worker (SW). The SW confirmed that she arranged for R43 to receive home health services upon discharge and arranged a follow-up medical appointment with the resident's doctor upon discharge. The SW stated that she initiated the Discharge Instructions and Plan of Care and noted the follow-up doctor appointment and home health agency information. The SW said she then gave the form to nursing for completion of the other areas. On 8/21/24 at 2:12 p.m., the SW provided the surveyor with a copy of the form where the resident's family member and the nurse signed upon R43's discharge on 8/10/24. The following areas were noted to be incomplete and blank, . 2. Medications released, 3. Treatments, 4. Diet, and 6. Other education needs . (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24, in the afternoon, an interview was conducted with the medical records employee (other employee #5- OE #5). OE #5 indicated in the misc. tab of the closed record was a discharge summary. The surveyor accessed this document, which was dated 8/10/24. It was titled, Discharge Summary and read as follows: discharge date : undefined 8/10/2024. discharged to: Home. Rehabilitation Potential: Good. Primary Diagnosis on admission: Resident has a history of HTN [hypertension], sacral fracture, chronic diastolic CHF [congestive heart failure], chronic hypoxic resp [respiratory] failure, chronic a fib [atrial fibrillation], h/o TAVR [history of Transcatheter aortic valve replacement] secondary to aortic stenosis, recurrent GI [gastrointestinal] blood loss anemia, CKD [chronic kidney disease] stage 3b, hypothyroidism, blindness in both eyes. Primary Diagnosis at time of discharge: same. Reason for discharge: completion of care. Recapitulation of stay: Other resident completed all required therapies and treatments. Resident stable for discharge. Review of systems: Constitutional: generalized weakness. All other systems negative. Vital Signs: [no information recorded]. Physical Exam: [made no mention of any wounds or treatments to the leg(s)], Medications: chart and medications reviewed, prescriptions written, Discharge Medication/Treatment list reviewed. Instructions: advised to f/u [follow up] with PCP [primary care physician] in 1-2 days and keep all f/u appointments. Discusses with: Patient; Responsible Party; Staff On 8/21/24, the medical records employee and social worker confirmed that no additional information was available with regards to a discharge summary or recapitulation of R43's stay. Review of the facility policy titled; Discharge Planning was reviewed. It read in part, Discharge Summary: When a resident's discharge is anticipated, the interdisciplinary team members will communicate the necessary information to the resident, continuing care provider, and other authorized persons at the time of an anticipated discharge. Method: The resident will have a discharge summary that includes, but is not limited to: A recapitulation of the resident's stay that includes diagnosis, court of illness/treatment or therapy, and pertinent lab, radiology, and consultation results, including any pending lab results; A final summary of the resident's status at the time of discharge that is available for release to authorized persons and agencies . that includes: identification and demographic information, customary routine, cognitive pattern, communication, vision, mood and behavior patterns, psychological well-being, physical functioning, and structural problems, continence, disease diagnosis and health conditions, dental and nutritional status, skin conditions, activity pursuit, medications, special treatments and procedures, discharge planning as evidenced by most recent discharge care plan, documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS [an assessment type], and documentation of participation in the assessment process . On 8/21/24 at 4:30 p.m., during an end of day meeting, the facility administrator and corporate nurse consultant were made aware of the above concerns and asked if they find any additional information with regards to a recapitulation of stay, discharge summary or discharge plan of care to provide it to the survey team. No additional information was provided prior to conclusion of the survey.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on resident interview, staff interview and clinical record review, the facility staff failed to implement a physician's order for one of twenty-one residents in the survey sample (Resident #5). The findings include: A physician's order for as needed Orajel topical gel was not added to Resident #5's medication administration record (MAR) so that nurses were aware to offer/administer the medicine if needed for tooth/gum pain. Resident #5 (R5) was admitted to the facility with diagnoses that included multiple sclerosis, hypertension, diabetes, depression, osteopenia, neurogenic bladder and cognitive communication deficit. The MDS dated [DATE] assessed R5 as cognitively intact. On 8/20/24 at 2:22 p.m., R5 was interviewed about quality care in the facility. During this interview, R5 stated she had a tooth on the lower, right side that hurt when she chewed or put pressure on it. R5 stated she was on pain medication and received Tylenol as needed for the sore tooth. R5's clinical record documented a physician's order dated 8/14/24 for Orajel every 2 hours as needed for tooth pain. R5's MAR for August 2024 was reviewed on 8/20/24 and revealed no entry or listing for the administration of Orajel. On 8/21/24 at 7:39 a.m., R5 was interviewed again about her tooth pain and if she had used the prescribed Orajel. R5 stated her tooth was not hurting this morning but she was not aware she had an order for Orajel. R5 stated she was not aware Orajel was available if needed for tooth/gum pain. On 8/21/24 at 1:40 p.m., licensed practical nurse (LPN #2) caring for R5 was interviewed about the Orajel order. LPN #2 stated the resident was on scheduled pain medication and was administered Tylenol as needed for pain. LPN #2 reviewed R5's MAR and stated she did not see an order for Orajel. LPN #2 stated she was not aware that Orajel was an option R5's tooth/gum pain. LPN #2 stated when medication orders were received, the nurse taking the order was supposed to send the order to pharmacy and add the medication to the MAR. On 8/21/24 at 3:04 p.m., the nurse consultant (administration #3) was interviewed about R5's Orajel order. The nurse consultant stated the nurse faxed the order to pharmacy but did not record the medication on the MAR. The nurse consultant stated the medication was received from pharmacy, was available in the cart but nursing failed to list the medicine on the MAR. This finding was reviewed with the administrator and nurse consultant during a meeting on 8/21/24 at 4:30 p. m. with no further information presented prior to the end of the survey.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 49456 Based on observations, staff interviews, resident interview and clinical record review the facility staff failed to provide a physician's ordered supplement for Resident #64 (R64), one resident out of 21 residents in the survey. The findings included: The facility staff failed to provide a nutritional supplement on R64's lunch meal tray. On 8/20/24 at 12:00 p.m. an observation was made of the lunchtime meal. R64's lunch tray was observed and there was no boost on the tray. On 8/20/24 at 12:05 an interview was conducted with R64. R64 stated, my daughter will bring me in some boost sometimes, but I don't get one on my trays here. On 8/21/24 at 11:40 a.m. an observation was made of R64's lunchtime meal. There was no nutritional supplement on R64's tray. R64 shook her head and stated, not one today either. On 8/21/24 at 11:45 an interview was conducted with CNA#5 (CNA5). CNA5 was in R64's room and verified that there was no nutritional supplement on the lunch tray. CNA5 stated, it should be on it every day and it is on the meal ticket. On 08/21/24 at 3:15 p.m. an interview with the dietary manager was conducted. The dietary manager verified she had the order for the supplement to be on the lunch tray and stated, don't know why the girl did not put the boost on the tray. This surveyor was going to interview the dietary aide that was working but the dietary manager said the aide was gone for the day. On 8/21/24 at approximately 3:30 p.m. a clinical record review was performed. R64 had a physician's order written on 8/14/24 for the nutritional supplement to be on the lunch tray and this was a recommendation from the registered dietician. On 8/21/24 a facility document was provided titled, Dietetic Services Policy, it read in part, .importance of providing a hygienic dietetic service that meets the food and nutritional needs of the residents in accordance with the attending physician's orders. On 8/21/24 a facility document was provided titled, Bulk nourishments/supplements, read in part, .high calorie, high protein supplemental oral feeding can be provided for residents experiencing weight loss. Order should indicate name of product, ounces or cc's ordered and number of times a day. Residents receiving supplement will have a physician's order. On 8/21/24 at approximately 4:10 p.m. an end of day meeting was held with the administrator and the nurse consultant to discuss the above concerns. No additional information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 28106 Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to accurately label three medications out of 41 opportunities during the medication pass and pour observations. 1. The medication Provera administered to Resident #11 (R11) during a medication pass observation was not labeled with a dosage. 2. Phenytoin sodium extended release 100 mg administered to Resident #8 (R8), and Atenolol/Chlorthalidone 50-25 mg administered to Resident #20 (R20) were not labeled with a dosage and had incomplete medication name. The findings include: 1. The medication Provera administered to Resident #11 (R11) during a medication pass observation was not labeled with a dosage. A medication pass observation was conducted on 8/21/24 at 7:58 a.m., with licensed practical nurse (LPN #1) administering medications to Resident #11. Among the medications administered was Provera. Observation of the multi-medication pill pack did not evidence a dosage for the Provera. LPN #1 also reviewed the pill packet and agreed there was no indication of the dosage and verbalized that the order is for 10 milligrams (MG) of Provera. The medication (Provera) was then verified with the physicians order documenting Provera 10 mg tab daily. Future daily doses of Provera was also reviewed and also did not indicate the dosage on the packaging. On 8/21/24 at 9:16 a.m. an interview with a pharmacist (other staff, OS #2) via phone was conducted. After explaining the concern, OS #2 verbalized that he was also a supervisor and would look into the concern and call back. On 8/21/24 at 9:48 a.m. the director of nursing (DON) was made aware of the concern. The DON said she was going to remove all of the medication in question and reach out to the pharmacy. On 8/21/24 at 9:55 a.m. OS #2 called and verified the dosage should be on the label and had been cut off (missing from the packaging), and that the software company that creates the labels would have to be notified in order to fix the problem. On 8/21/24 at 4:30 p.m. the above information was presented to the administrator and nurse consultant. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No other information was provided prior to exit conference on 8/22/24. 21875 2. A medication pass observation was conducted on 8/21/24 at 8:05 a.m., with licensed practical nurse (LPN) #3 administering medications to Resident #20 (R20). A medication administered to R20 was from a sealed pharmacy pouch labeled atenolol/chlorthalido. There was no dosage listed on the pharmacy label for this medication. R20's clinical record documented a physician's order dated 7/19/21 for Tenoretic (atenolol/chlorthalidone) 50-25 milligrams with instructions to take once daily for hypertension. A medication pass observation was conducted on 8/21/24 at 8:19 a.m., with LPN #3 administering medications to Resident #8 (R8). A medication was administered to R8 from a sealed pharmacy pouch labeled, Phenytoin Sodium Exten. There was no dosage printed on the label for this medication. R8's clinical record documented a physician's order dated 7/9/24 for Dilantin (phenytoin) extended release 100 mg with instructions to take one capsule twice per day for seizures. On 8/21/24 at 8:30 a.m., LPN #3 that administered the medications with no dose labeling was interviewed. LPN #3 stated she had not noticed the missing dose information on the above medication labels. LPN #3 stated she assumed the medication dose was correct since it came from the pharmacy. On 8/21/24 at 9:00 a.m., the registered nurse (RN #2) caring for R8 and R20 was interviewed. RN #2 reviewed medications supplied in the cart for R8 and R20 and stated the labels for the two medications questioned did not have a dose listed on the label. RN #2 stated she was not aware the pharmacy labels for the phenytoin and Tenoretic did not include a dose and the labels looked like the printing was incomplete. On 8/21/24 at 9:54 a.m., the facility's consultant pharmacy supervisor (other staff #2) was interviewed about the pharmacy labels printed with no dosage. After reviewing, the pharmacy supervisor stated the dose for medicines should be printed on the label along with the complete medication name. The pharmacy supervisor stated the label printing was a software issue and needed to be adjusted so that complete prescribing information was printed on the labels. The facility's policy titled Medication Administration (undated) documented regarding medication labeling guidelines, .All prescription medications and all non-prescription medications not in the original manufacturer's package shall be dispensed in an approved container. Each container shall have at least the following information contained on the label .trade and/or generic name of the medication .directions for use . First and last name of the resident .date of dispensing .Strength/concentration of the medication . This finding was reviewed with the administrator and nurse consultant during a meeting on 8/21/24 at 4:30 p. m. with no further information presented prior to the end of the survey.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to provide dental services for two of twenty-one residents in the survey sample (Residents #5 and #21). The findings include: 1. Resident #5, with a physician's order for dental services, had not been referred or seen by a dentist. Resident #5 (R5) was admitted to the facility with diagnoses that included multiple sclerosis, hypertension, diabetes, depression, osteopenia, neurogenic bladder and cognitive communication deficit. The MDS dated [DATE] assessed R5 as cognitively intact. On 8/20/24 at 2:22 p.m., R5 was interviewed about quality of care in the facility. R5 was observed at this time with multiple missing teeth and visible teeth with broken edges and dark areas. R5 stated she had a tooth on the lower, right side that hurt when she chewed or put pressure on it. R5 stated she had taken medication for the tooth but had not seen a dentist. R5's clinical record documented the resident was seen by the nurse practitioner (NP) on 4/12/24 and assessed with a right lower molar abscess. The NP prescribed the antibiotic Augmentin for 10 days for treatment of the infection. The NP documented on 4/12/24, .Refer to dentist if possible . Nursing notes dated 4/24/24 documented, .Writer has phoned multiple practices last week and this week to try to find a dentist that is taking new patients, that will also accept resident's insurance, and accommodate resident via stretcher. Writer has had no success finding a provider thus far .NP made aware. Writer plans to call back next month to try to get an appt. [appointment] for resident . R5's clinical record documented no provision of dental services for R5 following this attempt to schedule an appointment. R5 had ongoing assessments by the NP and nursing with no further dental issues noted until 8/9/24. A nursing note dated 8/9/24 documented the NP was notified that the resident complained of tooth pain. The NP ordered the antibiotic Augmentin 875-125 milligrams twice per day for 10 days in response to the tooth pain. The NP assessed R5 on 8/14/24 and entered an order stating, Please try [and] get her in to dentist to have abscessed tooth extracted . R5's clinical record revealed no evidence of dental referral or scheduled appointment in response to the 8/9/24 order. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 11:43 a.m., the social worker (other staff #1) was interviewed about dental services for R5. The social worker stated, As far as I know, we were unable to find a dentist that will take her [R5]. The social worker stated the resident required a stretcher during transport and the facility had been unable to locate a dentist that accommodated the stretcher. The social worker stated they currently had no dentist that provided services in-house. The social worker stated there were dentists available that accepted Medicaid, but the stretcher created a problem. On 8/21/24 at 2:18 p.m., the administrator was interviewed about dental services for R5. The administrator stated, We've struggled getting anyone to help. The administrator stated they got a contract approved for a provider to come to the facility and then the provider stated they had no dentist in the area to provide services. The administrator stated there were local Medicaid providers, but they were unable to manage stretcher-bound residents. The administrator stated, We've been trying to get appointments and have been unsuccessful. On 8/21/24 at 2:41 p.m., the NP (other staff #4) that assessed/treated R5 was interviewed about dental care. The NP stated she treated R5 earlier in the year (April 2024) for an infection of the right, lower molar. The NP stated the infection cleared with the antibiotics and there had been no further issues until recently. The NP stated the resident was ordered the dental referral because she likely had an abscessed tooth. The NP stated she had successfully managed the infection and pain with medication but that the tooth most likely needed extraction to resolve the issue long-term. The NP stated she was aware there had been difficulty finding dental providers but again stated the resident needed to see a dentist for resolution of the tooth issue. R5's plan of care (revised 1/9/24) documented the resident had oral/dental health problems due to aging and multiple comorbidities. Interventions to prevent infection and maintain oral/dental health included, Follow therapeutic regime for resolution of infection .Observe for and notify physician of s/sx [signs/symptoms] or oral/dental problems needing attention . This finding was reviewed with the administrator and nurse consultant during a meeting on 8/21/24 at 4:30 p. m. with no further information presented prior to the end of the survey. 2. Resident #21 (R21) had no dental care for extractions as recommended by an oral surgeon consultant. Resident #21 (R21) was admitted to the facility with diagnoses that included psychosis, mood disorder, anxiety, depression, stroke, vascular dementia, colitis, aphasia, dysphagia, chronic obstructive pulmonary disease, and heart failure. The MDS dated [DATE] assessed R21 with moderately impaired cognitive skills. R21's clinical record documented an oral surgery consultation dated 4/24/23 regarding cavities and mobile teeth. The oral surgery consultation report dated 4/24/23 documented, carious and mobile teeth, however no signs of acute infection. Patient will need to be seen for evaluation by general dentist to come up with restorative plan prior to us extracting any necessary teeth .Please have patient evaluated by general dentist to come up with treatment plan .Our surgical treatment plan include: Extraction of multiple teeth in an or [operating room] setting . R21's clinical record documented no general dentist services provided in response to the consultation. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 11:51 a.m., the social worker (other staff #1) was interviewed about any dental referral or services for R21 following the oral surgery consultation. The social worker stated she was not aware the R21 needed to see a dentist or had been recommended to see a dentist. The social worker stated R21 transported in a wheelchair and that if needed, staff could accompany the resident to appointments and assist with transfer to a dental chair. The social worker stated nobody had asked her about getting a dental appointment for R21. On 8/21/24 at 2:18 p.m., the administrator was interviewed about dental services. The administrator stated, We've struggled getting anyone to help. The administrator stated they got a contract approved for a provider to come to the facility and then the provider stated they had no dentist in the area to provide services. The administrator stated, We've been trying to get appointments and have been unsuccessful. On 8/21/24 at 2:44 p.m., the nurse practitioner (NP - other staff #4) that assessed/treated R21 was interviewed his dental care. The NP stated she recalled R21 being referred to an oral surgeon or dentist. The NP stated she was aware there had been difficulty with getting dental providers. The NP stated R21 had been treated in the past with antibiotics for a tooth infection and the issue was resolved with antibiotic treatment. The NP stated R21 needed to be seen by a dentist, either in-house or by an outside provider to resolve and address ongoing dental problems. R21's plan of care (revised 3/20/24) documented the resident had poor oral/dental health and had a consultation on 4/24/23 with plans for future extractions. Interventions to maintain oral/dental health included, Coordinate arrangements for dental care as needed . This finding was reviewed with the administrator and nurse consultant during a meeting on 8/21/24 at 4:30 p. m. with no further information presented prior to the end 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 physician ordered therapeutic diet for one resident (Resident #35-R35) in a survey sample of 21 residents. The findings included: For R35, who had experienced significant weight loss, the physician ordered the resident to receive double portions at meals, which were not provided as ordered. On 8/20/24-8/21/24, a clinical record review was conducted of R35's chart. This review revealed that R35 had an active physician order that read, Regular diet, Pureed texture, Honey consistency double portions, EMP [enriched meal program]. A review of R35's weights was conducted and noted that on 7/3/24 R35 weighed 120.2 pounds. On 8/14/24, R35 weighed 113 pounds, which was a 7.2-pound weight loss in one month. According to R35's care plan with a revision date of 5/24/24, a focus area read, State of nourishment; less than body requirement characterized by weight loss . One of the associated interventions for this care plan focus area read, Diet is regular double portions pureed with honey thick liquids. According to a progress note written by the registered dietician dated 8/20/24, it read in part, Resident noted with weight loss 5% x 30d. Diet: Pureed, EMP, HTL [honey thick liquids] with 2x portions. All food in bowls - intake ~75-100% . On 8/21/24 at 11:29 AM, R35 was observed in the dining room being fed by certified nursing assistant #1 (CNA #1). R35's food was in bowls and the bowls were observed to be half full. The tablemate, another resident at the same table also had foods in bowls which were also half full. CNA #1 was asked about R35's portion sizes. CNA #1 looked at the meal ticket and confirmed that R35 was supposed to have double portions. CNA #1 agreed that R35's portions did not appear to be double. Licensed practical nurse #1 (LPN #1) was called over to the table and confirmed that it did not appear that R35 had received double portions as ordered. On 8/21/24 at approximately 11:45 a.m., the surveyor requested that the dietary manager come to the dining room. The dietary manager was asked about R35's portion sizes and said for double portions the bowls should have been full. The surveyor accompanied the dietary manager to the kitchen and observed the tray line. Another resident was served foods in bowls and one scoop resulted in a half full bowl, which was the same that R35 had received. The dietary manager confirmed that R35 was to receive two scoops of all food items. (continued on next page)

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	495318	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berry Hill Nursing Home	621 Berry Hill Road South Boston, VA 24592

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled; Therapeutic Program was reviewed. The policy read in part, The consulting dietitian advises on the planning, preparation, and serving of diets as prescribed by the resident's attending physicians. No diets will be changed without a written order from the attending physician . The policy titled; Menu Policy was reviewed. The menu policy read in part, . Other specific diets will be adjusted and indicated on the individual tray card as ordered utilizing an approved diet manual . On 8/21/24, during an end of day meeting held at 4:30 p.m., the facility administrator and corporate nurse consultant 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 food in accordance with professional standards for food service safety in the main kitchen and the nourishment refrigerators on two of two nursing units. The findings included: 1. In the main kitchen, the facility staff failed to store food in a manner to prevent contamination and to label items to indicate when they were opened and when they were to be used by. On 8/20/24 at 10:40 a.m., observations were conducted in the main kitchen with the dietary manager accompanying the surveyor. In the dry storage area, there was a bag of graham cracker crumbs that the bag was folded over and secured with a binder clip, used to secure a stack of papers. There was no date to indicate when they were opened or when they were to be used by. The dietary manager stated that she expects all items to be secured and closed properly, labeled when opened and when to be used by for safety reasons and to keep items fresh. In the stand-alone freezer there was a bag of breaded patties that the dietary manager identified as crab cakes. The bag was twisted at the top but not secured and had no date to indicate when it was opened. There was a bag of chicken tenders that had no date and a bag of french fries that were open, not closed or secured and had no date of when it was opened. In the stand alone cooler there was a container covered with aluminum foil that was labeled as chicken noodle soup. The foil was torn and had an open area approximately one and a half inches long which left the food open to air and contaminates. There was an item that was covered with aluminum foil that was not labeled with the contents, date prepared or date to be used by. The cook identified the item as boiled eggs. In the walk-in cooler there was a metal tray rack that had cherry cheesecakes that were covered in parchment paper. There was no date to indicate when they were prepared or to be used by. The dietary manager stated they had just made them, and they were for the next day's supper. In the walk-in freezer a bag of meatballs that was twisted at the top and not secured, was observed to not have a date they were opened. There was a bag of chicken that was tied closed but had no date. The dietary manager said they had taken it out of the box yesterday and confirmed there was no date on the package. Review of the facility policy titled; Food Storage was conducted. The policy read in part, All incoming foods will have a delivery date and an open date or use by date. When the foods are stored in a container other than the original container, the container will be labeled with the name of the product and incoming wash and fill date . 2. In the main kitchen the facility staff failed to ensure milk was maintained at an appropriate temperature. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/24 at approximately 11 a.m., just before the dietary staff were to begin the meal service/tray line at 11:15 a.m., the dietary manager took temperatures of the foods on the tray line. This also included a beverage station where juices and milk here being held until time to serve. The dietary manager took the temperature of a carton of milk which was 45.7 degrees farenheight. During the above observation, the dietary manager was interviewed. When asked what temperature milk is to be held at, she said it should have been less than 40 degrees. The dietary manager asked the food service aide to put the milk back in the cooler until they were ready to serve. Review of the facility provided policies with regards to food storage were reviewed and did not address the temperature dairy products are to be held at. According to the Temperature Chart for Refrigerators and Freezers the Temperature Ranges were noted as Refrigerators 35-41 degrees. 3. On two of two nursing units, the refrigerators used for resident foods had items stored beyond the date to be used and items were not labeled and dated appropriately. On 8/21/24 at 9:29 a.m., observations were conducted of the unit two nourishment fridge. It was noted that there were two cups of what appeared to be apple sauce that had no labeling as to the contents, date prepared or date to be used by. There was a small container of what appeared to be coleslaw that had no label of contents or date. On 8/21/24 at 9:37 a.m., observations were conducted of the unit one nourishment refrigerator. It was noted that the temperature log did not have any temperature recordings for August 17-19. There was a Ziplock bag containing an undetermined food item and multiple food storage containers that had no label as to whom they belonged to, contents, date prepared or to be used by. There was a pan covered in aluminum foil with no date or labeling. There was a cake that was not labeled or dated. There was a container of honey thickened cranberry juice that had a date of 8/13/24, written on it. The director of nursing confirmed that this was supposed to be for the storage of resident's food items but stated that it appeared the majority of the items belonged to staff. On 8/21/24 at approximately 9:45 a.m., the dietary manager provided a document titled, use by dates: refrigerator that noted prepared thickened juice, tea, water was to be used within 5 days of opening. Review of the facility provided policy titled, Use and Storage of Leftovers was reviewed. This policy read in part, . Each day, an assigned person will check leftovers and throw out any foods that have been kept up to the maximum length of time allowed. The maximum length of time a food may be kept is shown on the following chart . The policy titled; Outside Food Policy was reviewed. It detailed no information as to how foods would be stored if maintained in the nourishment refrigerators on the units. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to SERV Safe Fourth Edition manual page 7-3 read, When food is stored improperly and not used in a timely manner, quality and safety suffer. Poor storage practices can cause food to spoil quickly with potentially serious results. General Storage Guidelines: Label food. All potentially hazardous, ready-to-eat food prepared onsite that has been held for longer than twenty-four hours must be properly labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded. Page 7-4 stated, Discard food that has passed the manufacturer's expiration date. 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. According to the 2017 Food Code published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 3, section 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 . Section 3-501.17 Ready-to-eat, Time/temperature control for safety food, date marking read, (A) .refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises . The CFR [Code of Federal Regulations] 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 . On 8/21/24 at 9:55 a.m., the facility administrator was made aware of concerns with food storage as noted above. He stated he had already been made aware. No additional 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 an accurate clinical record for one of twenty-one residents in the survey sample (Resident #49). The findings include: Resident #49's plan of care listed the resident as a DNR (do not resuscitate) and the care plan interventions regarding advance directives documented a requirement for cardiopulmonary resuscitation. Resident #49 (R49) was admitted to the facility with diagnoses that included cancer, atrial fibrillation, deep vein thrombosis, hypertension and schizoaffective mood disorder. The minimum data set (MDS) dated [DATE] assessed R49 with severely impaired cognitive skills. R49's clinical record documented a current do not resuscitate (DNR) order. R49's plan of care (revised [DATE]) listed under the Focus column that the resident was on hospice and had a DNR order. Interventions to honor the resident's advance directives documented, CPR (cardio-pulmonary resuscitation): Full Code. On [DATE] at 2:00 p.m., the registered nurse MDS coordinator (RN #1) was interviewed about the inaccurate full code intervention for R49. RN #1 stated she reviewed/updated the care plan and changed the problem/focus area but did not change the intervention column. RN #1 stated, The intervention did not get changed. This finding was reviewed with the administrator and nurse consultant during a meeting on [DATE] at 4:30 p. m. with no further information presented prior to the end of the survey.