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
	495261	A. BUILDING ______ B. WING ______	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEESBURG	122 MORVEN PARK ROAD NW LEESBURG, VA 20176

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 9/20/22 through 9/21/22 The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 09/20/2022 through 09/21/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 164 certified bed facility was 141 at the time of the survey. The survey sample consisted of 36 current resident reviews and four closed records.	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).	F 578	F578 Corrective Action(s): Advance Directive information has been presented to Resident #R44. That information has been reviewed and discussed with the resident to ensure that she is able to make an informed choice regarding an advance directive. Identification of Deficient Practice(s) & Corrective Action(s): All other residents may have been potentially affected. The Admission Director and/or Social Services Director will review all resident's medical records to ensure that information has been provided to each resident regarding' advance directives and information has been reviewed and discussed with residents found to be at risk.	11/5/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — [signature] TITLE Administrator (X6) DATE 9/29/2022

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 (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 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, staff interview and facility document review, it was determined that the facility staff failed to conduct a review of the advance directive for one of 40 residents in the survey sample, Resident # 44 (R44). The findings include: For (R44) the facility staff failed to evidence documentation of a discussion regarding advance directives for Resident # 44.	F 578	Systemic Change(s); The Facility policy and procedure was reviewed and no changes are warranted at this time. The Admissions Director, Social Worker, and nursing administration have been inserviced on the presentation, discussion and review of advance directive information to residents or responsible party's as indicated. Monitoring: The Social Services Director is responsible for maintaining compliance. The Admissions Director, Social Service Director will audit all Residents medical records monthly to monitor compliance for having a current resuscitation order and/or advance directive. Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation. Completion Date: 11/5/2022	11/5/22

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F 578	Continued From page 2	F 578		

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/12/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.

Review of the facility's "Advance Directive Acknowledgement" for (R44) dated 08/24/2020 revealed that (R44) executed an advance directive and provided the facility with a copy of the advance directive.

The facility's social service note for (R44) dated 02/05/2022 documented in part, "Resident will remain a DNR code status." Further review of the social service note failed to evidence discussion of an advance directive.

The POS (physician's order sheet) for (R44) dated "September 2022" documented in part, "Do Not Resuscitate (DNR). Order Date: 12/06/20."

The social service note for (R44) dated 07/18/2022 documented in part, "Resident remains a DNR per her choice." Further review of the note failed to evidence that (R44's) advance directive was discussed or reviewed.

On 09/21/22 at approximately 12:29 p.m., an interview was conducted with OSM (other staff member) #2, director of Social Services. After reviewing their notes for (R44) dated 07/18/2022 and the facility's policy for advance directives, OSM #2 was asked about the review of (R44's) advance directive. OSM #2 stated that it was discussed, however did not have documentation of it. OSM # 2 further stated that if it was not documented then they could not say it was done.

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F 578	Continued From page 3 The facility's policy "Advance Directives" documented in part, "18. The Interdisciplinary Team will review annually with the resident his or her advance directive to ensure that such directives are still the wishes of the resident ..." On 09/21/2022 at approximately 2:17 p.m., ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, ASM # 3, regional VP of operations, ASM # 4, administer in training and ASM # 5, regional nurse consultant, were made aware of the above findings. No further information was provided prior to exit	F 578		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to	F 640	**F640** **Corrective Action(s):** Resident #2 has had their Discharge MDS completed to accurately reflect the resident's discharge date. Resident #433 has had their Discharge MDS completed to accurately reflect the resident's discharge date. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have potentially been affected. A review of all current residents discharged from the facility in the previous 100 days will be completed by the MDS Coordinator and/or designee to identify residents at risk. All negative findings will be reported to the MDS department for immediate correction. A correction will be completed for each discrepancy identified on the most current MDS.	11/5/22

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F 640	Continued From page 4 standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined the facility staff failed to accurately code an MDS (Minimum Data Set) assessment for two of 40 residents, Resident #2 and Resident #433. The facility staff failed to code an MDS (minimum data set) discharge assessment for Resident #2 and Resident #433.	F 640	**Systemic Change(s):** The MDS Coordinator has been inserviced by the Regional Nurse consultant on the proper assessment and coding of all areas of the MDS to include the requirements in completing a discharge MDS. All discharged residents will be reviewed monthly to ensure that a discharge MDS has been completed. **Monitoring:** The DON and RCC are responsible for monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS calendar to monitor for compliance. All negative findings from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 11/5/2022	11/5/22

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F 640	Continued From page 5	F 640		

The findings include:

1. Resident #2 was admitted to the facility on 4/21/22 and discharged home on 4/27/22.

The most recent MDS (minimum data set) assessment, a 5 day Medicare assessment, with an ARD (assessment reference date) of 4/27/22, coded the resident as scoring a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired.

Further review of Resident #2's MDS dated 4/27/22, the last MDS done for this resident revealed Section A0310 Type of Assessment: F: Entry/Discharge Reporting: revealed coding of 99 (none of the above). MDS Section A2000 Discharge Date: revealed no discharge date entered.

A review of the nursing progress note dated 4/27/22, revealed, "Resident discharge home with family."

An interview was conducted on 9/21/22 at 1:25 PM with RN (registered nurse) #2, the MDS coordinator. When asked to review Resident #2's MDS dated 4/27/22 Section A2000, RN #2 stated, yes, there should have been a discharge date entered there. When asked what standard is followed for MDS completion, RN #2 stated, we follow the RAI (resident assessment instrument).

On 9/21/22 at 2:15 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations and ASM #4, the administrator in training.

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F 640	Continued From page 6	F 640		

Continued From page 6

A review of the RAI included: "Assessment Types and Definitions: In order to understand the requirements for conducting assessments of nursing home residents, it is first important to understand some of the concepts and definitions associated with MDS assessments. Concepts and definitions for assessments are only introduced in this section. Discharge Assessment refers to an assessment required on resident discharge from the facility, or when a resident's Medicare Part A stay ends, but the resident remains in the facility..."

No further information was provided prior to exit.

2. Resident #433 was admitted to the facility on 4/15/22 and discharged on 5/16/22.

The most recent MDS (minimum data set) assessment, a 5 day Medicare assessment, with an ARD (assessment reference date) of 5/16/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired.

Further review of Resident #433's MDS dated 5/16/22, the last MDS done for this resident revealed Section A0310 Type of Assessment: F: Entry/Discharge Reporting: revealed coding of 99 (none of the above). MDS Section A2000 Discharge Date: revealed no discharge date entered.

A review of the nursing progress note dated 5/16/22, revealed, "Resident discharge to assisted living facility."

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F 640	Continued From page 7 An interview was conducted on 9/21/22 at 1:25 PM with RN (registered nurse) #2, the MDS coordinator. When asked to review Resident #433's MDS dated 5/16/22 Section A2000, RN #2 stated, yes, the resident came off of skilled services on 5/16/22 and transferred to an ALF (assisted living facility) and there should there have been a discharge assessment completed return not anticipated, there should have been a discharge date entered there. When asked what standard is followed for MDS completion, RN #2 stated, we follow the RAI (resident assessment instrument). On 9/21/22 at 2:15 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations and ASM #4, the administrator in training. A review of the RAI included: "Assessment Types and Definitions: In order to understand the requirements for conducting assessments of nursing home residents, it is first important to understand some of the concepts and definitions associated with MDS assessments. Concepts and definitions for assessments are only introduced in this section. Discharge Assessment refers to an assessment required on resident discharge from the facility, or when a resident's Medicare Part A stay ends, but the resident remains in the facility..." No further information was provided prior to exit.	F 640		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656	F656 Corrective Action(s): Resident #6's attending physician has been notified that facility staff failed to follow the comprehensive care plan for oxygen administration.	11/5/22

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F 656	Continued From page 8 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656	**Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all comprehensive care plans will be conducted by the DON /designee to identify residents with interventions that have not been implemented. Negative findings will be addressed at the time of discovery. **Systemic Changes:** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development, revision and implementation process of individualized care plans. **Monitoring:** The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the DON / RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:11/5/2022**	11/5/22

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F 656	Continued From page 9 section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to follow the comprehensive care plan for one of 40 residents in the survey sample; Resident #6. The findings include: For Resident #6, the facility staff failed to implement the comprehensive care plan for administering oxygen at the ordered rate. Resident #6 was admitted to the facility on 3/5/20. On the most recent MDS (Minimum Data Set), a quarterly assessment dated 9/21/22, the resident was coded as being cognitively intact in ability to make daily decisions. The resident was coded as being on oxygen therapy. On 9/20/22 at 12:30 PM and 9/21/22 at 8:05 AM, Resident #6 was observed in bed, wearing the nasal cannula for the oxygen. The oxygen concentrator was set for 2.5 liters per minute. A review of the comprehensive care plan revealed one dated 3/5/20 for "At risk for respiratory/cardiac complications...." This care plan included an intervention dated 12/12/21 for "O2 per order." A review of the clinical record revealed a physician's order dated 12/21/21 for "O2 (oxygen) on 2L (two liters) via NC (nasal cannula) cont (continuous)." On 9/21/22 at 8:10 AM an interview was	F 656		

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F 656	Continued From page 10 conducted with LPN #3 (Licensed Practical Nurse). She stated that the resident's oxygen rate should be at 2 liters. She observed the oxygen concentrator and verified it was set at 2.5 liters. She adjusted the rate. When asked if the care plan for administering oxygeh at the physician ordered rate was being followed, she stated that it was not. The facility policy "Care Plans, Comprehensive Person-Centered" was reviewed. This policy documented, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. On 9/21/22 at 1:05 PM, ASM #1 (Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey.	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to	F 695	**F695** **Corrective Action(s):** Resident #6's attending physician has been notified that the facility staff failed to provide oxygen to the resident at the prescribed flow rate. **Identification of Deficient Practices & Corrective Action(s):** All residents receiving oxygen therapy may have potentially been affected. A 100% review of all resident's oxygen orders will be conducted by the DON/designee to identify residents at risk. Residents found to be at risk will be corrected at the time of discovery.	11/5/22

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(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 695	Continued From page 11 administer oxygen at the physician ordered rate for 1 of 40 residents in the survey sample; Resident #6. The findings include: For Resident #6, the facility staff failed to administer oxygen at the physician ordered rate. Resident #6 was admitted to the facility on 3/5/20. On the most recent MDS (Minimum Data Set), a quarterly assessment dated 9/21/22, the resident was coded as being cognitively intact in ability to make daily decisions. The resident was coded as being on oxygen therapy. A review of the clinical record revealed a physician's order dated 12/21/21 for "O2 (oxygen) on 2L (two liters) via NC (nasal cannula) cont (continuous)." On 9/20/22 at 12:30 PM and 9/21/22 at 8:05 AM, Resident #6 was observed in bed, wearing the nasal cannula for the oxygen. The oxygen concentrator was set for 2.5 liters per minute. On 9/21/22 at 8:10 AM an interview was conducted with LPN #3 (Licensed Practical Nurse). She stated that the resident's oxygen rate should be at 2 liters. She observed the oxygen concentrator and verified it was set at 2.5 liters. She adjusted the rate. When asked how is the rate read, she stated that the ball is set at the line for the ordered rate, with the line crossing through the center of the ball. When asked if physician's orders for oxygen being followed, she stated it was not. A review of the comprehensive care plan	F 695	Systemic Change(s): The facility policy and procedure for Oxygen administration and documentation of oxygen administration have been reviewed and no changes were warranted at this time. All licensed nursing staff will be inserviced on the facility policy and procedure for accurate oxygen administration and documentation per physician order. Monitoring: The DON is responsible for maintaining compliance. The DON/designee will perform daily audits of all residents using oxygen to monitor for compliance. All negative findings will be corrected at time of discovery and appropriate disciplinary action will be taken as needed. All negative findings will reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 11/5/2022	11/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495261	A. BUILDING ______ B. WING ______	09/21/2022

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F 695	Continued From page 12 revealed one dated 3/5/20 for "At risk for respiratory/cardiac complications...." This care plan included an intervention dated 12/12/21 for "O2 per order." The facility policy "Oxygen Administration" was reviewed. This policy documented, "1. Verify that there is a physician's order for this procedure. Review the physician's orders of facility protocol for oxygen administration." On 9/21/22 at 1:05 PM, ASM #1 (Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey.	F 695		
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	F 812	**F812** **Corrective Action(s):** The open box of dinner rolls was discarded by staff during the survey. **Identification of Deficient Practices & Corrective Action(s):** The food service manager will inservice dietary staff on the safe and sanitary handling of food to include the appropriate storage of bulk boxes of food that have been opened. **Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The consulting Registered Dietician and/or Dietary manager will inservice the dietary staff on the proper preparing, storing and distribution of food under sanitary conditions.	11/5/22

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
	495261	A. BUILDING ______ B. WING ______	09/21/2022

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F 812	Continued From page 13 by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to store food in a sanitary manner in 1 of 1 facility kitchens. The findings include: On 9/20/22 at 12:15 PM, a tour of the facility kitchen was conducted with OSM #1 (Other Staff Member) the Dietary Manager. In the walk-in freezer, a box of dinner rolls was noted to have been opened, and the bag inside with the dinner rolls was left open to air, exposing the rolls to the freezer environment. When asked if the box should be left open, OSM #1 stated that it should be closed and sealed. He removed the box and discarded it. The facility policy, "Cost Containment - Food Storage: General" was reviewed. This policy documented, "6. All foods that have been opened and partially used shall be dated and sealed before returning to a storage area." On 9/21/22 at 1:05 PM, ASM #1 (Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey.	F 812	Monitoring: The Dietary Manager is responsible for maintaining compliance. The Food service manager/designee will complete random reviews of food storage in the dietary department not less than 3 times weekly to monitor for compliance. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. Completion Date: 11/5/2022	11/5/22