State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH2707	A. BUILDING: _____ B. WING _____	02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RICHMOND	1600 WESTWOOD AVENUE AZALEA, VA 23227

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 2/14/23 through 2/15/23. One complaint was investigated during the inspection and was found to be substantiated. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 104 bed facility was 44 at the time of the survey. The survey sample consisted of 4 current resident reviews (Residents #2 through #5) and one closed record review (Resident #1).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC-317-150 (A). Resident Rights. Based on observation, staff interview, clinical record review and facility document review, it was determined that facility staff failed to promote dignity for one of five current residents in the survey sample, Resident #3 (R3), and in one of three neighborhood dining rooms. The findings include: 1. For (R3), the facility staff failed to display care and treatment directions in a private location. (R3) was admitted to the facility with diagnoses that included but were not limited to dementia. On the most recent MDS (minimum data set), a	F 001		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE A S Shay TITLE Executive Director (X6) DATE 3/8/23

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F 001	Continued From page 1 quarterly assessment with an ARD (assessment reference date) of 01/03/2023, the (R3) scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired of cognition for making daily decisions. On 02/14/2023 at approximately 2:55 p.m., an observation of (R3's) room revealed four 8.5 x 11 pieces of paper attached to the wall over the head of the bed. The first paper documented, "Please encourage rest on right or left sides in bed w/ (with) pillows B/w (between) knees. Rehab (rehabilitation)." The second paper documented, "Positioning in bed to minimize pressure (a drawing attached to the bottom of the paper showing the position.). Rehab." The third paper documented, "TED HOSE. To be worn during the day! Off at night! Rehab." The fourth paper documented, "To Do List. A & D ointment to buttocks." On 02/14/2023 at approximately 3:00 p.m., an interview was conducted with (R3). When asked about the signs posted over the head of their bed (R3) stated that they could not recall them. On 02/15/2023 at approximately 11:47 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. When asked about the signs posted above (R3's) bed ASM #2 stated that the information should have been placed on the back of the resident's door or placed in a Kardex at the nurse's station. When asked who placed the signs above the bed, ASM #2 stated it was someone from the rehabilitation department, but they were unable to identify them. When asked if this was dignified to display the information described above on the wall above the (R3's) bed ASM #2 stated no.	F 001	12VAC-317-150(A) Residents Rights 1. Actions to Correct Deficiency a. A;; visible signs were removed for Resident #3 room b. Staff member was reminded that she could not eat in the Residents dining room unless she was eating with them. 2. Affected Population a. All residents are affected when the staff fails to promote the Dignity of the resident 3. Prevention of Deficiency Staff including the Rehabilitation Department will be in-service on how to place instructions sheets or cues for the resident so they are not visible, Signs should be out of view behind bathroom or closet doors and in the Kardex. b. Staff was re-inserviced on taking meals with residents, snacking or drinking in front of them. 4. Implementation to monitor compliance a. Random and weekly rounds of	2/14/23 2/15/23 Will be in compliance by 2/15/23 3/6/23 3/6/23 Will be in compliance by 3/6/23

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F 001	Continued From page 2 The facility's "Bill of Rights for Nursing Home Residents" documented in part, "If you are a nursing home resident, it is your Right by Virginia State Law: To be treated with recognition of your dignity, individuality and privacy." On 02/14/2023 at approximately 4:45 p.m., ASM (administrative staff member) #1, executive director, was made aware of the above findings. No further information was provided prior to exit. 2. The facility staff ate their lunch in view of five residents who were waiting for their lunch in the Mulberry Neighborhood dining area. On 02/14/2023 at approximately 11:50 a.m., an observation of the facility's dining area on the Grove Unit in the Mulberry Neighborhood revealed OSM #3, non-clinical residential assistant, was sitting at the counter, in front of the kitchenette, eating their lunch. Further observation of the dining area revealed five residents seated at two separate tables without anything to eat or drink, waiting for the meal to be sent to the neighborhood from the main kitchen. On 02/14/2023 at approximately 4:45 p.m., ASM (administrative staff member) #1, executive director, was made aware of the above findings. On 02/15/2023 at approximately 9:01 a.m., an interview was conducted with OSM #3. When informed of the above observation OSM #3 stated that that they don't eat in front of the residents and usually eats with them. OSM #3 stated that there were a lot of activities going on that day due to it being Valentine's Day and wanted to get through their lunch so they could assist with the	F 001	each room will be made by the Clinical Leader and MDS coordinator to ensure no signs are visible. Any deficient practice will be corrected and reported to the DON or designee. The Neighborhood Leader will ensure that staff are not eating or drinking in front of the resident. Any deficient practice will be corrected immediately and reported to the DON or designee	

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F 001	Continued From page 3 activities for the residents. OSM #3 stated that the facility had provided the lunch for the facility staff and that they should have eaten in the staff breakroom and not in front of the residents who had not been served their meal. When asked if it was dignified to eat in front of residents who had not been served their meal OSM #3 stated no. On 02/15/2023 at approximately 11:47 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. When informed of the observation of OSM #3 eating their meal in front of residents who had not received their meal at that time ASM #2 stated that it was not dignified. No further information was provided prior to exit. 12VAC5-371- 220 (A),(B),(C). Nursing Services. Based on clinical record review, staff interview and facility document review, it is determined that the facility staff failed to follow the physician's orders for one of five residents in the survey sample, Resident #1 (R1). For (R1), the facility staff failed to follow the physician's order for the use of an Arjo sit to stand lift during a transfer. The findings include: (R1) was admitted to the facility with diagnoses that included but were not limited to cerebellar ataxia (1). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/09/2022, (R1) scored 9 out	F 001	1. Action to correct deficiency. a. Resident #1 is no longer in the facility. 2. Affected Population All residents are affected when staff fail to follow physician's orders 3. Prevention of Deficiency a. Staff will be re-educated on the importance of following physicians' orders. An assignment sheet has been created to instruct the staff as to how a resident is transferred. The Charge Nurse will fill out the assignment sheet daily. b. Staff have been re-in serviced	Will be in compliance by 2/15/23 Will be in compliance by 3/6/23

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F 001	Continued From page 4 of 15 on the BIMS (brief interview for mental status), indicating (R1) was moderately impaired of cognition for making daily decisions. Section G0110 "Activities of Daily Living (ADL) Assistance" coded (R1) as requiring extensive assistance of one person for transfers. Under G0400 "Functional Limitation in Range of Motion" coded (R1) as being impaired on both sides of lower extremities "(hip, knee, ankle, foot.)." The facility's synopsis of event for (R1) dated 09/28/2022 documented in part, "Type of Occurrence: Other." Under "Describe incident, including location, and action taken" it documented, "On 9/28/22 resident was sent to ED (emergency department) for further evaluation upon sustaining a fall during a transfer. The fall took place in the resident's room (room number). The resident sustained a left femur fractures as a result of the fall. The LPN (licensed practical nurse) assessed her noting the left leg was rotated outward. MD (medical doctor) and POA (power of attorney) were notified of the incident and the resident was transferred to the ED for evaluation." The facility's progress note for (R1) dated 09/28/2022 at 5:30 p.m., documented, "Resident sent out to (Name of Hospital), s/p (status/post) witnessed fall, to evaluate possible head injury and to evaluate left leg and hip. (Family Member) in community during time of EMS (emergency medical services) transport along with one of her private care sitters. (Name of Physician) notified of transport. Clinical leader contacted POA, (Name of POA) of incident, obtained vital signs and assessed resident." The facility's progress note for (R1) dated 09/29/2022 at 4:35 p.m., documented in part,	F 001	on the importance of using the plan of care when taking care of the resident. 4. Implementation to monitor Compliance. The Assignment sheet will be completed daily on each shift and signed by the Charge Nurse. The Clinical Leader/designee will make random rounds on each neighborhood to ensure staff are following the correct orders for transferring residents. The assignment sheets will be collected weekly and given to the Clinical Leader who will report unfavorable outcomes to the DON/designee. Any deficient practice will be corrected in a timely manner	Will be in compliance by 3/8/23

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F 001	Continued From page 5 "(Family Member) stated, resident is in hospital, with multiple fractures to femur." Review of the EHR (electronic health record) for (R1) revealed a physician's order dated 06/08/2021 that documented, "Arjo (2) sit to stand for all transfers with team member assist d/t (due to) weakness in bilateral lower extremities." The "OT (Occupational Therapy) Recert (recertification), Progress Report & Updated Therapy Plan" for (R1) dated 05/23/2022 documented in part, "STG (short term goal) #5. PT (patient)/staff will be independent with transfer recommendations with use of DME (durable medical equipment) to avoid injury to both pt and staff. Baseline 5/9/2022. Currently pt is being transferred using the sit to stand pivot method. Pt's movements are jerky, rigid, and unexpected. Pt and staff at risk for falls and injury. Current 5/23/2022. OT recommends sit to stand lift for all transfer needs for the pt and staff safety." The "OT Recert, Progress Report & Updated Therapy Plan" for (R1) dated 06/15/2022 documented in part, "Assessment and Summary of Skilled Services. Interventions Provided: Pt and staff have been provided with recommendations in regard to how to safely transfer it with use of sit to stand lift." Under Patient Progress" it documented in part, "Pt continues to be transferred using the sit to stand lift and pt and staff educated re (regarding): the importance of allowing pt to stand for a couple of minutes on the lift for the change in position/pressure relief, for the weight bearing, and maintain pt's ability to weight bear through Les (lower extremities)." On 02/14/2023 at approximately 11:00 a.m., a	F 001		

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F 001	Continued From page 6 request was made to ASM (administrative staff member) #1, executive director, to speak with CNA #1. ASM # 1 stated CNA #1 was no longer employed with the facility. On 02/15/2023 at approximately 8:32 a.m., an interview was conducted with OSM (other staff member) #2, registered occupational therapist. When asked if they conducted an evaluation of (R1) about the transfer status of (R1), OSM #2 stated that they had and (R1) was unable to transfer safely because they could not static stand, had poor balance and was uncoordinated due to their diagnosis of cerebral ataxia. OSM #2 stated they recommended the use of an Arjo lift since transferring (R1) using a stand-pivot transfer was unsafe. When asked about staff education in being informed of using the Arjo lift and training in using the lift for (R1), OSM #2 stated staff would be educated using a return demonstration technique to ensure staff used the lift correctly. When asked if they were aware of incident involving (R1) and CNA (certified nursing assistant) #1, OSM #2 stated that they heard about it the next day that the CNA did not use the lift during a transfer with (R1). On 02/15/2023 at approximately 9:16 a.m., an interview was conducted with LPN (licensed practical nurse) #1. After reviewing their statement regarding the event on 09/28/2022 with (R1) and CNA #1, LPN #1 was asked to describe what had occurred and what they saw. LPN #1 stated they were in their office documenting when the sitter for (R1) came to them and stated that a staff member had dropped (R1). LPN #1 stated they went to (R1's) room and saw (R1) laying on the floor with their leg twisted outward. They didn't move (R1) because they were afraid the leg was fractured, conducted an assessment and	F 001		

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F 001	Continued From page 7 obtain vital signs. LPN #1 stated that (R1) was in pain and when asked them what happened (R1) stated that their leg gave out and they fell. LPN #1 stated they had another nurse notify the physician, 911 and the responsible party. When they asked CNA #1 what had happened LPN #1 stated that CNA #1 told her that when they were transferring (R1) the resident's leg gave out. LPN # 1 stated they asked why the Arjo lift was not used for the transfer but could not recall the response from CNA #1. When asked how they knew the Arjo lift was not used during the transfer LPN #1 stated that the lift was outside (R1's) room when they arrived at the room. When asked how staff knew to use the lift for (R1), LPN #1 stated that the rehabilitation department had communicated verbally with the staff regarding its use and there was a physician's order for it. When asked about training on how to use the lift LPN #1 stated they received training during their orientation. The facility's policy "Physician Visits and Orders" documented in part, "4. The Neighborhood leader or Medical leader will be responsible for ...orders given by physician to reflect the most current status of the resident's needs." On 02/14/2023 at approximately 4:45 p.m., ASM #1, executive director, was made aware of the above findings. On 02/15/2023 at approximately 11:47 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. After informed of the physician's order for the use of the Arjo lift for (R1's) transfers ASM #2 was asked if the physician's orders were being followed for the use of the lift during (R1's) transfer resulting in a fall and fractures. ASM #2 stated the orders	F 001		

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F 001	Continued From page 8 were not followed. No further information was provided prior to exit. References: (1) Uncoordinated muscle movement due to disease or injury to the cerebellum. This information was obtained from the website: Acute cerebellar ataxia: MedlinePlus Medical Encyclopedia. (2) A mobile raising aid. Intended to be used on a horizontal surface for raising to a standing position and short transfer of residents (e.g., raising from bed and transition to wheelchair, or from wheelchair to toilet) in hospitals, nursing homes or other health care facilities ..." This information was obtained from the manufacturer's product manual for instructions for use. 12VAC5-371- 250 (G). Resident Assessment & Care Planning Based on clinical record review and staff interview, it is determined that the facility staff failed to implement the comprehensive care plan for one of five residents in the survey sample, Resident # 1 (R1). For (R1), the facility staff failed to implement the comprehensive care plan for the use of an Arjo sit to stand lift during a transfer. The findings include: (R1) was admitted to the facility with diagnoses that included but were not limited to cerebellar ataxia (1).	F 001	1. Actions to Correct Deficiency a. Resident #1 is no longer in facility 2. Affected Population a. All residents are affected when staff fail to implement the comprehensive care plan 3. Prevention of Deficiency a. Staff will be re-in serviced on the importance of following the plan of care for each resident. The Comprehensive Plan of Care and Kardex will be up-dated quarterly	2/14/23. 2/15/23 Will be in compliance by 3/8/23

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F 001	Continued From page 9 On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/09/2022, (R1) scored 9 (nine) out of 15 on the BIMS (brief interview for mental status), indicating (R1) was moderately impaired of cognition for making daily decisions. Section G0110 "Activities of Daily Living (ADL) Assistance" coded (R1) as requiring extensive assistance of one person for transfers. Under G0400 "Functional Limitation in Range of Motion" coded (R1) as being impaired on both sides of lower extremities "(hip, knee, ankle, foot.)." The facility's synopsis of event for (R1) dated 09/28/2022 documented in part, "Type of Occurrence: Other." Under "Describe incident, including location, and action taken" it documented, "On 9/28/22 resident was sent to ED (emergency department) for further evaluation upon sustaining a fall during a transfer. The fall took place in the resident's room (room number). The resident sustained a left femur fractures as a result of the fall. The LPN (licensed practical nurse) assessed her noting the left leg was rotated outward. MD (medical doctor) and POA (power of attorney) were notified of the incident and the resident was transferred to the ED for evaluation." The facility's progress note for (R1) dated 09/28/2022 at 5:30 p.m., documented, "Resident sent out to (Name of Hospital), s/p (status/post) witnessed fall, to evaluate possible head injury and to evaluate left leg and hip. (Family Member) in community during time of EMS (emergency medical services) transport along with one of her private care sitters. (Name of Physician) notified of transport. Clinical leader contacted POA, (Name of POA) of incident, obtained vital signs	F 001	and on an as needed basis by the Charge Nurse and MDS coordinator. The staff will be re-in serviced on the importance of checking the Kardex and Plan of Care daily, 3 b. An assignment sheet was created to include the use of Maxi-Move or Sit to Stand for transfers. Staff will be in service on the new assignment sheet. 4. Implementation to monitor Compliance. The assignment sheet will be completed by the Charge Nurse on each shift daily to comply with the Plan of Care. Random rounds will be made by the Nurse Management Team or designee to ensure the assignment sheets are completed and the staff is aware of the method of transfer. The assignment sheets will be reviewed weekly by the Clinical Leader or designee and signed. Any deficient practice will be corrected in a timely manner and reported to the DON/designee	Will be in compliance by 3/8/23 Will be in compliance by 3/8/23

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F 001	Continued From page 10 and assessed resident." The facility's progress note for (R1) dated 09/29/2022 at 4:35 p.m., documented in part, "(Family Member) stated, resident is in hospital, with multiple fractures to femur." Review of the EHR (electronic health record) for (R1) revealed a physician's order dated 06/08/2021 that documented, "Arjo (2) sit to stand for all transfers with team member assist d/t (due to) weakness in bilateral lower extremities." The comprehensive care plan for (R1) dated 08/09/2022 documented in part, "Focus. I require maximum assistance with transfers. I require the Arjo lift and team member assistance for safety d/t unsteady gait imbalance ..." Under "Interventions" it documented in part, "Staff will demonstrate the appropriate use of the Arjo lift during transfers." The "OT (Occupational Therapy) Recert (recertification), Progress Report & Updated Therapy Plan" for (R1) dated 05/23/2022 documented in part, "STG (short term goal) #5. PT (patient)/staff will be independent with transfer recommendations with use of DME (durable medical equipment) to avoid injury to both pt and staff. Baseline 5/9/2022. Currently pt is being transferred using the sit to stand pivot method. Pt's movements are jerky, rigid, and unexpected. Pt and staff at risk for falls and injury. Current 5/23/2022. OT recommends sit to stand lift for all transfer needs for the pt and staff safety." The "OT Recert, Progress Report & Updated Therapy Plan" for (R1) dated 06/15/2022 documented in part, "Assessment and Summary of Skilled Services. Interventions Provided: Pt	F 001		

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F 001	Continued From page 11 and staff have been provided with recommendations in regard to how to safely transfer it with use of sit to stand lift." Under Patient Progress" it documented in part, "Pt continues to be transferred using the sit to stand lift and pt and staff educated re (regarding): the importance of allowing pt to stand for a couple of minutes on the lift for the change in position/pressure relief, for the weight bearing, and maintain pt's ability to weight bear through Les (lower extremities)." On 02/14/2023 at approximately 11:00 a.m., a request was made to ASM (administrative staff member) #1, executive director, to speak with CNA #1. ASM # 1 stated CNA #1 was no longer employed with the facility. On 02/15/2023 at approximately 8:32 a.m., an interview was conducted with OSM (other staff member) #2, registered occupational therapist. When asked if they conducted an evaluation of (R1) about the transfer status of (R1), OSM #2 stated that they had and (R1) was unable to transfer safely because they could not static stand, had poor balance and was uncoordinated due to their diagnosis of cerebral ataxia. OSM #2 stated they recommended the use of an Arjo lift since transferring (R1) using a stand-pivot transfer was unsafe. When asked about staff education in being informed of using the Arjo lift and training in using the lift for (R1), OSM #2 stated staff would be educated using a return demonstration technique to ensure staff used the lift correctly. When asked if they were aware of incident involving (R1) and CNA (certified nursing assistant) #1, OSM #2 stated that they heard about it the next day that the CNA did not use the lift during a transfer with (R1).	F 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH2707	A. BUILDING: _____ B. WING _____	02/15/2023

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F 001	Continued From page 12 On 02/15/2023 at approximately 9:16 a.m., an interview was conducted with LPN (licensed practical nurse) #1. After reviewing their statement regarding the incident on 09/28/2022 with (R1) and CNA #1, LPN #1 was asked to describe what had occurred and what they saw. LPN #1 stated they were in their office documenting when the sitter for (R1) came to them and stated that a staff member had dropped (R1). LPN #1 stated they went to (R1's) room and saw (R1) laying on the floor with their leg twisted outward. They didn't move (R1) because they were afraid the leg was fractured, conducted an assessment and obtain vital signs. LPN #1 stated that (R1) was in pain and when asked them what happened (R1) stated that their leg gave out and they fell. LPN #1 stated they had another nurse notify the physician, 911 and the responsible party. When they asked CNA #1 what had happened LPN #1 stated that CNA #1 told her that when they were transferring (R1) the resident's leg gave out. LPN # 1 stated they asked why the Arjo lift was not used for the transfer but could not recall the response from CNA #1. When asked how they knew the Arjo lift was not used during the transfer LPN #1 stated that the lift was outside (R1's) room when they arrived at the room. When asked how staff knew to use the lift for (R1), LPN #1 stated that the rehabilitation department had communicated verbally with the staff regarding its use and there was a physician's order for it. When asked about training on how to use the lift LPN #1 stated they received training during their orientation. On 02/14/2023 at approximately 4:45 p.m., ASM #1, executive director, was made aware of the above findings. On 02/15/2023 at approximately 11:47 a.m., an	F 001		

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F 001	Continued From page 13 interview was conducted with ASM (administrative staff member) #2, director of nursing. After informed of the comprehensive care plan for the use of the Arjo lift for (R1's) transfers ASM #2 was asked if the care plan was implemented in regard to the use of the Arjo lift during (R1's) transfer, fall and fracture. ASM #2 stated the care plan was not implemented. No further information was provided prior to exit. References: (1) Uncoordinated muscle movement due to disease or injury to the cerebellum. This information was obtained from the website: Acute cerebellar ataxia: MedlinePlus Medical Encyclopedia. (2) A mobile raising aid. Intended to be used on a horizontal surface for raising to a standing position and short transfer of residents (e.g., raising from bed and transition to wheelchair, or from wheelchair to toilet) in hospitals, nursing homes or other health care facilities ..." This information was obtained from the manufacturer's product manual for instructions for use. 12VAC5-371-340 (A). Dietary & Food Service Program Based on observation, staff interview, and facility document review it was determined facility staff failed to store food in a sanitary manner in one of one facility kitchens. The findings include: On 02/14/2023 at approximately 10:55 a.m., an	F 001		

State of Virginia

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F 001	Continued From page 14 observation of the facility's kitchen was conducted with OSM (other staff member) #1, director of dining services. An observation of the kitchen's dry storage room revealed a Styrofoam cup laying in the bulk sugar bin on top of the sugar. An observation of the kitchen's walk-in refrigerator revealed a package containing approximately two pounds of diced potatoes, wrapped in plastic wrap, on the middle shelf without an open or use-by date, a package containing approximately three cups of mozzarella cheeses wrapped in plastic wrap, on the middle shelf without an open or use-by date, and a package containing approximately three pounds of parmesan cheese wrapped in plastic wrap, on the middle shelf without an open or use-by date. An observation of the kitchen's walk-in freezer revealed approximately one cup of frozen green beans wrapped in plastic wrap, on the middle shelf without an open or use-by date, a 20-pound box of frozen beef patties open to the environment on the middle shelf, and a zip lock bag containing approximately five pounds of frozen beef brisket pieces open to the environment. On 02/14/2023 at approximately 2:00 p.m., an interview was conducted with OSM #1. When asked to describe the procedure for the bulk sugar bin OSM #1 stated that nothing should be laying in the sugar due to the possibility of contamination. When asked about the procedure for the food items without an open and use-by date OSM #1 stated that after a food item has been opened, the remaining contents should be	F 001	1. Action to Correct Deficiency a. All food open and not timed and dated were discarded. The Bin with Styrofoam cup in it was emptied, cleaned, and refilled. A scoop with holder was attached to the side of the BIN 2. Affected Population All residents are affected when facility staff fail to store food in a sanitary manner. 3. Prevention of Deficiency Staff were re-in serviced in the proper way to store food. All food needs to be stored in airtight containers, timed and dated prior to putting them in the freezer or refrigerator. Bulk items in a bin must have a scoop with handle attached. No scoops or other equipment should be laid in the bin on top of the item. In-service to include Food Safety Policies , product labeling and Dating, and preventing cross-contamination. 4. Implementation to monitor Compliance. Management Staff or designee will make rounds each shift using a check off list to ensure food is stored in a sanitary manner. Any deficiency will be reported immediately and reported to the Director of Dining or designee	2/15/23 2/15/23 3/8/23 Will be in compliance by 3/8/23

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F 001	Continued From page 15 wrapped completely or placed in a baggie with the date it was opened and the use-by date so they know how long it can be used and when to dispose of it, so it is safe for eating. When asked to describe the procedure regarding the food items that were left open to the environment OSM #1 stated that the beef patties should have had the plastic bag twisted closed and the box closed. OSM #1 further stated that the baggie containing the beef brisket pieces split open and should have been brought to their attention so it could be discarded. When asked why it was important to keep the frozen food products closed OSM #1 stated that it was to prevent freezer burn and cross contamination. The facility's policy "Food Safety Management System" documented in part, "C-8 Preventing Cross Contamination. Food must be covered/protected from environmental contamination during storage and transportation. C-26 Date Marking Ready to Eat TCS/PHF (Time/Temperature Controlled for Safety Food/Potentially Hazardous Food) Foods. Refrigerated, ready to eat, TCS/PHF food prepared and held in a food establishment must be clearly marked with a consume by /discard date." On 02/14/2023 at approximately 4:45 p.m., ASM (administrative staff member) #1, executive director, was made aware of the above findings. No further information was provided prior to exit.	F 001		