DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495112	A. BUILDING ______ B. WING ______	C 01/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VA BAP HOSP DIV CEN	3300 RIVERMONT AVE LYNCHBURG, VA 24503

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 01/14/19 through 01/16/19. The facility was not in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Two complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/14/19 through 1/16/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey. The census in this 170 certified bed facility was 93 at the time of the survey. The survey sample consisted of 19 current Resident reviews and 3 closed record reviews.	F 000		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F 623		2/10/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/04/2019

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.

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F 623	Continued From page 1 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in	F 623		

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completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §

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F 623	Continued From page 3 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to provide written notification of a hospital transfer for two of 22 residents in the survey sample: Residents # 80 and # 23. 1. The facility staff failed to provide written documentation to Resident # 80 of a transfer to the hospital. 2. The facility staff failed to provide written documentation to Resident # 23 of a transfer to the hospital. Findings include: 1. Resident # 80 did not receive a written notice of his transfer from the facility to the hospital. Resident # 80 was admitted to the facility 7/25/16 with a readmission date of 10/16/18. Diagnoses for Resident # 80 included, but were not limited to: high blood pressure, chronic kidney disease, anemia, and pressure ulcers upon admission. The admission MDS (minimum data set) dated 10/20/18 had Resident # 80 assessed as cognitively intact with a total summary score of 15 out of 15. The closed clinical record was reviewed 1/15/19 at approximately 2:00 p.m. Nurses notes documented the resident was sent to the local emergency room for evaluation of the sacral pressure wound 12/12/18. The resident was subsequently admitted to the hospital and did not	F 623	1- Resident #80 and Resident #23 and their Responsible Parties were given written notice of their transfer from the facility to the hospital on 1/18/2019. 2- A 100% audit of all residents discharged from the facility in the month of January was conducted by the Lead Social Worker and written notification was provided to each resident that was discharged. 3- Education will be obtained through independent study of the regulations from the CMS.gov website by the SW department on the requirements before a transfer or discharge. 4- A 100% audit of all resident discharges from the facility will be completed monthly x 3 months by the SW department. The findings will be reported to the QAPI Committee to ensure ongoing compliance.	

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return to the facility. Further review of the record failed to reveal documentation that the resident, who was his own RP (responsible party) was notified in writing of the transfer to the hospital.

On 01/15/19 at 3:42 PM The administrator stated "We use a verbal notification; we don't send or give a notice in writing. (Name of resident) was his own RP and knew he was being transferred; we haven't given anyone a written notification." The administrator further stated the facility does notify the Ombudsman office, and produced documentation of same.

The administrator, DON (director of nursing), and the regional corporate consultant were made aware of the above findings during an end of day meeting beginning at 4:00 p.m.

No further information was provided prior to the exit conference.
2. Resident #23 was discharged to hospital and the facility did not notify the responsible party (RP) in writing.

Resident #23 was admitted to the facility on 10/10/18 with the most readmission on 11/17/18. The most current MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 11/24/18. Resident #23 was assessed as being cognitively intact with a score of 15 of 15. Diagnoses for Resident #23 included: Cellulitis, chronic pressure ulcer, diabetes, and sleep apnea.

Resident #23's medical record was reviewed on 1/15/19 and evidenced via a nursing note that Resident #23 was sent to the hospital on 11/13/18. According to a hospital discharge

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F 623	Continued From page 5 summary dated 11/17/18, Resident #23 was admitted to the hospital on 11/13/18 for recurrent cellulitis and confusion. Resident was later discharged back to the facility on 11/17/18. On 1/15/19 at 3:00 PM the administrator was asked to provide evidence that the RP received written notification of being discharged from the facility to the hospital. The administrator was able to provide evidence that the state Ombudsman's office had been notified in writing, but not able to provide evidence that the RP had been notified in writing. 01/16/19 08:16 AM Administrator verbalized that it was not the facilities practice to notify the RP or resident in writing of their discharge to the hospital and also verbalized unawareness of the regulation. No other information was presented prior to exit conference on 1/16/19.	F 623		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		2/10/19

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F 657	Continued From page 6 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to give advance notice of a care plan meeting for two of 22 residents in the survey sample. Residents #39 and #60 were not given advance notice of their most recent care plan meeting and stated they had not been invited to the meeting. The findings include: 1. Resident #39 was not given advance notice of her last care plan meeting and stated she was not invited to attend and/or participate in the meeting. Resident #39 was admitted to the facility on 6/25/15 with a re-admission on 11/20/18. Diagnoses for Resident #39 included diabetes, atherosclerotic heart disease, depression, gastroesophageal reflux and osteoarthritis. The minimum data set (MDS) dated 11/30/18 assessed Resident #39 as cognitively intact. On 1/14/19 at 4:10 p.m., Resident #39 was	F 657	1- Residents #39 and #60 were given a written notice of their next care plan meeting scheduled. 2- A 100% audit of all January scheduled care plan meetings was conducted to ensure that the resident and Responsible Party were given written advanced notice of their scheduled care plan meeting. 3- Education will be provided to the Social Work staff of the requirements of advanced notification of care planning meetings through the CMS.gov website. 4- After the initial 100% audit in January, a 10% audit will be conducted by the lead SW or designee to ensure that written advanced notification was provided to the resident	

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interviewed about quality of life and care in the facility. When asked about her attendance or participation in her care plan conference, Resident #39 stated she did not recall a recent meeting. Resident #39 stated she had not been invited to a recent care plan meeting and denied receiving any advance notice or schedule regarding her meeting date/time.

Resident #39's clinical record was reviewed from November 2018 through 1/13/19. The record made no mention of a resident invitation to a care plan meeting and documented no resident participation or refused attendance.

On 1/15/19 at 1:30 p.m., the facility's social worker was interviewed about any advance notification to Resident #39 regarding the last care plan meeting. The social worker stated Resident #39's last care plan meeting was held on 12/11/18. The social worker stated the resident did not attend the meeting. The social worker stated letters were routinely mailed in advance of meetings to family members and/or responsible parties but not to residents. The social worker presented a copy of an undated letter sent to Resident #39's emergency contact regarding the 12/11/18 meeting. There was no documentation of any advance notice of this meeting to Resident #39.

On 1/15/19 at 1:50 p.m., the registered nurse unit manager (RN #1) was interviewed about any notification to Resident #39 regarding care plan meetings. RN #1 stated she verbally invited residents to care plan meetings but made no notation about the invitation and the resident's participation. RN #1 stated she did not remember why Resident #39 did not participate in

Plan of correction (F 657):

and
the RP of the scheduled meeting.The findings
will be reported to the QAPI Committee to ensure ongoing compliance.

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her last care plan meeting.

This finding was reviewed with the administrator and director of nursing during a meeting on 1/15/19 at 4:00 p.m.

2. Resident #60 was not given advance notice of her last care plan meeting and stated she was not invited to attend and/or participate in the meeting.

Resident #60 was admitted to the facility on 3/17/18 with a re-admission on 9/17/18. Diagnoses for Resident #60 included multiple sclerosis, osteomyelitis, pressure ulcer, quadriplegia and urinary retention. The minimum data set (MDS) dated 12/19/18 assessed Resident #60 as cognitively intact.

On 1/14/19 at 12:00 p.m., Resident #60 was interviewed about quality of life and care in the facility. When asked about her attendance or participation in a recent care plan meeting, Resident #60 stated she did not recall a recent meeting. Resident #60 stated she had not been invited to a recent care plan meeting and denied receiving an advance notice or schedule regarding her meeting date/time.

Resident #60's clinical record was reviewed from November 2018 through 1/13/19. The record made no mention of a resident invitation to a recent care plan meeting and documented no resident participation or refused attendance.

On 1/15/19 at 1:38 p.m., the facility's social worker was interviewed about any advance notification to Resident #60 regarding the last care plan meeting. The social worker stated Resident #60's last care plan meeting was held

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F 657	Continued From page 9 on 12/27/18. The social worker stated the resident did not attend the meeting. The social worker stated letters were routinely mailed in advance of meetings to family members and/or responsible parties but not to residents. The social worker stated there was no care plan letter mailed regarding the 12/27/18 meeting as Resident #60 was her own decision-maker and there was no contact information for her next of kin. There was no documentation of any advance notice of the meeting to Resident #60. On 1/15/19 at 1:42 p.m., the registered nurse unit manager (RN #1) was interviewed about any notification to Resident #60 regarding the 12/27/18 care plan meeting. RN #1 stated they did not give letters about the meetings to the residents but she verbally invited residents to care plan meetings. RN #1 stated the notification was "verbal" and she made no note about the invitation and the resident's participation in the clinical record. RN #1 stated she did not know why Resident #60 did not participate in her last care plan meeting. This finding was reviewed with the administrator and director of nursing during a meeting on 1/15/19 at 4:00 p.m.	F 657		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		2/10/19

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F 758	Continued From page 10 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758		

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F 758	Continued From page 11 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to discontinue an order for PRN (as needed) psychotropic medication for one of 22 residents in the survey sample. Resident #43 had a physician's order for PRN (as needed) Lorazepam for more than 14 days without a stop date reflected. The findings include: Resident #43 was admitted to the facility on 07/29/17. Diagnoses for Resident #43 included hyperlipidemia, dementia, anxiety, depression, chronic obstructive pulmonary disease (COPD), chronic pain, restless/agitation and palliative care/hospice. The most recent minimum data set (MDS) dated 11/17/18 assessed Resident #43 as having severe cognitive impairment. Resident #43's clinical record was reviewed on 01/15/19 at 1:30 p.m. Included in this resident's physician order sheet was an order that stated, "Lorazepam 0.5 mg (milligrams) (1) TABLET Oral. Notes: Anxiety, Instructions: **Take one (1) tablet p.o. (by mouth) every 12 hours as needed for anxiety or agitation., Therapeutic Range: Physical Monitors: Behavior Ordering Prescriber: [name of physician], Order Date: 08/31/2018. Order Source: TelePhone - Read back by [name of RN], (08/31/2018 13:32)., Frequency: As Needed Every Twelve Hours Starting 08/31/2018." There was not an end date documented. A review of the pharmacy consultation reports documented the following:	F 758	1- The PRN medication was discontinued for Resident #43 and MD to assess if continued use is needed. 2- A 100% audit was conducted on residents with PRN psychotropics to ensure that each order contained a stop date. 3- Education was provided to the Nursing staff and Medical Providers on Requirement 483.45- PRN Psychotropic Drugs and reevaluation after 14 days and stop date requirements. 4- After initial 100% audit, each resident with a PRN Pyschotropic drug will be audited every 14 days x 3 months to ensure compliance. The findings will be reported to the QAPI Committee to ensure ongoing compliance.	

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F 758	Continued From page 12 1. September 4, 2018 - "This resident currently takes lorazepam as needed. CMS guidelines require routine attempts to gradually reduce the dose/discontinue prn psychotropic medications. In order to reach the minimum effective dose, consider reducing/discontinuing the dose. If not desired at this time, please document rationale." The Physician/Prescriber Response documented: "pt very anxious dose change not appropriate at this time." The report was signed and dated on 9/13/18 by the physician. 2. October 2, 2018 - "This resident currently takes lorazepam as needed. CMS guidelines require routine attempts to gradually reduce the dose/discontinue prn psychotropic medications. In order to reach the minimum effective dose, consider reducing/discontinuing the dose. If not desired at this time, please document rationale." The Physician/Prescriber Response documented: "pt very anxious & continues to need medication." The report was signed and dated on 10/15/18 by the physician. 3. November 6, 2018 - "This resident currently takes lorazepam as needed. CMS guidelines require routine attempts to gradually reduce the dose/discontinue prn psychotropic medications. In order to reach the minimum effective dose, consider reducing/discontinuing the dose. If not desired at this time, please document rationale." The Physician/Prescriber Response documented: "Pt continues to need lorazepam for behaviors. Not appropriate for reduction in dose/discontinuation." The report was signed and dated on 11/21/18 by the physician. 4. December 4, 2018 - "This resident currently	F 758		

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	495112	A. BUILDING ______ B. WING ______	C 01/16/2019

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takes lorazepam as needed. CMS guidelines require routine attempts to gradually reduce the dose/discontinue prn psychotropic medications. In order to reach the minimum effective dose, consider reducing/discontinuing the dose. If not desired at this time, please document rationale." The Physician/Prescriber Response documented: "patient on LOA (leave of absence) at this time & will likely be dc'ing (discharging) form the facility this week." The report was signed and dated on 12/18/18 by the physician.

A review of the Medication Administration Records (MAR) for January 2019, revealed the PRN Lorazepam was administered.

The January 2019 (MAR) documented the following dates and reasons for administration:
1. "1/1/2019. 20:11 Administered. Behavior: Fidgeting. Results: Behavior less frequent or improved."
2. "1/7/2019. 16:05 Administered. Behavior: Restless. Results: Behavior less frequent or improved." Notes: "Observed resident seated in Dining Room, visiting with family member and consistently fidgeting her hands and wringing hands x 2 during this period of observation. Attempts x 2 were made to converse with resident, in an attempt to provide reassurance and reduce anxiety, without success. Lorazepam 0.5 mg - 1 tablet administered orally @ 1605 for relief will continue to monitor RE: effectiveness.
3. "1/12/19. 23:55 Administered. Behaviors: Fidgeting. Results: Behavior less frequent or improved.

On 1/15/19 at 2:30 p.m., the unit manager (RN #1) was interviewed about the PRN Lorazepam order. RN #1 stated the order was originally

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started on 03/07/18 for 1 tablet in the afternoon. Then the order was changed on 4/12/18 to PRN every 12 hours. RN #1 stated she updated the order on 08/31/18 to include behavior monitoring. RN #1 was asked if any non-pharmacogical interventions were used for Resident #43. RN #1 stated Resident #43 enjoyed coloring and listening to music. She continued and stated the staff would attempt to redirect Resident #43, however sometimes the resident would attempt to hit the staff. RN #1 stated Resident #43 appeared more anxious in the recent weeks because her daughter had changed her discharge date a few times, due to concerns that she may not be able to safely take care of Resident #43 at home. RN #1 was asked if the physician had reevaluated resident #43 since the December Pharmacy review when the physician stated the resident would probably discharge. RN #1 stated "no she did not believe so."

On 1/15/18 at 4:00 p.m, during a meeting with the survey team the above information was shared with the administrator, the director of nursing (DON) and the corporate consultant. The Administrator stated in the past Resident #43 enjoyed coloring and staff would encourage her to do this as a means of redirection, however she had become more anxious lately due to her discharge date being changed by her daughter. The DON stated Resident #43 would sometimes come to her office and listen to music. The corporate consultant stated she couldn't speak directly on Resident #43's situation, however there appears to have some concern from the physicians regarding PRN psychotropic medications use for residents who are on hospice. The corporate consultant continued and stated despite this concern, they know the

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F 758	Continued From page 15 regulations states there is a 14 day limit on psychotropic medications.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, facility staff failed to prepare, store and serve food in a sanitary manner in the main kitchen. Facility staff failed to obtain initial food temperatures before plating food for resident consumption on the first floor and the cook failed to wear a cover over his beard while preparing and serving food. Two quart-size containers of V8 juice and two pint-size containers of cranberry juice were noted open and not dated in the	F 812	1- The identified employee immediately donned a beard cover. The open juice containers were immediately thrown away. The 10 identified trays were immediately discarded and food temperatures were taken and within range before food was plated. 2- A 100% audit was conducted on all open	2/10/19

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F 812	Continued From page 16 refrigerator. Findings included: During the initial tour of the kitchen on 01/14/19 at 11:35 a.m. the cook was observed without a beard cover in place. He was observed preparing and serving food in the main kitchen. Also during the tour, the tray line was observed set up. This surveyor asked if initial food temperatures had been obtained. The cook stated, "No, I am getting ready to do them here in a minute." A cart with plated food on trays was noted behind the serving line. The Dietary Manager (DM) was asked what those trays were. The DM stated, "Those are trays for the first floor." This surveyor asked the DM why these trays had been plated before initial food temperatures had been obtained. The DM stated, "They shouldn't have been." She then instructed one of the servers to remove the top tray so food temperatures could be obtained. The sloppy joe on the plated tray was temped at 126.1 degrees. The DM instructed the kitchen servers to remove all of the plated trays from the cart and stated, "They are not up to temp." The DM stated, "I think they pulled about ten trays." One of the servers was interviewed regarding food temperatures. She stated, "I figured [referring to the cook] he did it when he put them back [referring to the cook placing the prepared food on the serving line]." While touring the kitchen along with the DM, two quart-size containers of V8 juice and two pint-size containers of cranberry juice were noted open and not dated in the refrigerator. The DM stated,	F 812	food containers to ensure proper dating. A daily visual audit of all 3 meals with be conducted to ensure that temperatures have been taken prior to plating of the meals for a week. Daily observations will be conducted each shift for a week to ensure that all facial hair is properly contained. 3- Education was provided to all dietary staff of the importance of ensuring proper food temperatures prior to plating food, dating all open containers immediately to ensure quality and safety of the product and that facial hair is covered appropriately. 4- After 100% audit was conducted, weekly audits will be conducted x3 months to ensure compliance with dating open containers, beard covers and food temperatures. The findings will be reported to the QAPI Committee to ensure ongoing compliance.	

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"I think they were opened this morning, but they aren't dated and I am not sure, so I am going to throw them away."

The DM was interviewed regarding the cook not having a beard cover in place. The DM stated, "Yes, he should have one on. We have them. I will get him one right now."

Facility policies for food temperatures and beard covers was requested by this surveyor. Policies were received at approximately 1:00 p.m.

The policy, "Senior Care Services Food Temperatures At Point of Service" Approved: "02/16/2018" included: "Purpose: Food that is sent to residents is tasted and checked for temperature to meet quality standards...Procedures: 1. Menu food items are recorded on meal temperature sheets...2. Temperature of food is recorded at each meal prior to serving the first plate...4. Hot foods shall be heated and held at 135 degrees F or greater..."

The policy, "Senior Care Services Nutrition Services Personal Hygiene" Approved: "02/16/2018" included: "Purpose: ...Personal cleanliness is necessary to protect residents from potential food contamination...Standards should reflect federal, state, and local regulations...Procedures: 5. Beards and mustaches must be covered when working with food or on the tray line..."

The Administrator and DON (director of nursing) were informed of the above findings during and end of the day meeting with the survey team on 01/15/19. No further information was received

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F 812	Continued From page 18 prior to the exit conference on 01/16/19.	F 812		