STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495373	A. BUILDING ______ B. WING ______	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON OAKS NURSING AND REHABILITATION CENTER	3837 BRANDON AVENUE ROANOKE, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/25/2020 through 02/27/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 62 certified bed facility was 50 at the time of the survey. The survey sample consisted of 16 current Resident reviews and 3 closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578	**F-tag 578** **Corrective Action:** Residents #206 and #212 DDNR forms have been completed as of 2/28/20. **Others at risk:** All new admissions and all residents were potentially at risk. A 100% audit or all resident records will be audited and findings will be addressed accordingly. **Systemic changes:** All Licensed nurses and the Admissions staff were in-serviced by Social Worker on proper completion the DDNR forms. There were no necessary changes to the facility policy. **Evaluation & Monitoring:** Social Worker or designee will perform chart reviews weekly x 4 weeks, then monthly x 2 months, and as needed to monitor for compliance. Any findings and trends will be reported at the monthly QAPI meeting. After this time frame, the QAA Committee may determine to discontinue reporting if sustained compliance has been demonstrated. **Responsible Party:** Social Worker	4/10/20

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

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 578	Continued From page 1 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to ensure the resident's right to formulate an advanced directive by failing to ensure the advanced directive in the resident's record was complete for 2 of 19 residents, Resident #206 and #212. The findings included: 1. For Resident #206, the facility staff failed to accurately complete the resident's DDNR (Durable Do Not Resuscitate Order) form. Resident #206's diagnosis list indicated diagnoses, which included, but not limited to Encephalopathy, Essential Hypertension, and Personal History of Traumatic Brain Injury. Resident #206 did not have a completed MDS (minimum data set) at the time of the survey. A "Nursing Admission Assessment" dated 2/24/20	F 578		

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F 578	Continued From page 2	F 578		

documented the resident's cognitive status as alert and oriented to all spheres.

Resident #206's clinical record included a current physician's order dated 2/24/20 stating "DNR" (do not resuscitate).

The clinical record also included a Virginia Department of Health DDNR (Durable Do Not Resuscitate) Order form dated 2/24/20 signed by the physician and the resident's authorized representative.

This DDNR read in part
Under section 1 "I further certify (must check 1 or 2):
1. The patient is CAPABLE of making an informed decision ...
2. The patient is INCAPABLE of making an informed decision ..."
Number 2 was circled

Section 2 of the DDNR read, "If you checked 2 above, check A, B, or C below ...". All three options were left unmarked.

The concern of Resident #206's incomplete DDNR was discussed with the administrative team consisting of the Administrator, Administrator in Training, Director of Nursing, and Unit Manager #1 during a meeting on 2/26/20 at 5:30pm.

No further information was provided prior to the exit conference on 2/27/20.

2. For Resident #212, the facility staff failed to accurately complete the resident's DDNR (Durable Do Not Resuscitate Order) form.

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F 578	Continued From page 3	F 578		

Resident #212's diagnosis list indicated diagnoses, which included, but not limited to Aftercare following Joint Replacement Surgery, Presence of Left Artificial Shoulder Joint, Alzheimer's Disease, Chronic Kidney Disease Stage 3, Type 2 Diabetes Mellitus, and Nonrheumatic Aortic Valve Stenosis.

Resident #212 did not have a completed MDS (minimum data set) at the time of the survey. A "Nursing Admission Assessment" dated 2/25/20 documented the resident's cognitive status as alert and oriented to person only with memory problems.

Resident #212's clinical record included a current physician's order dated 2/25/20 stating "DNR" (do not resuscitate).

The clinical record also included a Virginia Department of Health DDNR (Durable Do Not Resuscitate) Order form dated 9/24/19 signed by the physician and the resident's authorized representative.

This DDNR read in part
Under section 1 "I further certify (must check 1 or 2):
1. The patient is CAPABLE of making an informed decision ...
2. The patient is INCAPABLE of making an informed decision ..."
Number 2 was circled

Section 2 of the DDNR read, "If you checked 2 above, check A, B, or C below ...". All three options were left unmarked.

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F 578

Continued From page 4

The concern of Resident #212's incomplete DDNR was discussed with the administrative team consisting of the Administrator, Administrator in Training, Director of Nursing, and Unit Manager #1 during a meeting on 2/26/20 at 5:30pm.

No further information was provided prior to the exit conference on 2/27/20.

F 580 SS=D

Notify of Changes (Injury/Decline/Room, etc.)
CFR(s): 483.10(g)(14)(i)-(iv)(15)

§483.10(g)(14) Notification of Changes.
(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the

F 580 — Completion date: 4/10/20

F-tag 580
Corrective Action:
Attending physician for resident #12 was notified of the medications that were administered late. No new orders noted.
Others at risk:
All other residents were potentially at risk. A 100% audit of all MARs will be completed by the Director of Nursing or designee and findings will be addressed accordingly.
Systemic changes:
All licensed nursing staff will be in-serviced by the Director of Nursing on the facility's medication administration policy, including physician notification when a medication is administered late. There were no necessary changes to the facility policy.
Evaluation & Monitoring:
Director of Nursing or designee nursing staff will audit MARs weekly for medications not being administered within proper time-frame and physician notification. Findings and trends will be addressed at the monthly QAPI meeting for at least 6 months. After this time, the QAPI Committee may determine to discontinue the reporting if sustained compliance has been demonstrated.
Responsible Party:
Director of Nursing.

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F 580	Continued From page 5	F 580		

resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to notify the physician in regards to administrating routine scheduled medications as evidenced by administrating medications to 1 of 19 residents at another time other than the routine scheduled times (Resident #12).

The findings included:

Resident #12 was a resident in the facility at the time of this survey of 2/25/2020 through 2/27/2020. On the most recent significant change MDS (Minimum Data Set), the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score

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F 580	Continued From page 6 of 15. Resident #12 was also coded as requiring extensive assistance of one staff member for dressing and bathing and being totally dependent on one staff member for bathing. The resident had the following diagnoses of, but not limited to atrial fibrillation, heart failure, high blood pressure, and depression. During the clinical record review that was conducted 2/25/2020 through 2/27/2020, the surveyor noted the following in the January 2020 MAR (Medication Administration Record) for Resident #12: " Scheduled Date 1/5/2020 Scheduled Time 9 AM Charted Date 1/5/2020 10:46 AM Reasons/Comments " ...Administrated Late ..." This was documented for the medication Augmentin 875-125 mg (milligram) to be administrated to the resident twice a day. " Scheduled Date 1/5/2020 Scheduled Time 9 AM Charted Date 1/5/2020 10:46 AM Reasons/Comments " ...Administrated Late ..." This was documented for the medication of Carvedilol 6.25 mg to be administrated to the resident twice a day, " Scheduled Date 1/4/2020 Scheduled Time 9 AM Charted Date 1/4/2020 10:13 AM Reasons/Comments: " ...Administrated Late ..." This was documented for the medication Eliquis 2.5 mg to be administrated to the resident twice a day. " Scheduled Date 1/5/2020 Scheduled Time 9 AM Charted Date 1/5/2020 10:46 AM Reasons/Comments " ...Administrated Late ..." This was documented for the medication Keppra 1,000 mg to be administrated to the resident twice a day.	F 580		

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F 580	Continued From page 7 The surveyor notified the DON (director of nursing) of the above documented findings on 2/27/2020 at 1:30 pm. The surveyor asked the DON if the staff member administrators a medication other than the scheduled times (ie: an hour and 45 minutes after the scheduled time) what is the expectation of that staff member doing regarding this. The DON stated "The nurse has an hour before and an hour after the scheduled time to administer the medication to the resident without it being considered outside of the schedule time. If the medication is given outside of that scheduled time than the nurse is to notify the physician that this has occurred." The surveyor requested a copy of the facility's policy regarding the administration of medication to the residents. The suryeor asked the DON if this documentation was present in the nurses' notes for these dates and times when the medication was not given at the scheduled time. The DON stated, "I could not find any documentation that the physician had been notified on these dates." At 2 pm, the surveyor received the facility's policy titled "Medication Administration General Guidelines" from the DON. In this policy it read in part, " ...If a dose of regularly scheduled medication is withheld, refused, not available or given at a time other than the scheduled time, the nurse will enter the reason the medication was withheld, refused, not available or given at the time other than the scheduled time into the electronic medication record along with documentation the physician is notified. Nursing documents the notification and physician response." The surveyor notified the administrator and the DON at 4:46 pm on 2/27/2020 of the above	F 580		

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F 580	Continued From page 8 documented findings. No further information was provided to the surveyor prior to the exit conference on 2/27/2020.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate MDS (minimum data set) for 1 of 19 residents, Resident #53. The findings included: For Resident #53, facility staff coded the resident as being discharged to an acute hospital when in fact the resident had been discharged to an assisted living facility. Resident #53's diagnosis list indicated diagnoses, which included, but not limited to Thrombocytopenia, Myelodysplastic Syndrome, Vascular Dementia without Behavioral Disturbance, Essential Hypertension, and Muscle Weakness. The most recent discharge MDS with an ARD (assessment reference date) of 1/24/20 assigned the resident a BIMS (brief interview for mental status) score of 8 out of 15 in section C, Cognitive Patterns. Resident #53 is coded as being discharged to an acute hospital in section A,	F 641	F-tag 641 **Corrective Action:** Resident #53 MDS was fixed on 2/27/20 by an MDS Coordinator to accurately reflect that the resident was discharged to the community and not to an acute hospital. **Others at risk:** All other MDSs were potentially affected by this. All discharges for the year have been audited for by MDS coordinators to make sure it accurately reflects where residents are being discharged to. **Systemic changes:** MDS Coordinators have been educated by the Director of Nursing on making sure MDS continues to accurately reflect the discharge destination. There were no necessary changes to facility policy. **Evaluation & Monitoring:** Director of Nursing or designee nursing staff will audit MDSs weekly for 4 weeks, then monthly for accurate discharge destination. Findings and trends will be addressed at the monthly QAPI meeting for at least 6 months. After this time, the QAPI Committee may determine to discontinue the reporting if sustained compliance has been demonstrated. **Responsible Party:** Director of Nursing.	4/10/20

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F 641	Continued From page 9 Identification Information. A review of Resident #53's medical record revealed a signed physician's order dated 1/23/20 stating "Discharge to (name omitted) Intensive Assisted Living 1/24/20. Outpatient PT (physical therapy) and OT (occupational therapy) to eval (evaluate) and treat as indicated". A social services progress note dated 1/24/20 12:52pm states "Patient discharge to (name omitted) IAL (Intensive Assisted Living) on 1/24/20. Patient outpatient services secured with (name omitted). Patient had no DME needs. Family present at discharge. No mood issues at this time". The medical record contained a "Discharge Plan of Care" signed by the discharging nurse on 1/24/20 indicating discharge destination is (name omitted) IAL. A nursing progress note dated 1/24/20 12:24pm states "RSD (resident) transferred to IAL with all belongings". On 2/27/20 at 10:49am, the surveyor spoke with the MDS staff, RN (registered nurse) #1 and LPN (licensed practical nurse) #1, concerning coding for A2100 "Discharge Status" on the 1/24/20 MDS. LPN #1 stated the question should have been coded as "1", indicating discharge to the community. On 2/27/20 at 11:20am, RN #1 provided surveyor with a modified discharge MDS with an ARD of 1/24/20 with question A2100 coded as discharge to the community. On 2/27/20 at approximately 4:45pm, the administrator and director of nursing were notified	F 641		

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F 641	Continued From page 10 of the inaccurate MDS assessment for Resident #53. No further information was provided prior to the exit conference on 2/27/20.	F 641		
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. (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 staff interview and clinical record	F 657	F-tag 657 **Corrective Action:** Resident #13 Care Plan was updated on 2/28/20 to reflect the specific transfer status. **Others at risk:** All other residents were potentially at risk. A 100% audit of all resident care plans will be completed by Nursing staff to make sure resident transfer status as well as all other interventions are resident-specific. Any findings will be addressed accordingly. **Systemic changes:** Licensed nursing staff will be in-serviced by Director of Nursing or designee on specifying resident transfer status in all resident care plans. The facility policy has been revised to specify the resident transfer status in the resident care plan. **Evaluation & Monitoring:** All resident care plans will be monitored weekly x 4 weeks, then monthly for 6 months, and as needed to monitor for compliance. Findings and trends will be addressed at the monthly QAPI meeting for at least 6 months. After this time, the QAPI Committee may determine to discontinue the reporting if sustained compliance has been demonstrated. **Responsible Party:** Director of Nursing.	4/10/20

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F 657	Continued From page 11 review, the facility staff failed to have an interdisciplinary team prepared plan that was resident centered specifying "Transfer per Handling Program" on the comprehensive care plan for 1 of 19 residents (Resident #13). The findings included: Resident #13 was a resident in the facility at the time the survey was conducted. The resident was admitted with the following diagnoses of, but not limited to atrial fibrillation, coronary artery disease, high blood pressure and hip fracture. On the most recent MDS (Minimum Data Set), the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #13 was also coded as requiring extensive assistance of two or more staff members for dressing and personal hygiene and being totally dependent on two or more staff members for bathing, During the clinical record review on 2/26/2020 and 2/27/2020, the surveyor noted the following entry on the resident centered comprehensive care plan (CCP) under the ADL Functional/Rehabilitation Potential which stated, " ...Transfer per Handling Program ..." There was no explanation of how the resident was to be transferred according to this program. The surveyor notified the DON (director of nursing) of the above documented findings on 2/27/2020 at 2 pm. The surveyor asked the DON according to this resident centered CCP, how is this resident supposed to be transferred. The DON stated, "The staff would transfer the resident according to the transfer handling program." The surveyor asked the DON, does	F 657		

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

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F 657	Continued From page 12 this resident centered CCP explain to the staff how this resident is supposed to be transferred (for example, one person assist, two person assist). The DON stated, "No it does not. It just states "Transfer per Handling Program." The surveyor notified the administrator and the DON of the above documented findings on 2/27/2020 at 4:46 pm in the end of the day conference. No further information was provided to the surveyor prior to the exit conference on 2/27/2020.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to ensure that residents receive treatment and care in accordance with the comprehensive person-centered care plan as evidenced by failure to administer medication per physician's order for 1 of 19 residents, Resident #217. The findings included:	F 684	F-tag 684 **Corrective Action:** The physician was notified of the medication being held due to resident's pulse and the physician assistant clarified the order for Carvedilol to Resident #217 to include parameters. **Others at risk:** All other residents were potentially at risk. A 100% audit of all MARs will be completed by the Director of Nursing or designee for held medications. Any findings will be addressed accordingly. **Systemic changes:** All licensed nursing staff will be in-serviced by the Director of Nursing on the facility's medication administration policy, including physician notification when a medication is held. There were no necessary changes to the facility policy. **Evaluation & Monitoring:** Audits on MARs will be performed weekly x 4 weeks, then monthly x 2 months, and as needed to monitor for compliance. Findings and trends will be addressed at the monthly QAPI meeting for at least 6 months. After this time, the QAPI Committee may determine to discontinue the reporting if sustained compliance has been demonstrated. **Responsible Party:** Director of Nursing.	4/10/20

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F 684	Continued From page 13	F 684		

For Resident #217, the facility staff failed to follow physician's orders for the administration of the medication Carvedilol (a beta-blocker used to treat hypertension and heart failure).

Resident #217's diagnosis list indicated diagnoses, which included, but not limited to Hypertensive Urgency, Essential Hypertension, Unspecified Atrial Fibrillation, and Presence of Cardiac Pacemaker.

Resident #217 did not have a completed MDS (minimum data set) at the time of the survey. A "Nursing Admission Assessment" dated 2/18/20 documented the resident's cognitive status as alert and oriented to all spheres.

A review of Resident #217's medical record revealed a signed physician's order dated 2/18/20 for Carvedilol 12.5 mg (milligrams) oral twice a day at 9:00am and 9:00pm for HTN (hypertension). Surveyor reviewed the resident's February 2020 MAR (medication administration record) and noted Carvedilol was not administered on 2/25/20 at 9:00am with the reason documented as due to condition, pulse 50.

On 2/26/20 at approximately 5:35pm, the administrative team consisting of the administrator, administrator in training, director of nursing, and unit manager #1 were made aware of Resident #217 not receiving Carvedilol as ordered on 2/25/20.

On 2/27/20 at 12:07pm, surveyor spoke with Unit Manager #2 who stated the resident's physician's assistant clarified the order for Carvedilol adding parameters for administration. The clarified order

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F 684	Continued From page 14 for Carvedilol dated 2/27/20 added the parameter to hold if pulse is under 55. No further information regarding this issue was presented to the survey team prior to the exit conference on 2/27/20.	F 684		
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 document review, the facility staff failed to properly store food in resident accessible refrigerators in 2 of 2 Nourishment Stations in the facility located on Units 1 and 3. The findings included:	F 812	F-tag 812 **Corrective Action:** The undated sandwich found on Unit 1 and the 2 cartons of expired chocolate milk from Unit 3 were discarded by Dietary manager on 2/25/20. All of the undated items found on Unit 1 on 2/26/20 were discarded by the Dietary Manager on 2/26/20. **Others at risk:** All other refrigerators were inspected by Dietary manager for expired or undated foods or beverages. There were no other unlabeled or undated items noted. **Systemic changes:** All refrigerators will be monitored daily by Dietary Manager or designee for expired or undated foods or beverages. Dietary and nursing staff will also be in-serviced on monitoring refrigerators for expired and undated foods and beverages by Dietary Manager. **Evaluation & Monitoring:** All refrigerators will continue to be monitored daily by Dietary Manager or designee. Administrator or designee will monitor weekly. Findings and trends will be addressed at the monthly QAPI meeting for at least 3 months. After this time, the QAPI Committee may determine to discontinue the reporting if sustained compliance has been demonstrated. **Responsible Party:** Dietary Manager.	4/10/20

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F 812	Continued From page 15	F 812		

For Unit 1, the facility staff failed to date a pre-made sandwich prior to placing in the refrigerator and failed to discard food that was brought in from outside the facility and placed in the refrigerator without a date. For Unit 3, facility staff failed to remove out of date milk from the refrigerator.

On 2/25/20 at approximately 3:30pm, surveyor observed the contents of the Unit 3 Nourishment Station refrigerator and noted two cartons of chocolate milk with a sale by date of 2/24/20 and a carton of fat free milk with the sale by date of 2/21/20.

On 2/25/20 at approximately 4:05pm, surveyor spoke with the CDM (certified dietary manager) who stated the facility uses the sell by date listed on each carton of milk as the discard card. Surveyor and CDM went to the Unit 3 Nourishment Station refrigerator and the CDM removed with the three cartons of milk and stated they would discard them and check the other refrigerators in the facility.

On 2/26/20 at approximately 4:15pm, surveyor observed the following in the Unit 1 Nourishment Station refrigerator: ½ of a sandwich wrapped in plastic wrap labeled "ham and cheese", a clear plastic container with sliced fruit labeled with a resident's name and room number, a clear plastic bag containing an open container of palmetto cheese and a container with chocolate covered strawberries labeled with a resident's name and room number, and a plastic container of soup in the freezer labeled with a resident's name , room number, and "soup". None of these items included a date. The CDM was notified and observed the undated items in the refrigerator

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F 812	Continued From page 16	F 812		

and removed the sandwich and stated they would notify the families of the other items.

Surveyor requested and received the policy "Food Brought Into the Facility by Visitors" which stated in part:
Family or visitors must label the containers with the date it was brought into the facility and the name and room number
of the resident receiving it
As a rule, discard time/temperature for safety (TCS) food within 7 days from the date it was made
Monitor refrigerators for foods that are beyond their 7 day date and discard food items

On 2/26/20 at approximately 5:35pm, the administrative team consisting of the administrator, administrator in training, director of nursing, and unit manager #1 were notified of the outdated milk in the refrigerator on Unit 3 and the undated food items in the refrigerator on Unit 1.

No further information regarding these issues were presented to the survey team prior to the exit conference on 2/27/20.