| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495408 | A. Building<br>B. Wing | 04/16/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| King's Grant Lacy Health Center | 350 King's Way Road<br>Martinsville, VA 24112 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, staff interviews, and facility document review, the facility staff failed to store, prepare and distribute food in the facility kitchen to prevent foodborne illnesses. The findings included: 1.The facility staff failed to discard out of date perishable food items and failed to label items when removed from the facility freezer. The kitchen contained out of date bread in the active food supply on two observations. The first observation had out of date bread dated 03/13/26 and the second observation had out of date bread of 4/7/26.<br><br>On 4/14/2026 at 11:56 am, a walk through of the kitchen was conducted with the Dietary Director. Bread was observed placed on four trays in a separate area near the back of the kitchen containing sandwich breads and sandwich rolls. Two packages of bread had a date of 3/13/2026. When the Dietary Director was asked if the date was an expiration date, she stated the bread is pulled from the freezer and served each day. She could not say when the bread was pulled and could not locate a label for a used by date. The two packages with the date 3/13/2026 were thrown away by the Dietary Director. She reports receiving bread that day from the supplier. Due to the bread not being labeled with dates that the bread was received, used by dates, or dates when bread was pulled from the freezer, it was not clear when the other bread would expire or if it had expired.<br><br>4/15/2026 at 5:10pm, observation and interview with kitchen staff #1 revealed she was making sandwiches with bread that had a date of 4/7/2026. Five other loaves of bread had no date (expiration or date received) and one loaf was dated with the proper dates, not expired. When asked about why all the bread is not labeled she reports it was pulled that morning. When asked how she knows it was not expired since there is no date on the bread, she stated it is the same as using bread at home, you know when something is bad. She also reports that Serve Safe recommends six-seven days for bread to be used. This would also make the bread dated 4/7/2026 expired by one to two days.<br><br>4/15/2026 at 5:15 pm, interview with kitchen staff #2, who stated he had pulled the bread from the freezer that morning, they use what they pull each day, heat in a warmer and use by the evening. He did not have an explanation as to why some bread had a date and others did not.<br><br>A facility policy titled, Food Storage, revised on 03/2015 indicated, leftover food must be stored appropriately in covered containers or wrapped carefully and clearly labeled and dated. Leftover food is to be used within three days of storage or discarded.<br><br>On 04/16/2026 at 11:40 a.m., the issue with the out-of-date bread items and labeling was reviewed during a meeting with the Administrator and Director of Nursing.<br><br>No further information regarding this issue was provided to the survey team prior to the exit<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | conference.<br><br>2. The facility dietary staff failed to ensure the sanitizing station for the three-compartment sink was maintained in proper working order.<br><br>On 04/16/2026 at approximately 9:00 a.m., the dietary manager (DM) tested the sanitizing solution in the three-compartment sink using a test strip. Multiple tests were conducted, with no observable change in the color of the test strips.<br><br>Dietary personnel #2 added additional sanitizing solution to the water, and another test strip was used. The strip showed only a minimal color change and remained blue in appearance. According to the labeling on the sanitizing solution bottle, this result corresponded to a concentration range of 0-170 parts per million (ppm). The test strips were confirmed to be unexpired, with an expiration date of 12/2026.<br><br>Signage posted above the sink indicated that the test strip readings should fall between 272-700 ppm. An additional sign on the adjacent wall indicated an acceptable range of 200-400 ppm.<br><br>The DM and dietary personnel #2 stated that the facility had recently changed vendors, and the sanitizing station had been replaced. The DM stated they would contact the vendor, they only used the three-compartment sink for plastic trays that would crack in the dish machine, and they would use bleach if they used the three-compartment sink.<br><br>On 04/16/2026 at 9:15 a.m., the Director of Nursing (DON) was made aware that the sanitizing tests strips for the three-compartment sink in the kitchen were not reading within the appropriate range.<br><br>On 04/16/2026 at 9:35 a.m., during an interview with dietary personnel #2 this staff stated that there was no current log in place to document sanitizing solution test results for the three-compartment sink.<br><br>On 04/16/2026 at 11:40 a.m., the issue with the sanitizing station for the three-compartment sink was reviewed during a meeting with the Administrator and DON. During this meeting these staff were also informed that the dietary staff did not maintain a log documenting the results of sanitizing solution checks.<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on staff interview and clinical record review, the facility staff failed to review and revise a comprehensive care plan (CCP) for 1 of 13 current residents, Resident #6.The findings included: Resident #6's CCP included the focus area full code. The clinical record included a provider order dated 01/17/2026 indicating the resident was a Do Not Resuscitate (DNR). Resident #6's diagnoses included dementia, Alzheimer's disease, and major depressive disorder. Section C (cognitive patterns) of Resident #6's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 01/08/26 was coded 1/1/3 to indicate the resident had problems with long- and short-term memory and was severely impaired in cognitive skills for daily decision making. The clinical record for Resident #6 included:A DNR order dated 01/17/2026. A Durable Do Not Resuscitate (DDNR) order dated 10/18/2025, signed by Resident #6's power of attorney and physician. Resident #6's CCP included the focus area Resident's code status is a full code. Date initiated 10/02/25. On 04/14/2026 at 4:53 p.m., the Director of Nursing (DON) was notified that Resident #6's CCP listed full code while the clinical record included a provider order for DNR. At 5:00 p.m. on 04/14/2026 the DON acknowledged the CCP was inaccurate and stated it would be corrected. On 04/14/26 the facility staff updated Resident #6's CCP to reflect their DNR status. On 04/16/2026 at 8:10 a.m., during an interview with the MDS coordinator this staff stated Resident #6 was a full code upon admission, their status was later changed to DNR, and they had missed that it had been changed. On 04/16/26 at 11:40 a.m., during a meeting with the Administrator and DON the failure to revise the CCP when Resident #6's status changed to DNR was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference. |