STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495105	A. Building B. Wing	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynchburg Health & Rehabilitation Center	5615 Seminole Avenue Lynchburg, VA 24502

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29123 Based on staff interview and clinical record review, the facility staff failed to notify the physician in a timely manner of medication (Hydrocodone) not given per order, for one of thirteen residents, Resident #201. Findings were: Resident #201 was admitted to the facility on [DATE] with the following diagnoses, including but not limited to: COPD (chronic obstructive pulmonary disease), malignant neoplasm of the endometrium, vascular dementia and hypertension. The most recent MDS (minimum data set) was a quarterly review with an ARD (assessment reference date) of 06/23/2021. Resident #201 was assessed as moderately impaired with a cognitive summary score of 10. On 09/21/2021 the clinical record was reviewed. The physician order section contained the following: HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain. The progress note section included the following documentation: 09/11/2021 20:44 [8:44 p.m.] HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain Medication on Order. 09/13/2021 12:06 [p.m.] Medication not available, notified pharmacy. 09/13/2021 13:51 [1:51 p.m.] Not available ordered from pharmacy. 09/14/2021 07:17 [a.m.] HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain Awaiting medications from pharmacy. 09/14/2021 14:42 [2:42 p.m.] HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain Script faxed pharmacy. NP [nurse practitioner] aware. 09/15/2021 07:27 [a.m.] HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain Awaiting medication from pharmacy. Script sent to pharmacy. NP aware. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/15/2021 13:16 [1:16 p.m.] HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain Script sent to pharmacy. NP aware. 09/15/2021 20:54 [8:54 p.m.] HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain On order 09/16/2021 09:18 [a.m.] Lortab 5-35 mg [Same as HYDROcodone-Acetaminophen 5-325- the 35 is a typo] not available in cart for administration at this time. New script printed and forwarded to [name] NP for signature. Order faced to [name of pharmacy] and should arrive with evening delivery per [name of pharmacy representative]. NP and resident made aware. 09/17/2021 12:14 [p.m.] HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain hold until arrive from pharmacy NP [name] aware medication script has been faxed. Additional progress notes regarding the hydrocodone were written until 09/20/2021. The MAR (Medication administration record was reviewed. Resident #201's last dose of physician ordered Hydrocodone was administered on 09/11/2021 at 2:00 p.m. The nurse practitioner was not notified until 09/14/2021 (after eight missed doses) that Resident #201 was not receiving her medications. A new prescription was sent to the pharmacy on 09/16/2021. The medication was still not available for administration during the survey on 09/21/2021. There was no documentation that the nurse practitioner or the physician were notified after 09/17/2021 that the medication was still not available. A meeting was held with the administrator, the DON (director of nursing) and the two corporate nurse consultants on 09/21/2021 at approximately 4:00 p.m. Concerns were voiced that Resident #201 had not received her pain medication as ordered and neither the physician nor nurse practitioner were notified for three days. The question was asked as to what should have happened. The corporate nurse consultant stated, If the medications are not here, the nurse needs to call the pharmacy and see where they are, every time .not say someone else called, they need to continue calling and notify the physician that the medicine isn't being given as ordered .every time it is scheduled .and they need to write a descriptive progress note . each nurse is responsible for medication administration on her shift. The note from 09/17/2021 was discussed. There was no order on the POS to hold the Hydrocodone. The corporate nurse consultant was asked if there was some place else that the order might be written. He stated, No, if there was an order that is where it would be. No further information was received prior to the exit conference on 09/21/2021.

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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 ensure an accurate minimum data set (MDS) for one of 38 residents in the survey sample. An admission MDS for Resident #56 had an inaccurate assessment of the resident's dental issues. The findings include: Resident #56 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation, atherosclerotic heart disease, hypertension, heart failure, benign prostatic hyperplasia, inguinal hernia, gastroesophageal reflux disease and localized edema. The MDS dated [DATE] assessed the resident with moderately impaired cognitive skills. On 6/29/21 at 2:52 p.m., Resident #56 was interviewed about quality of care in the facility. The resident was observed when talking with missing front teeth. Other visible teeth were broken, dark in color with several teeth black and decayed next to the gum tissue. The resident was interviewed about the condition of his teeth at this time. Resident #56 stated his teeth were in bad shape and he had not been to a dentist in over two years. The resident stated he only had six teeth with a fragment of a tooth near the front. Resident #56 stated, Sometimes it's hard to chew. Section L of Resident #56's admission MDS assessment dated [DATE] documented the resident had no dental issues. Form sections to indicate tooth fragments, obvious/likely cavities, broken teeth and difficulty with chewing were blank. The form was marked, None of the above [tooth fragments, obvious/likely cavities, broken teeth, difficulty chewing] were present. On 6/30/21 at 5:30 p.m., the registered nurse (RN #2) responsible for MDS assessments was interviewed about Resident #56's dental assessment. RN #2 stated her assessment included interviews with the resident and a review of the clinical record. RN #2 stated she did not have an explanation for the inaccurate assessment of the resident's dental condition. This finding was reviewed with the administrator and director of nursing during a meeting on 7/1/21 at 1:10 p. m.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 29123 Based on clinical record review, staff interview, and facility document review, the facility staff failed to review and revise the comprehensive care plan for 5 of 38 Residents, (Resident #10, #23, #133, and #71). Resident #10's care plan was not reviewed and revised regarding hospice services, enhanced droplet precautions, and diabetes mellitus. Resident #23's care plan was not reviewed and revised regarding the resolution of pressure ulcers. Resident #133's care plan did not include hospice services. Resident #86's care plan was not reviewed and revised to include hospice admission and the use of geri-sleeves. Resident #71's care plan was not revised with problems, goals and interventions regarding pressure ulcers. Findings were: 1. Resident #10 was admitted to the facility on [DATE] with the following diagnoses, including but not limited to: COPD (chronic obstructive pulmonary disease), malignant neoplasm of the endometrium, vascular dementia and hypertension. The most recent MDS (minimum data set) was a quarterly review with an ARD (assessment reference date) of 06/23/2021. Resident #10 was assessed as moderately impaired with a cognitive summary score of 10. On 06/29/2021 at approximately 11:00 a.m., during initial tour of the facility, Resident #10 was interviewed regarding life at the facility. During the interview, Resident #10 stated, I just had a birthday last week .I was 90 .my sister and I ate a whole chocolate cake to celebrate. Resident #10 was asked if she was a diabetic. She stated, Heck no! The clinical record was reviewed at approximately 2:00 p.m. An order was observed for Hospice Services. The care plan was reviewed. There were no interventions on the care plan for hospice services or any mention that hospice services were in place. Also observed on the care plan was a problem area, Enhanced Droplet Precautions with interventions in place. Resident #10 was not on enhanced droplet precautions. A problem area Diabetes Mellitus with interventions was also on the care plan. Resident #10 did not have a diagnosis of diabetes on her clinical record. On 06/30/2021 at approximately 3:30 p.m. the DON (director of nursing) was interviewed regarding the review and revision of care plans. She stated, It's a combination between nursing and MDS. The problems identified with Resident #10's care plan were discussed. The corporate nurse consultant stated, The nurses should be reviewing the care plans and updating them. He and the DON were asked how often care plans should be reviewed. The DON stated, MDS makes changes at the quarterly and annual meetings .anything else should be updated and changed as it happens, usually within 24 hours. They were asked who should have made the changes to Resident #10's care plan. The DON stated, The charge nurse but (name of LPN-licensed practical nurse #6) just took that position back over, (Name of LPN #5) was doing it before .I will look at it though and update it. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/01/2021 at approximately 9:00 a.m., LPN #6 was interviewed regarding care plan revision. She stated, I try to review them, but I just came back .(Name of LPN #5) would have done that. LPN #5 was then interviewed. She stated, (Name of LPN #6) should do that. The facility policy Care Planning was obtained and reviewed. The following was observed: Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly. The above information was discussed with the administrator, the DON, the unit manager, and the corporate nurse consultant, during an end of the day meeting on 07/01/2021 at approximately 1:30 p.m. The DON was asked if there was an additional policy regarding reviewing and revising care plans that discussed the frequency of care plan revision. The corporate nurse consultant stated, It is nursing .it's taught in school and it carries over to their job .they should have done it. The DON stated, What you have is the only policy we have .there isn't one about revising. No further information was obtained prior to the exit conference on 07/01/2021. 2. Resident #23 was admitted to the facility on [DATE]. Her admitting diagnoses included but were not limited to: Ulcerative colitis, hypertension, adult failure to thrive and major depressive disorder. An admission MDS (minimum data set) with an ARD (assessment reference date) of 04/13/2021, assessed Resident #23 as moderately impaired with a cognitive summary score of 08. During the initial tour of the facility on 06/29/2021, at approximately 11:15 a.m., Resident #23 was interviewed. She was asked if she had any wounds, or sores on her body that the facility was treating. She stated, No, I had some, but they done healed them all up. I'm good now. On 06/29/2021 at approximately 1:30 p.m., the unit manager, LPN (Licensed Practical Nurse) #6 was asked if Resident #23 had any current skin issues. She stated, No, she had some pressure areas at one time, but they are healed now. The clinical record was reviewed on 06/30/2021 at approximately 8:30 a.m. The care plan was reviewed. Observed were problem areas listed for: .has DTI [deep tissue injury] to left heel .Unstageable pressure ulcer to right heel .has stage 3 pressure ulcer sacrum . with interventions to Administer treatments as ordered and monitor for effectiveness for all three areas. On 06/30/2021 at approximately 10:00 a.m., Resident #23's care plan was discussed with the DON. She stated that the nurses should have updated the care plan when the pressure areas resolved. On 07/01/2021 at approximately 9:00 a.m., LPN #5, who was the former unit manager was interviewed regarding Resident #23's care plan for pressure areas and deep tissue injury. She stated, I thought I had resolved that off the care plan .I am sure I did. LPN #5 was told the problem areas were still showing as current. She stated, I don't know what happened. The above information was discussed with the administrator, the DON, the unit manager, and the corporate nurse consultant, during an end of the day meeting on 07/01/2021 at approximately 1:30 p.m. No further information was obtained prior to the exit conference on 07/01/2021. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident # 133 was admitted to the facility on [DATE] with the following diagnoses, including but not limited to: Dysphagia, vascular dementia, and adult failure to thrive. The admission MDS (minimum data set) with an ARD (assessment reference date) of 05/30/2021, assessed her as severely cognitively impaired with a summary score of 06. The clinical record was reviewed on 06/30/2021 at approximately 1:00 p.m. A physician order for Hospice services was observed. The hospice records were reviewed indicating Resident #133 was admitted to hospice services on 06/18/2021. The facility care plan was reviewed. There were no interventions or indications on the care plan that Resident #133 was receiving hospice services. On 06/30/2021 at approximately 1:30 p.m., Resident #133's care plan for hospice was discussed with the DON. She stated, That resident is a recent admission to hospice, but the care plan should have been updated within 24 hours by the nursing staff to include that. The above information was discussed with the administrator, the DON, the unit manager, and the corporate nurse consultant, during an end of the day meeting on 07/01/2021 at approximately 1:30 p.m. No further information was obtained prior to the exit conference on 07/01/2021. 40027 4a. Resident #86 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hospice, acute kidney failure, hypertension, mood disorder, dementia, anxiety, anemia, depression, and hyperlipidemia. The most recent minimum data set (MDS) dated [DATE] was a significant change and assessed Resident #86 as severely cognitively impaired for daily decision making with a score of 7 out of 15. On 06/29/2021 at 10:51 a.m. during the initial tour, Resident #86 was observed sitting near the nurse's station on the [NAME] Unit wearing geri-sleeves on both of his arms. On 06/30/2021 at 8:23 a.m. Resident #86 was observed sitting near the nurse's station on the [NAME] Unit, he was not wearing geri-sleeves at this time. On 06/30/2021 at 10:50 a.m., Resident #86 was observed sitting near the [NAME] Unit nurse's station wearing geri-sleeves on both of his arms. On 06/30/21 8:23 a.m., Resident #86 was observed sitting near the [NAME] Unit nurse's station, he was not wearing geri-sleeves at this time. On 06/30/21 at 10:50 a.m., Resident #86 was observed being transported in his wheelchair on the [NAME] Unit by the certified nursing assistant (CNA #3) who routinely provides care for him. Resident #86 was observed attempting to removing his geri-sleeves. CNA #3 was interviewed regarding the use and application of the geri-sleeves for Resident #86 at the time of the transport. CNA #3 stated at times Resident #86 becomes upset and will remove his geri-sleeves at other times he will not allow staff to place them on him at all. CNA #3 was asked if they documented Resident #86's refusal to wear the geri-sleeves. CNA #3 stated yes she notifies the charge nurse each time Resident #86 refuses care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/30/2021 Resident #86's clinical record was reviewed. Observed on the physician's order summary was the following order: Geri Sleeves bilateral Arms every shift for prevention Order Status: Active. Order Date: 04/13/2021. Start Date 04/13/2021 Resident #86's care plan did not document the use of the geri-sleeves as a preventive measure. On 06/30/2021 at 12:30 p.m. and 6:30 p.m., Resident #86 was observed on the [NAME] Unit wearing geri-sleeves on both of his arms. On 06/30/2021 at 6:30 p.m., the unit manager (LPN #4) was interviewed regarding the use and application of the geri-sleeves for Resident #86. LPN #4 stated Resident #86 would often remove his geri-sleeves and slipper socks and she had educated staff on the importance of documenting his refusals and removals. LPN #4 was asked if the geri-sleeves should be included on the treatment orders and the care plans. LPN #4 stated yes this would be a way to document Resident #86's refusal to wear and/or removal of the geri-sleeves. LPN #4 was asked who was responsible for updating the care plans and treatment orders. LPN #4 stated both nursing and the MDS coordinators updated care plans and treatment orders. On 07/01/2021 at 9:10 a.m., the MDS Coordinator (RN #1) was interviewed regarding the geri-sleeves and updating the care plan. RN #1 stated the geri-sleeves should have been added to the care plan. The corporate consultant was present at the time of the interview and stated he spoke with the nursing staff on the [NAME] Unit and there was some confusion whether or not to include the geri-sleeves on the treatment record and the care plans because Resident #86 would remove the geri-sleeves. The corporate consultant was asked what was the expectation and he stated the geri-sleeves should have been placed on both the treatment record and the care plans as an intervention. 4b. Resident #86's clinical record was reviewed on 06/30/21. Observed on the physician's order summary was the following order: .ADMIT to Hospice [agency name and number]. Order Status: Active. Order Date: 05/13/2021 Observed within the clinical record was a progress note dated 05/13/2021 which documented, He (Resident #86) was admitted to Hospice [agency name] effective today 5/13/2021 Son [Name] has been updated, staff will continue to monitor for changes Resident #86's hospice binder was reviewed. Observed within the binder was weekly hospice documentation regarding Resident #86's care. Resident #86's care plan did not include the hospice admission. On 06/30/21 at 6:15 p.m. the unit manager, LPN #4 was interviewed regarding if the hospice admission should have been included on Resident #86's care plan. LPN #4 stated yes that the MDS nurses should have included it when the significant change was completed. On 07/01/21 at 9:10 a.m., the MDS coordinator (RN #1) was interviewed regarding if the hospice admission should be included on the care plan. RN #1 stated she normally reviewed and revised the care plans during the comprehensive assessments for any triggered CAAs (care area assessments) and the hospice admission should have been added to the care plan during the recent significant change assessment on 05/18/2021. The above findings was shared with the administrator, director of nursing and corporate consultant during a meeting on 07/01/2021 at 1:10 p.m. 21875 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Resident #71 was admitted to the facility on [DATE] with a re-admission on 6/17/21. Diagnoses for Resident #71 included enterocolitis due to clostridium difficile (C-diff), neuropathic bladder, history of urinary tract infections, hypertension, chronic kidney disease, autistic disorder and anemia. The minimum data set (MDS) dated [DATE] assessed Resident #71 with moderately impaired cognitive skills. Resident #71's clinical record documented the resident was readmitted from the hospital on 6/17/21 with multiple pressure ulcers on his buttocks. A weekly skin evaluation sheet dated 6/17/21 documented the following pressure ulcer assessment for Resident #71: Left buttock - stage 2 pressure ulcer measuring 0.5 x 0.5 x 0 (length by width by depth in centimeters) Right buttock - two stage 2 pressure ulcers measuring 4.0 x 1.0 x 0 cm and 2.0 x 1.0 x 0 cm The clinical record documented a physician's order dated 6/18/21 to cleanse and apply zinc ointment with a dry dressing to the right and left buttock ulcers until healed. Nursing notes documented dressing changes and treatments were implemented as ordered. Resident #71's current plan of care (print date 6/30/21) was not revised with problems, goals and/or interventions regarding the pressure ulcers. The plan of care created on 5/17/21 listed the resident had potential for skin impairment but made no mention the resident currently had pressure ulcers with ongoing treatments. On 7/1/21 at 9:00 a.m., the registered nurse (RN #1) responsible for MDS and care plans was interviewed about Resident #71. RN #1 stated she and the nurses were responsible for updating care plans as needed. Concerning Resident #71's care plan, RN #1 stated if the pressure ulcers were not on the plan then it had not been updated. This finding was reviewed with the administrator and director of nursing during a meeting on 7/1/21 at 1:10 p. m.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09404 Based on observations, complaint investigation, clinical record review, and staff interview, the facility staff failed for three of 38 residents in the survey sample (Residents # 80, 88 and 127), to provide routine foot care. Residents # 80, 88 and 127 had elongated toenails with clearly visible debris under the great toes on their left and right feet. The findings include: 1. Resident # 88 was admitted to the facility on [DATE], and most recently readmitted on [DATE] with diagnoses that included malignant neoplasm of endometrium, anemia, hypertension, renal insufficiency, diabetes mellitus, depression, generalized muscle weakness, difficulty walking, dysphagia, pulmonary hypertension, cerebral atherosclerosis, and gastroesophageal reflux disease. According to a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/21/2021, Resident # 88 was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 09 out of 15. Under Section G (Functional Status), the resident was assessed as needing limited assistance with one person physical assist for personal hygiene. At approximately 9:00 a.m. on 6/30/2021, an observation of Resident # 88's fingernails and toenails was conducted. Resident # 88's toenails were elongated and in need of trimming. There was debris clearly visible under the nails on the great toes of her right and left feet. LPN # 7 (Licensed Practical Nurse) was present for the observation. 2. Resident # 127 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of the left breast, hypertension, diabetes mellitus, arthritis, history of falling, right hip pain, difficulty walking, generalized muscle weakness, and hypercalcemia. According to an Admission MDS with an ARD of 5/27/2021, Resident # 127 was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 11 out of 15. Under Section G (Functional Status), the resident was assessed as needing extensive assistance with one person physical assist for personal hygiene. At approximately 9:20 a.m. on 6/30/2021, an observation of Resident # 127's fingernails and toenails was conducted. Resident # 127's toenails were elongated and in need of trimming. There was debris clearly visible under the nails on the great toes of her right and left feet. LPN # 7 was present for the observation. During the observation, Resident # 127 was asked who trims her toenails and when was the last time they were trimmed. The resident said she did not know (who trimmed them), but thought it was several months since they were trimmed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 9:50 a.m. on 6/30/2021, SW # 2 (Social Worker), who was identified as the person who schedules podiatry visits, was interviewed. Asked how he decides who sees the Podiatrist, SW # 2 said, I start with the farthest out (meaning the resident with the longest time since a podiatry visit) and put them on the list. SW # 2 went on to say, The Podiatrist comes once a month and sees 20 residents. In six months he will have seen everyone. When asked what happens if nursing identifies a resident that needs to be seen by the Podiatrist, SW # 2 said, If nursing tells me about someone, I will put their name on the list. SW # 2 was asked for, and provided, a list of facility residents that included the date each was last seen by the Podiatrist, as well as a list of residents scheduled for the next podiatry visit. According to the facility list, Resident # 88 was last seen by the Podiatrist on 3/31/2021. Resident # 127 was on the facility list, but there was no last seen date. Resident # 127 was on the podiatry schedule for 7/7/2021. 3. Resident # 80 was admitted to the facility on [DATE], and most recently readmitted on [DATE], with diagnoses that included pneumonia, anemia, atrial fibrillation, depression, gastroesophageal reflux disease, acute respiratory failure with hypoxia, ventral hernia with obstruction, generalized muscle weakness, difficulty walking, overactive bladder, morbid obesity, and polyneuropathy. According to an Admission MDS with an ARD of 5/19/2021, Resident # 80 was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 13 out of 15. Under Section G (Functional Status), the resident was assessed as needing extensive assistance with one person physical assist for personal hygiene. At approximately 10:20 a.m. on 6/30/2021, an observation of Resident # 80's fingernails and toenails was conducted. Resident # 127's toenails were elongated and in need of trimming. There was debris clearly visible under the nails on the great toes of her right and left feet. CNA # 3 (Certified Nursing Assistant) was present for the observation. Resident # 80's name appeared on the facility podiatry list provided by SW # 2, but there was no date indicating when she was last seen. Resident # 80's name was listed on the on the podiatry schedule for 7/7/2021. A review of the Progress Notes (Nurses Notes) in Resident # 80's electronic health record revealed the following entry, dated 2/9/2021, made by Discharge Planning (SW # 2), Resident was seen by the podiatrist, Dr. (name) on this date At approximately 1:15 p.m. on 7/1/2021, during a meeting that included the Administrator, Director of Nursing, and the survey team, the findings regarding Residents # 88, 127 and 80 were discussed. COMPLAINT DEFICIENCY

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Lynchburg Health & Rehabilitation Center	5615 Seminole Avenue Lynchburg, VA 24502

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28107 Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to ensure glucose-monitoring devices were calibrated and accurate on three of three units. A total of twelve glucose monitoring devices were located on nine medication carts and available for use on all three units. Review of the calibration logs for the devices revealed calibration had not been completed on a nightly basis per facility policy. All twelve devices were calibrated for accuracy by facility staff, and nine devices were out of range. Staff observed conducting the calibration of the devices did not follow manufacturer instructions for correctly performing the calibrations, and control solutions for the testing of high and low values were expired. Thirty-two (32) residents were identified as requiring insulin and blood sugar monitoring. Thirteen (13) of those residents (Residents # 27, 95, 113, 108, 249, 384, 42, 97, 69, 84, 88, 236, and 247) were included in the survey sample and the extended survey sample. Four of the thirteen residents (#27, 108, 249, and 69) were identified as having concerns related to glucose monitoring. Staff were performing blood sugar tests and administering insulin based on blood sugar readings obtained on equipment that had not been calibrated. This was identified as Immediate Jeopardy (IJ) in the area of Quality of Care [DATE] at 4:55 p.m., with resulting SQC (substandard quality of care). The Immediate Jeopardy was abated on [DATE] at 1:10 p.m., and the Scope and Severity was lowered to Level II, pattern. The facility staff also failed to follow physician orders for four of 38 residents in the survey sample: Residents #56, #71, #42 and #32. Resident #56 was not provided support hose as ordered by the physician. Resident #71 was not started on antibiotics as ordered by the physician until four days after admission. Residents #32 and #42 did not have physician ordered weights obtained by staff. Findings include: 1. On [DATE] at 9:45 a.m., accompanied by the licensed practical nurse (LPN #6), the medication carts were inspected on the East unit. The January, February, and [DATE] blood glucose monitoring calibration sheets for the East unit glucometers were blank with no entries or control checks completed on the unit's three medication carts. There were no blood glucose monitoring calibration sheets for the glucometers for April, May, or [DATE]. On [DATE] at 10:15 a.m., accompanied by the East unit manager (LPN #6), three blood glucose monitors were checked with the manufacturer's control solution. The acceptable high range was labeled as ,d+[DATE] and the acceptable low range was ,d+[DATE]. Cart #1 included two glucometers. The first glucometer had a high reading of 233 and a low reading of 96 with both readings within range. The second glucometer had a high reading of 243 and a low of 94 with both readings within range. Cart #2 included two glucometers. There was no test solution for Cart #2. LPN #6 stated she would use the solution from cart #3. One of the glucometers from Cart #2 had a high reading of 258 and a low reading of 88, with the high reading out of range. The second glucometer on Cart #2, had a high reading of 237 and a low reading of 94, both readings were within range. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Cart #3 included two glucometers. One of the glucometers from Cart #3 had a high reading of 359 and a low reading of 79, both readings were out of range. The second glucometer on Cart #3 had a high reading of 223 and a low reading of 91, both readings were within range. LPN #6 stated at the time of the cart inspections that there was no documentation of which glucometer was used with which resident. 2. On [DATE] at 10:18 AM, medication storage and labeling was observed on the South wing. Medication cart B was observed. This cart had one glucometer; the glucometer was labeled with a permanent marker, Cart B #1.' LPN (Licensed Practical Nurse) # 3 stated that the device is cleaned before and after each use, and provided the cleaning protocol with demonstration. LPN #3 was asked if the glucometer had been calibrated. LPN #3 stated, I'll have to get an answer for that and stated, I don't do it. LPN #3 had a new bottle of test strips dated [DATE]. There was no control solution on this medication cart to do a calibration test. At 10:28 AM, LPN #3 asked LPN #2 about the glucometers being calibrated. LPN #2 stated that they should be calibrated every night on 3rd shift. LPN #2 stated that the 3rd shift nurse has a checklist with things to do and that is one of them. LPN #2 was asked how many glucometers were on the South unit. LPN #2 stated that Cart A has two glucometers, Cart B has one glucometer and Cart C has one glucometer, for a total of four glucometers on the South unit. The glucometers were labeled as Cart A #1 and #2, Cart B #1, and Cart C #1. At approximately 10:30 AM, LPN #3 asked LPN #1 where the calibration/control solution to test the glucometers was located. LPN #1 stated that they do the calibration test to see if the glucometers are operating correctly and then document in the book. LPN #1 stated that this is done every night on the glucometers. LPN #1 was asked to perform a control test. LPN #1 and LPN #3 both stated that they did not have any control solution on their carts [Cart B and Cart C]. LPN #1 was then asked to review the book with quality control tests. LPN #1 went to the nurse's station and pulled a binder book with glucometer control testing results. Inside the book were sheets titled, blood glucose monitoring meter checks quality control record. LPN #1 stated that there is a sheet for each glucometer on the unit. Each sheet had 13 columns, each column labeled as follows: the date, station/shift, operator initials, meter cleaned, check strip result, test strip lot #, expiration date, code #, Level 1 control range , Level 1 control result, Level 2 control range, Level 2 control result, and Corrective Action column [last]. The glucometers were counted on the South wing unit by staff and verified that four glucometers were on the South wing [2 glucometers on Cart A, 1 on Cart B, and 1 Cart C]. The quality control logs located in the book were reviewed for the last three months, [DATE] through present [[DATE]], the following was revealed: Cart A glucometer #1 only had one log sheet for June. The dates tested were [DATE]th, 25th, 28th, and 29th. It was documented that this glucometer was in range on those dates. There was no log for Cart A glucometer #2, although there were two glucometers on Cart A. There was no documentation for Cart A #1 or #2 glucometers for the months of April and May to evidence any testing. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Cart B glucometer #1 log sheet for June documented testing dates were [DATE]th, 25th, 28th, and 29th. There was no documentation for April or [DATE] to evidence any testing. Cart C glucometer #1 log sheet for June documented testing dates were [DATE]th, 25th, 28th, and 29th. There was no documentation for April or May to evidence any testing. At approximately 10:40 AM, LPN #2 stated that she had control solution on her cart, Cart A. At 10:42 AM, LPN #2 and LPN #3 gathered their assigned glucometers and supplies to perform the control tests, which included Cart A glucometers #1 and #2, and Cart B glucometer #1. All the supplies gathered [test strips, control solution] were verified by lot number, not expired, and not past an open date. Cart A glucometer #1 was tested and did not pass the control test for the level 2 test. The level 2 test range was listed on the bottle as ,d+[DATE]. The actual result for glucometer #1 was 345. Cart A glucometer #2 was tested and did not pass the control test for the level 2 test. The level 2 test range was listed on the bottle as ,d+[DATE]. The actual result for glucometer #2 was 349. Cart B glucometer #1 was tested and did not pass the control test for level 2 test. The level 2 test range was listed on the bottle as ,d+[DATE]. The actual result for glucometer #1 was 362. According to the control logs, all four glucometers were last tested on [DATE] and all four passed the control test [level 1 and level 2]. At 11:05 AM, LPN#1 was asked to test Cart C glucometer #1. LPN #1 stated, I don't have any controls [solution] on my cart because it expired and the facility doesn't have anymore. LPN #1 stated that she had thrown them away this morning. LPN #1 stated that she only had one glucometer on her cart. The control solution was borrowed from Cart A to perform the control test. Cart C glucometer #1 was tested and did not pass the control for the level 2 test. The level 2 test range was listed on the bottle as ,d+[DATE]. The actual result for glucometer #1 was 348. All four glucometers on the South wing were found out of calibration and none of the glucometers were removed from service. At approximately 11:45 AM, LPN #2 performed a blood glucose check on Resident #108 with glucometer #2 from Cart A. This glucometer was checked at approximately 10:45 AM and was found out of calibration [failed the level 2 test]. The resident's blood glucose result on this glucometer was 259. Resident #108 was admitted to the facility on [DATE]. Diagnoses for Resident #108 included, but were not limited to: type 2 diabetes with hyperglycemia [insulin dependent], muscle weakness, chronic kidney disease stage 3, and vascular dementia without behaviors. The most current MDS (minimum data set) for Resident #108 was a five day admission assessment dated [DATE]. This MDS assessed the resident with a cognitive score of 13. Resident #108 was assessed in Section N. [Medications] as receiving 3 injections of insulin in the last three days [with one order for insulin]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #108's physician's orders were reviewed and documented orders for, but not limited to: Accuchecks AC [before meals] and HS [bedtime] as needed for DM [diabetes mellitus] Notify MD [medical doctor] for BS [blood sugar] less than 60 or greater than 400 .Accuchecks AC and HS before meals and at bedtime for for DM Notify MD for BS less than 60 or greater than 400 .Hold meal insulin for blood sugars less than 100 . Insulin Glargine .inject 50 units subcutaneously in the morning .Insulin Lispro .inject 15 units subcutaneously with meals for Diabetes Hold meal time insulin for blood sugars less than 100 . Resident #108's care plan was reviewed and documented, .has Diabetes Mellitus .medication as ordered by doctor. Monitor/document for side effects .dietary consult .educate regarding medications .compliance . podiatry consult as needed . Resident #108's MARS [medication administration records] were then reviewed. According to the resident's MARS the resident was given 15 units of Lispro by LPN#2 on [DATE] at noon. The resident was also given Lispro 15 units at 5:00 PM, the blood glucose reading was 173. 3. On [DATE] at 4:13 PM, glucometer calibration tests were performed on the west wing by registered nurse, (RN) #4. Test solution and test strips were not expired. The results were as follows: Glucometer labeled west C cart was tested . The bottle of test strips indicated the range for low side (Level 1) should be ,d+[DATE]. The bottle also indicated the range for high side (level 2) should be ,d+[DATE]. The test was run for low side with the results being 79 (indicating out of parameter). The test was completed for the high side with the results being 355 (indicating out of parameter). B cart glucometer was tested . The bottle of test strips indicated the range for low side should be ,d+[DATE]. The bottle also indicated the range for high side should be ,d+[DATE]. The test was run for low side with the results being 90 (indicating within parameter). The test was completed for the high side with the results being 357 (indicating out of parameter). A cart glucometer was tested . The bottle of test strips indicated the range for low side should be ,d+[DATE]. The bottle also indicated the range for high side should be ,d+[DATE]. The test was run for low side with the results being 83 (indicating within parameter). The test was completed for the high side with the results being 350 (indicating out of parameter). RN #4 stated that she would take the glucometers out of service and get a new one. Glucometer calibration logs were then reviewed with the unit manager (license practical nurse, LPN #4). Documentation showed each cart glucometers (A, B, and C) were last tested on [DATE] with only one test done prior on [DATE]. LPN #4 stated that tests on the glucometers are supposed to be run on every night shift. Resident #27 was admitted to the facility on [DATE]. Diagnoses for Resident #27 included: Type 2 diabetes, cognitive deficit, coagulation defect, and muscle weakness. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of [DATE]. Resident #27 was assessed with a cognitive score of 9 indicating moderately cognitively impaired. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] Resident #27's medical record was reviewed. A progress noted dated [DATE] documented a call from the facility contracted lab indicating Resident #27 had a critical glucose result of 24 from a lab that was taken earlier in the morning. The lab report dated [DATE] documented that the lab test was taken at 5:38 AM on [DATE] and also documented the glucose lab was confirmed by a repeat analysis. Resident #27's blood sugar test flow sheet was then reviewed and documented a blood sugar test had been obtained on [DATE] at 5:51 AM with results being 83 (13 minutes after the lab had drawn blood). 4. Resident #69 was admitted to the facility on [DATE] with the following diagnoses, including but not limited to: end stage renal disease, dementia, hypertension, schizoeffective disorder, and diabetes mellitus. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of [DATE]. Resident #69 was assessed as cognitively intact with a summary score of 12. The clinical record was reviewed on [DATE] at approximately 4:00 p.m. The following progress notes were observed: [DATE] 23:37 [11:37 p.m.] Resident blood sugar at 2154 [9:54 p.m.] was 67. Resident was alert and stated he did not feel like his blood sugar was low. Went and got a coke and snacks from vending machine for resident. Resident was eating snacks and drinking his coke when leaving room. Went to recheck bs [blood sugar] at 2230 [10:30 p.m.] and resident was in the floor between the two beds, Resident was laying on his left side. Resident had spilled his coke and was laying in the coke on the floor. Resident would open his eyes but was unresponsive. Resident was breathing and had a pulse. Call for nursing assistants and called 911 from the room. Attempted several times to get a BS and got reading all over the place. One read HI, one read 85, one read 247, last one read 54. Gave resident glucose since he was being [beginning] to be a little more alert. However, resident would just cough and not swallow glucose. 3 emts [emergency medical technicians] arrived and assisted resident to stretcher . [DATE] 01:55 [a.m.] Received report from [Name] in ER [emergency room] who states when resident got to hospital he was alert and answering correctly. She noted he had urinated on himself and she walked him to the bathroom and cleaned him. His BS was 226. His white blood cells are up @ 21.8 she states. He was DX [diagnosed] with UTI [urinary tract infection .States he is returning back to the facility via car and wife. The following note was a late entry created [DATE] at 2:36 a.m.: [DATE] 02:09 During report, evening shift nurse stated resident had had a low BS at bedtime. She asked to stop report and recheck up on him. This nurse was the third nurse in to see resident. He was laying in the floor. He was on his left side with a small amount of white froth noted at the corners of his mouth. He barely had his eyes open but they weren't focused. He could not answer or response to stimuli by nurses. His skin was very cold and clammy. He had his coke spilled all over him. He was making the snoring noises diabetics make when they are trying to slip into a coma. All nurses were called to the room and crash cart brought in. No code performed r/t [related to] he has a heart beat and he is breathing at this time. 911 was called. Evening nurse unable to obtain an accurate blood sugar r/t [related to] spilled coke on his hands. Staff stayed at bedside until EMTs arrived and took him to the ambulance around 2348 [11:48] pm. Ambulance remained in the lot for 20 minutes before leaving for the hospital. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	[DATE] 15:20 [3:20 p.m.] MEDICAL NOTE: ProMedical Progress Note CC: Okay .S: Patient is being evaluated today for hospital follow-up. On [DATE], patient had an episode of hypoglycemia. Nursing staff found the patient laying on the floor on his left side with a small amount of white frothy at the corners of his mouth. Patient barely can keep his eyes open and focus. He cannot answer or respond to stimuli by nurses. Patient was very cold and clammy. Patient was sent to the emergency department for further evaluation. CT scan of the head and neck were unremarkable. There was concern for UTI and patient was started on Keflex. On [DATE], patient was evaluated for hypoglycemia. Patient's blood sugars were 64 and 87 and insulin was held. At the time he was thought this could have been an isolated incident. An A1c was checked. On [DATE], patient was evaluated to follow-up on diabetes to follow-up on the results of the A1c. A1c was 9.9 on [DATE]. Patient was currently taking Humalog 8 units with meals, glargine insulin 50 units daily and a sliding scale as needed for blood sugars greater than 200. Glargine was increased from 50 units to 55 units daily. Lispro was increased to 10 units with meals. Since [DATE], blood sugar ranges have been between 95 and 472. Patient states that he is eating all of his meals. He denies any changes in his diet. He is on a diabetic diet .A: This is a [AGE] year-old male with a history of diabetes being evaluated for a fall that occurred on [DATE] and an episode of hypoglycemia resulting in a hospital follow-up. P: Consulted for mechanical ground-level fall with no significant injuries. There was questionable loss of consciousness due to hypoglycemia. Medications were evaluated and no changes are indicated at this time. We will follow-up with patient in 2 weeks. The hospital records from the emergency room documented the following: Basic information Chief complaint: Pt (patient) sent for suspected syncopal episode from [name of facility] d/t [due to] hypoglycemia. Pt stated, I don't know what I was doing but I was lightheaded and then it all went blank. Pt was hypoglycemic upon EMS arrival, blood sugar rose w/ [with] D10 . History of Present Illness: 58-year-old male with history of end stage renal disease now status post kidney transplant .type 2 diabetes with brittle blood sugars presents with concern for hypoglycemia and subsequent syncopal episode. Patient reports he ate a full dinner of a cheeseburger, fries, tea, and coffee. He then went back to his room and his blood sugar was checked and found to be in the 50s. Staff immediately brought him things to eat. He does remember drinking a coke but then had a syncopal episode and fell from the bed .daughter reports that he has very labile blood sugars and has had syncopal episodes from hypoglycemia in the past .states this event appears very similar to past events. Laboratory data from the emergency room showed a Glucometer POCT [point of contact testing] reading on [DATE] at 23:58 [11:58 p.m.] of 226. A routine Chemistry lab test dated [DATE] and resulted at 00:57 [12:57 a.m.] showed a blood glucose level of 254. Concerns were voiced to the DON, administrator, the corporate nurse consultant on [DATE] at approximately 4:50 p.m., that the blood glucose monitors in the facility were not calibrated per facility policy and when tested with the control solution were testing out of range. Documentation in Resident #69's record indicated that blood sugar readings were all over the place. 5. Resident #249 had scheduled insulin and insulin administered before meals and at bedtime each day with dosages determined by blood sugar readings (sliding scale). These readings were obtained with glucometers that either had not been calibrated, were calibrated with out of date solution or were found out of calibration (not meeting manufacturer's specifications for calibration). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #249 was admitted to the facility on [DATE] with diagnoses that included status post orthopedic surgical amputation, diabetes, hypothyroidism, hypertension, gout, history of breast cancer, asthma and gastroesophageal reflux disease. The admission nursing assessment dated [DATE] assessed Resident #249 as cognitively intact. Resident #249's clinical record documented the following physician orders dated [DATE] for insulin to manage diabetes. Insulin Lispro100 units/milliliter (ml), inject per sliding scale subcutaneously before meals and at bedtime. Sliding scale listed: blood sugar 200 to 299 give 5 units, 300 to 399 give 10 units, 400 to 401 give 15 units, above 400 call physician. NPH Isophane & regular suspension insulin pen (,d+[DATE]) 100 units/ml, inject 20 units subcutaneously each evening and 30 units each morning. Accuchecks (blood sugar) before meals and at bedtime each day. The record documented a physician's order dated [DATE] for Glucagen Hypokit solution (Glucagon HCL (rDNA)) 1 milligram with instructions to inject one application intramuscularly as needed for low blood sugar Resident #249's clinical record documented the insulin was administered as ordered. Blood sugar checks were documented before meals and at bedtime each day, with insulin administered per sliding scale. A nursing note dated [DATE] at 1:17 p.m. documented, .rsd [resident's] BS [blood sugar] was 61 @ [at] 1230 pm gave rsd. teddy grams and graham crackers. rsd. alert and verbal at this this time stated she felt okay and didn't feel like her BS was low. recheck BS at 1245 pm it was 59 gave rsd 1 IM [intramuscular] glucagon rechecked BS at 105 pm bs 149 . (Sic) On [DATE] at 2:15 p.m., the director of nursing (DON) was interviewed about calibration of the facility's glucometers. The DON stated the night shift (11:00 p.m. to 7:00 a.m.) nurses were responsible for calibrating the glucometers each night. The DON stated any glucometers found out of calibration were supposed to be taken out of service and replaced with a meters meeting control checks. The DON stated any problems with glucometer calibrations were supposed to be reported to her or the unit managers. The DON stated she had not been made aware of any issues with glucometers out of calibration in the facility. The facility was determined to be in immediate jeopardy on [DATE] at 4:55 p.m. regarding a system failure with glucometers on all nursing units found without recent calibrations, found out of calibration or had been calibrated with out of date solution. There was no system to track which glucometers were used with which residents and glucometers were found without accurate date setup for historical reference of blood sugar readings. The facility staff presented the following plan of correction that was accepted by the survey team on [DATE] at 6:37 p.m.: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1) New blood glucose meters will be purchased immediately, calibrated per manufacturer's guidelines and documented on the Blood Glucose Monitoring Control Log. 2) An audit will be conducted to identify all residents with current blood glucose monitoring orders. All identified residents will have their blood glucose level checked immediately with a one-time order. We will use the new glucometers post calibration to obtain blood glucose levels. 3) All licensed staff will be educated by the Director of Nursing or designee on the manufacturer's guidelines for calibrating blood glucose monitors and appropriate documentation. Calibration and documentation will be completed once a shift. By tomorrow ,d+[DATE] at 1200 will educate remaining nursing staff before their shift is scheduled. 4) Blood Glucose Monitoring Control Log will be audited daily for 4 weeks and weekly thereafter. 5) Step 1 will be completed by [DATE] at 1900. Step 2 will be completed by [DATE] at 2100. Step 3 will be completed by [DATE] at 1200. On [DATE] at 6:40 PM, LPN #2 was interviewed and was asked if glucometer #1 and glucometer #2 for Cart A had been taken out of service and if the information regarding the failed control tests for both of these glucometers had been reported. LPN #1 stated that they had not been taken out of service and the information had not been reported to anyone. LPN #2 was then asked if Resident #108 received any insulin after the glucose reading. LPN #1 stated that she did administer the resident 15 units of Lispro [with lunch per order] based on the blood glucose reading from the glucometer that failed the control test. On [DATE] at 6:50 PM, LPN #3 was interviewed and was asked if glucometer #1 for Cart B had been taken out of service and if the information regarding the failed control test the glucometer had been reported. LPN #3, No, you took the book. LPN #3 was asked again, if the failed test had been reported to anyone. LPN #3 stated, No. On [DATE] at 8:22 a.m., the licensed practical nurse (LPN #2) that administered the Glucagon to Resident #249 on [DATE] was interviewed. LPN #2 stated the unit glucometers were used for blood sugar checks and administration of scheduled and sliding scale insulin. LPN #2 stated she did not think Resident #249 was checked with an out of range glucometer but there was no record of which glucometers were used with the resident. On [DATE] at 8:57 AM, Resident #27 was interviewed regarding the hypoglycemic event on [DATE]. Resident #27 said he has been a diabetic most of his adult life and knows when his blood sugar is getting low. Resident #27 stated he could not remember what day the lab technician drew labs but had not been feeling that his blood sugars had been low lately. Resident #27 said he did not remember eating anything after the labs test were taken but did eat breakfast. On [DATE] at approximately 9:00 AM, the glucometer control solution test information was reviewed for the [name of glucometer] that were being used by the facility. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The glucometer manual, [Name of glucometer] blood glucose monitoring system .Compare the result to the range printed on the test strip bottle. Make sure the result is within the acceptable range. If the result falls within the range, the meter and test strip are working correctly. Do not use system if control solution is out of range. Healthcare professionals: Record result in quality logbook . On [DATE] at 10:00 AM, the DON (director of nursing), the administrator and nurse consultant were again made aware of the serious concerns regarding staff not performing glucometer control checks and using glucometers after failing the control tests and administering insulin based on a test result from a glucometer that had failed control tests. The DON stated that they did not have a policy, but stated that the glucometer control tests are done every night by night shift and that the glucometer manual is the policy and stated that is what we go by. On [DATE] at 11:30 a.m., in-service education records were presented by the facility documenting staff education regarding: blood glucose meter control logs; completion of the calibration logs; blood glucose meter calibration protocol per manufacturer's guidelines; visual, verbal and return demonstrations of performing calibration; use of control solutions; and logging results in calibration test book. All current nursing staff were educated and a system was in place to educate any unavailable staff prior to their next scheduled shift. Glucometer checks were documented on all residents with current orders for blood sugar checks (30 residents) using newly purchased and successfully calibrated glucometers. On [DATE] at 12:08 p.m., the survey team inspected all glucometers in use on the three nursing units. All glucometers in use had been calibrated and were documented as meeting manufacturer's calibration requirements. Nurses on each unit demonstrated to surveyors the calibration protocol using testing solutions and demonstrated competency in calibration performance and documentation in logbooks. Staff were interviewed at the time of the demonstrations and all verified participation in staff education concerning glucometers, calibration protocols, documentation of calibrations and steps to take glucometers out of service if found out of calibration. On [DATE] at 1:09 p.m., the survey team informed the administrator, director of nursing and corporate consultant that the survey team had verified implementation of their plan of removal of immediate jeopardy. The Immediate Jeopardy was abated on [DATE] at 1:10 p.m., and the Scope and Severity was lowered to Level II, pattern. No further information was provided prior to exit. 6. Resident # 42 was admitted to the facility [DATE] with diagnoses to include, but were not limited to: congestive heart failure, osteoarthritis, diabetes, COPD, and GERD. The most recent MDS (minimum data set) was quarterly review dated [DATE] had Resident # 42 coded 15 out of 15 for cognition, indicating cognitively intact. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The clinical record was reviewed [DATE] at 2:45 p.m. There was an order written and carried forward from [DATE] for daily wts [weights] at night shift .call cardiovascular if wts greater than ,d+[DATE] pounds . The MAR (medication administration record) and TAR (treatment administration record) were reviewed but no daily weights were located on the records. The Weights and Vitals tab of the record was then reviewed, but no daily weghts were recorded. On [DATE] 3:30 p.m. the DON (director of nursing) was asked for assistance in locating the daily weights. On [DATE] at 8:24 a.m. the DON was asked if any documentation for the daily weights had been found. She stated I didn't see any daily weights. The DON was asked if that meant the weights were not done, and she replied Yes. The administrator, DON, and nurse consultant were made aware of the findings [DATE] at 1:15 p.m. during a meeting with facility staff. No further information was provided prior to the exit conference. 21875 7. Resident #56 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation, atherosclerotic heart disease, hypertension, heart failure, benign prostatic hyperplasia, inguinal hernia, gastroesophageal reflux disease and localized edema. The MDS dated [DATE] assessed the resident with moderately impaired cognitive skills. On [DATE] at 2:52 p.m., Resident #56 was interviewed about quality of care in the facility. Resident #56 stated that he had ongoing swelling in his feet and legs. The resident stated he wore support hose prior to coming to the facility and was told several times hose would be provided by the facility. Resident #56 stated he did not currently have support hose and had not had a pair since his admission. The resident was observed at this time with no hose or socks in use. Resident #56's clinical record documented assessment of lower extremity edema by the nurse practitioner (NP). A NP progress note dated [DATE] documented, .Patient states he noticed last couple days he has had increased swelling to bilateral lower extremities. He states when he was at home he had TED hose but he forgot to bring them with him .1+ edema noted bilateral lower extremities .We will order TED hose in a.m. and off in p.m. as needed for edema . Resident #56's clinic [TRUNCATED]

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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** 29123 Based on observation, staff interview, and clinical record review, the facility staff failed to ensure one of ten residents was administered oxygen as ordered by the physician, Resident #106. Findings were: Resident #106 was admitted to the facility on [DATE] with the following diagnoses, including but not limited to: COPD (chronic obstructive pulmonary disease), malignant neoplasm of the endometrium, vascular dementia and hypertension. The most recent MDS (minimum data set) was a quarterly review with an ARD (assessment reference date) of 06/23/2021. Resident #106 was assessed as moderately impaired with a cognitive summary score of 10. During initial tour of the facility on 08/10/2021 at approximately 9:15 a.m., Resident #106 was observed lying in bed. She was wearing a nasal cannula with oxygen running at 2 liters/minute. The clinical record was reviewed at approximately 11:00 a.m. The physician orders included: Oxygen therapy-Oxygen at 1 liters per minute via nasal cannula every shift for SOB [shortness of breath]. At 12:15 p.m., Resident #106's oxygen was again observed at 2 liters via nasal cannula. The unit manager was asked to go check the oxygen concentrator. She was asked at what level the oxygen was being delivered. She looked at the settings and stated, She is getting two liters. She was asked what was ordered. The unit manager went to the nurse's station and looked at the orders. She stated, It says oxygen at one liter, I'm not sure why she is on two I will ask her nurse. At 12:20 p.m., the unit manager stated, I am just [NAME] to put it back on one liter, I don't know why it got turned up. She was asked who checked the oxygen settings to ensure the appropriate amount was being delivered. She stated, I look at it if I'm taking care of the resident .the nurses should. She was asked who was caring for Resident #106. She stated, The nurse who was here this morning, left around 11:30 (a.m.), and another nurse took over (Name of licensed practical nurse [LPN] #4) has her now. LPN # 4 was interviewed about Resident #106. She was asked if she had been in to see her yet. She stated, Yes, that's the first room I went in. She was asked if she had checked her oxygen. She stated, No. She was asked who normally checked that. She stated, I only check it if it is on the TAR (Treatment Administration Record) or if they are having difficulty breathing. The TAR was reviewed at approximately 12:30 p.m. The following entry was observed: Oxygen therapy: Oxygen at 1 liters per minute via nasal cannula for SOB. The entry was not initialed indicating that it had been checked/verified for day shift. When the copies of the TAR were received from the facility at approximately 1:00 p.m., the entry had been initialed by LPN #4. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above information was reviewed during an end of the day meeting on 08/10/2021 at approximately 3:30 p.m., with the DON, ADON (assistant director of nursing), administrator, and corporate nurse consultant. No further information was obtained prior to the exit conference on 08/10/2021.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29123 Based on staff interview and clinical record review, the facility staff failed to ensure medications were available for two of 13 residents, Resident # 201 and Resident # 210. Resident #201 did not receive Hydrocodone three times per day as ordered by the physician because it was not available for administration. Resident # 210 was not administered Ofloxacin three times a day as ordered, and once a day as ordered. The findings were: 1. Resident #201 was admitted to the facility on [DATE] with the following diagnoses, including but not limited to: COPD (chronic obstructive pulmonary disease), malignant neoplasm of the endometrium, vascular dementia and hypertension. The most recent MDS (minimum data set) was a quarterly review with an ARD (assessment reference date) of 06/23/2021. Resident #201 was assessed as moderately impaired with a cognitive summary score of 10. On 09/21/2021 the clinical record was reviewed. The physician order section contained the following: HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain. The progress note section was reviewed. From 09/11/2021 through 09/20/2021, the nursesb documented that the medication Hydrocodone-Acetaminophen 5-325 mg was not available for administration. Entries in the nurses notes regarding the medication included: Medication on order; not available ordered from pharmacy; On order; Awaiting medications from pharmacy, script sent to pharmacy. The MAR (Medication administration record was reviewed. Resident #201's last dose of physician ordered Hydrocodone was administered on 09/11/2021 at 2:00 p.m. At the time of the survey on 09/21/2021 she had missed a total of 30 doses of Hydrocodone. On 09/21/2021 at approximately 2:00 p.m., LPN (licensed practical nurse) #2 was interviewed. She was assigned to give medications to Resident #201 her medicine and was asked if all of Resident #201's medication had been given as ordered. She stated, She doesn't have any of her pain medicine here, it's supposed to be coming. She was asked if she had called the pharmacy. She stated, No, they said it's coming. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A meeting was held with the administrator, the DON (director of nursing) and the two corporate nurse consultants on 09/21/2021 at approximately 4:00 p.m. Concerns were voiced that Resident #201 had not received her pain medication as ordered. The question was asked as to what should have happened when the nurses saw the medication was not on the medication cart. The corporate nurse consultant stated, If the medications are not here and the nurse needs to call the pharmacy and see where they are, every time .not say someone else called, they need to continue calling and notify the physician that the medicine isn't being given as ordered and they need to write a descriptive progress note .each nurse is responsible for medication administration on her shift. He was asked why the medication had not been delivered. He stated, I don't know, I need to follow up with the pharmacy. During then meeting the survey team was told that the whole company had switched to a new pharmacy on 09/01/2021 and that medications for the residents were being delivered from North Carolina three times per day. He was asked if the nurses knew how to contact the pharmacy. He stated, There are numbers for the new pharmacy at the nurses stations. The telephone number for the pharmacy was requested and received. At approximately 4:30 p.m., the pharmacist, OS (other staff) #5 was contacted at the pharmacy. He was asked why Resident #201's Hydrocodone had not been delivered. He looked up the information and stated, We got a new prescription on September 16th. It was filled and sent out that evening. Let me check with my driver. He returned to the phone and stated, The medication was delivered on 09/17/2021 and signed for by [Name of RN #2] at 3:02 a.m. He was asked how much hydrocodone had been delivered. He stated, Thirty tablets. He was asked how he knew they were delivered on that date at that time. He stated, We keep a history of the medications. The medication was placed in Tote #14189 .I also have the delivery receipt that the driver just sent to me. It shows the time and date the tote was delivered and the signature of the person who received it at the facility. He was asked when prior to 09/17/2021 the medication Hydrocodone had been delivered for Resident #201. He stated, That was the first time. We just took over on September 1st. They probably had medicine there from the previous pharmacy that carried them over until then. That's why we needed a new prescription in order to fill it. No further information was received prior to the exit conference on 09/21/2021. 2. Resident # 210 was admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident # 210's diagnoses at readmission included cerebral vascular disease, anemia, hypertension, renal insufficiency, pneumonia, diabetes mellitus, hyperlipidemia, aphasia, non-Alzheimer's dementia, depression, dysphagia, and polyneuropathy. According to the most recent Quarterly Minimum Data Set with an Assessment Reference Date of 9/1/2021, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 10 out of 15. Resident # 210 had the following physician's order, dated 9/10/2021: Ofloxacin Solution 0.3% - Instill 2 drop in right eye three times a day for conjunctivitis for 7 days. Review of the Progress Notes in the resident's Electronic Health Record revealed the following entry: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/14/2021 - 12:56 p.m. - Mr. (name of resident) missed a dose of her (sic) medication for conjunctivitis on 9/10 1400 (2:00 p.m.), 2100 (9:00 p.m.), and 9/11 1400 dose. Education provided to nursing in what to do if meds (medications) had not arrived from the pharmacy or could not be located Review of the Medication Administration Record in the resident's Electronic Health Record verified the Ofloxacin was not administered as ordered twice on 9/10/2021, and once on 9/11/2021. The order written on 9/10/2021 was discontinued on 9/14/2021. On 9/14/2021, the following new order for the ophthalmic solution was written: Ofloxacin Solution 0.3% - Instill 2 drop in right eye one time only for conjunctivitis for 4 days. According to the Medication Administration Record in the resident's Electronic Health Record, the medication was administered as ordered on 9/14/2021, but was not administered on 9/15, 9/16, or 9/17/2021. There was no documentation to indicate why the medication ordered on 9/14/2021 was not administered for three of four days. The findings were discussed during a meeting at 4:15 p.m. on 9/21/2021 that included the Administrator, Interim Director of Nursing, Executive Nurse, Nurse Consultant, and the survey team. No explanation was offered at that time as to why the medication was not available for administration as ordered for either the order of 9/10/2021 or the order of 9/14/2021.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28107 Based on observation, document review, and staff interview, the facility staff failed to ensure expired vaccine was not available for administration on one of 3 units: East unit. A bag containing seven expired vials of Afluria, an influenza vaccine, was in a thermal container in the medication room refrigerator. Findings include: On [DATE] at approximately 10:15 a.m. an inspection of the medication room on the East unit was conducted with LPN (licensed practical nurse) # 6. A silver thermal bag was located in the bottom of the refrigerator and contained seven multi-dose boxes of Afluria. The boxes were marked with an expiration date of [DATE]. LPN # 6 stated I had no idea those were even in there. The package insert for the Afluria vaccine under 16.2 Storage and Handling directs Do not use AFLURIA QUADRIVALENT (sic) beyond the expiration date . The administrator, DON, and nurse consultant were made aware of the findings [DATE] at 1:15 p.m. during a meeting with facility staff. No further information was provided prior to the exit conference.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 28107 Based on observation, resident interview, and staff interview the facility staff failed to honor food preferences for one of 38 residents in the survey sample: Resident # 18. Findings include: Resident # 18 was admitted to the facility 1/26/21 with diagnoses to include, but were not limited to: osteoporosis, muscle weakness, COPD, and Vitamin D deficiency. The most MDS (minimum data set) was a quarterly review dated 4/6/21 and had Resident # 18 assessed 13 out of 15 for cognition, indicating cognitively intact. On 6/30/21 at approximately 8:25 a.m. Residenty # 18 was observed with her breakfast tray on the overbed table. Resident # 18 was asked about her breakfast. She stated Not too good. I have scrambled eggs and oatmeal I am not going to eat, and look here: I have a biscuit but no butter or jelly or anything to put on it! Some of that sausage gravy would be nice to have to put on it . (Resident # 18's roommate had sausage gravy on her biscuit). The meal ticket for Resident # 18 was reviewed and revealed the resident should have also received a banana and bacon on her meal tray. Also included on the ticket was a note written in bold print Note: No Meat. (Can have eggs, Sausage, Bacon, and Sausage Gravy). On 6/30/21 at 8:45 a.m. the regional certified dietary manager, identified as Other Staff (OS) # 7, and the RD (registered dietitian) were interviewed about the meal ticket. OS # 1 and the RD were asked why the resident wasn't given sausage gravy for her biscuit as indicated she could have on the meal ticket. They were also asked about the lack of condiments on the meal tray. OS # 1 stated Well, that's my fault; I was afraid I'd get a tag if I served her meat .I didn't read past the 'No Meat' to see she could have had sausage gravy. I will send a new tray down right now. The RD then stated As far as butter, jelly, etc., there are condiment carts on the units so all the resident has to do is ask for that. The administrator, DON, and nurse consultant were made aware of the findings 7/1/21 at 1:15 p.m. during a meeting with facility staff. No further information was provided prior to the exit conference.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 21875 Based on observation, staff interview and facility document review, the facility staff failed to store and prepare food in a sanitary manner in the main kitchen. The findings include: On 6/29/21 at 10:48 a.m., accompanied by the dietary manager (other staff #2), the kitchen and food storage areas were inspected. Stored in the walk-in refrigerator was a plastic container of potato salad. The potato salad was labeled with a prep date of 6/12/21 and use by date of 6/19/21. A plastic container of applesauce was also stored and labeled with prep date of 6/17/21 and use by date of 6/28/21. The dietary manager was interviewed at the time of the observation. The dietary manager stated the potato salad and applesauce should have been discarded prior to today. On 6/29/21 at 11:04 a.m., accompanied by the dietary manager, meal preparation was observed in the kitchen. A scoop was observed stored in bulk container of raw sugar, with the handle touching the sugar. The dietary manager stated at the time of the observation that the scoop was supposed to be stored separately and not positioned in the food product. The facility's policy titled Leftovers (effective 9/14/18) documented, Leftovers shall be stored in a manner which maintains the food so that it is safe to eat, and retains optimal nutrient content and aesthetic quality . All leftovers shall be stored in sealed or air-tight containers .All leftovers containers shall be labeled, indicating the name of the product and the use-by-date .Storage of leftovers is a maximum of (7) seven days from date prepared . These findings were reviewed with the administrator and director of nursing during a meeting on 7/1/21 at 1:10 p.m.

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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** 27353 Based on clinical record review and staff interview, the facility staff failed to ensure a complete and accurate clinical record for two of 38 residents (Resident #285 and Resident #71). Resident #285's clinical record contained another resident's Covid-19 vaccination record, and Resident #71 had an incomplete treatment record for pressure ulcer dressing changes. Findings include: 1. Resident #285 was admitted to the facility on [DATE]. Diagnoses for this resident included, but were not limited to: cerebral infarct (stroke/sub-[NAME] hematoma), dysphagia, pneumonitis, muscle weakness, high blood pressure, peg tube placement, acute hypoxia and respiratory failure. The most current MDS (minimum data set) was an admission assessment (still in progress). This MDS was not complete. Resident #285 was assessed as alert and oriented to person and place on the nursing admission assessment dated [DATE]. On 06/29/21 at 2:59 PM, Resident #285's clinical records were reviewed. Another resident's [identified as Resident #286] Covid-19 vaccination record was located in Resident #285's chart. Resident #285's own Covid-19 vaccination record was also observed in the record. On 07/01/21 at 8:50 AM, the SW (social worker) was interviewed regarding the above information. The SW stated that when a new admission comes in she will see the residents and gather the information/documentation and then scan it all in. The SW stated that she didn't think anyone goes behind her to check that what she has scanned is accurate for each resident, but stated while scanning she will check and double check to ensure the records are accurate. The SW stated that she wasn't aware that the records were commingled, and stated that if other staff happen to see that scanned items are incorrect they will tell her that it has been scanned in error. The SW stated that she wasn't aware of the error and that it had not been reported to her. The DON and administrator were made aware on 07/01/21 at 1:30 PM. No further information and/or documentation was presented prior to the exit conference. 21875 2. Resident #71 was admitted to the facility on [DATE] with a re-admission on 6/17/21. Diagnoses for Resident #71 included enterocolitis due to clostridium difficile (C-diff), neuropathic bladder, history of urinary tract infections, hypertension, chronic kidney disease, autistic disorder and anemia. The minimum data set (MDS) dated [DATE] assessed Resident #71 with moderately impaired cognitive skills. Resident #71's clinical record documented the resident was readmitted from the hospital on 6/17/21 with multiple pressure ulcers on his buttocks. A weekly skin evaluation sheet dated 6/17/21 documented the following pressure ulcer assessment for Resident #71: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495105	A. Building B. Wing	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynchburg Health & Rehabilitation Center	5615 Seminole Avenue Lynchburg, VA 24502

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Left buttock - stage 2 pressure ulcer measuring 0.5 x 0.5 x 0 (length by width by depth in centimeters) Right buttock - two stage 2 pressure ulcers measuring 4.0 x 1.0 x 0 cm and 2.0 x 1.0 x 0 cm The clinical record documented a physician's order dated 6/18/21 to cleanse and apply zinc ointment with a dry dressing to the right and left buttock ulcers until healed. Resident #71's treatment administration record (TAR) documented no daily dressing changes/treatments for the pressure ulcers from 6/18/21 through 6/24/21 and on 6/26/21. Spaces for nurses' initials signing off completion of the treatments were blank. There were no attached notes or explanation of why the TAR was incomplete. Nursing notes from 6/18/21 through 6/26/21 documented treatments and dressing changes to the resident's pressure ulcers. On 7/1/21 at 8:25 a.m., the licensed practical nurse (LPN #2) routinely caring for Resident #71 was interviewed about the incomplete TAR. LPN #2 stated the treatments and dressing changes were done on the day shift as ordered. LPN #2 stated she did not know why the TAR was not signed off or completed. On 7/1/21 at 9:00 a.m., the director of nursing (DON) was interviewed about Resident #71's incomplete TAR. The DON stated skilled nursing notes made mention of the intact dressings on the resident. The DON stated the treatments should have been signed off on the TAR to document implementation of the physician's order. This finding was reviewed with the administrator and DON during a meeting on 7/1/21 at 1:10 p.m.

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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. 21875 Based on observation, staff interview, facility policy review and clinical record review, the facility staff failed to follow infection control practices during meal tray distribution on one of three nursing units. Staff members on the South wing failed to don gowns and gloves when serving meal trays to residents on droplet precautions. The findings include: On 6/29/21 at 12:20 p.m., meal tray service on the South unit was observed. On 6/29/21 at 12:36 p.m., certified nurses' aide (CNA) #2 with a mask on and no other personal protective equipment (PPE), entered room (number), positioned the over-bed table and placed the meal tray for A-bed resident. CNA #1, without gown or gloves, also entered this room and set up the meal tray for B-bed resident. CNA #1 and #2 exited the room and applied hand sanitizer to their hands. On 6/29/21 at 12:38 p.m., CNA #2 entered room (number), moved the over-bed table and setup the meal tray for the B-bed resident. CNA #2 had no gown or gloves on when entering the room and providing meal setup. All residents in this section of the South wing including rooms the CNAs entered, were identified and posted with signs for droplet precautions. Signs posted documented masks, gowns and gloves were required prior to entering rooms. Clinical record review for the residents in rooms above, documented they were new admissions and were on droplet precautions as part of the facility's COVID-19 prevention protocols. On 6/29/21 at 12:43 p.m., CNA #2 was interviewed about entering rooms without a gown or gloves. CNA #2 stated staff were supposed to wear masks, gowns and gloves when entering rooms on droplet precautions. CNA #2 stated the residents in the rooms observed were on droplet precautions like all the residents on the unit. On 6/29/21 at 2:37 p.m., CNA #1 was interviewed about not donning gowns and gloves during the meal observation. CNA #1 stated she thought the gowns and gloves were only required when performing direct care. CNA #1 stated she was not aware the gowns and gloves were required for meal tray delivery. CNA #1 stated the rooms observed were part of the quarantine unit due to COVID-19 and all rooms behind the designated red line required full PPE (gowns, gloves, masks). On 7/1/21 at 11:20 a.m., the director of nursing (DON) was interviewed about the PPE requirement when entering rooms with droplet precautions for meal service. The DON stated anytime staff entered rooms on droplet precautions, a gown, gloves and masks were to be worn. On 7/1/21 at 11:48 a.m., the infection preventionist (other staff #5) was interviewed about the meal observation on 6/29/21. The infection preventionist stated staff were required to wear gowns, gloves and masks anytime they entered rooms on droplet precautions. (continued on next page)

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	495105	A. Building B. Wing	07/01/2021

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Transmission Based Precautions - General Practice (effective 2/6/20) documented, The Center initiates transmission-based precautions (TBPs) to protect other patients, employees and visitors from the spread of a confirmed or suspected infection or contagious disease .Transmission based precautions are used in addition to standard precautions .Meal tray delivery to the room .Use gown, gloves, and/or mask if indicated by the type of isolation precautions being used for the patient .If gown, gloves, and/or mask were used, remove and dispose of properly .Perform hand hygiene . This finding was reviewed with the administrator and director of nursing during a meeting on 7/1/21 at 1:10 p. m.