

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

PRINTED: 09/19/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495373	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/08/2023
NAME OF PROVIDER OR SUPPLIER BRANDON OAKS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 09/05/23 through 09/08/23. 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 survey was conducted 09/05/23 through 09/08/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey VA00059392-Non-Compliant with regulations, deficient practice cited. The census in this 62 certified bed facility was 57 at the time of the survey. The final survey sample consisted of 15 current resident reviews and 2 closed record reviews.	F 000			
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 accurately code a significant change MDS assessment to capture the residents hospice status for 1 of 15 current residents, Resident #31.	F 641			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495373	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/08/2023
NAME OF PROVIDER OR SUPPLIER BRANDON OAKS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 641	<p>Continued From page 1</p> <p>The findings included:</p> <p>The facility staff failed to code Resident #31's significant change minimum data set (MDS) assessment to indicate the resident was receiving hospice services.</p> <p>Resident #31's face sheet included the diagnoses cerebrovascular disease, vascular dementia, and encounter for palliative care-hospice.</p> <p>Section C (cognitive patterns) of Resident #31's significant change MDS assessment with an assessment reference date (ARD) of 06/20/23 had been coded 1/1/3 to indicate this resident had problems with long and short term memory and as severely impaired in cognitive skills for daily decision making. Section O (special treatments, procedures, programs) was not coded to indicate this resident was receiving hospice services.</p> <p>The clinical record included a provider order dated 06/14/23 to admit to hospice services.</p> <p>Resident #31's comprehensive care plan included the problem area palliative care, resident has elected hospice benefits.</p> <p>09/06/23 8:56 a.m., when Registered Nurse #1 was asked about the missing documentation regarding hospice RN #1 stated the box for hospice services was missed on the MDS.</p> <p>09/06/23 4:00 p.m., during an end of the day meeting with the Administrator, Director of Nursing, and Administrator in Training, the issue with the coding of the MDS in regard to hospice</p>	F 641	<p>F641</p> <p>Corrective Action: Resident #31 MDS Significant Change ARD 6/20/2023 was modified and re-submitted to state data base on 09/06/2023. It was modified to show Hospice election by resident under Section O (special treatments, procedures, programs.) All other</p> <p>Systemic Changes: All other residents with hospice assessments were audited for not having Section O0100 box 2k (Hospice) checked. No other residents were identified. The facility's current policy and procedure has been reviewed and no changes are warranted at this time. The MDS Coordinators have been in-serviced on proper completion of MDS assessments, specifically the accuracy of Section O.</p> <p>Evaluation and monitoring: The DON or designee will review Significant Change MDS assessments 1 time a week for 4 weeks, then 1 time a month for 3 months to ensure accuracy of section O on MDS assessments.</p> <p>Findings will be reported to the QA committee for review, analysis, and recommendations of change in facility policy, procedure, or practice.</p> <p>Responsible Party: Director of Nursing and/or designee</p> <p>Corrective Date: 10/23/2023</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495373	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/08/2023
NAME OF PROVIDER OR SUPPLIER BRANDON OAKS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 641	Continued From page 2 services was reviewed.	F 641			
F 755 SS=D	<p>No further information regarding this issue was provided to the survey team prior to the exit conference.</p> <p>Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)</p> <p>§483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs</p>	F 755			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495373	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/08/2023
NAME OF PROVIDER OR SUPPLIER BRANDON OAKS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 755	<p>Continued From page 3</p> <p>is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure the nursing staff correctly implemented the facility's scheduled/controlled medication monitoring system to accurately account for the facility's scheduled/controlled medications for 1 of 15 current residents. Resident #19.</p> <p>The findings included:</p> <p>For Resident #19, the facility failed to ensure narcotics were accurately accounted for.</p> <p>Resident #19's face sheet included the diagnoses other acute postprocedural pain, hypertension, and presence of right artificial hip joint.</p> <p>Section C (cognitive patterns) of Resident #19's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 06/22/23 included a brief interview for mental status (BIMS) summary score of 12 out of a possible 15 points.</p> <p>Resident #19's comprehensive care plan included the problem area pain. Approaches included, but were not limited to, administer meds as ordered and encourage resident to report when pain interventions are not effective.</p> <p>The clinical record included a provider order for Oxycodone 5 mg every 6 hours PRN (as needed) for pain.</p> <p>A review of Resident #19's medication</p>	F 755	<p>F755</p> <p>Corrective Action: Resident #19, was not charged for medications that unaccounted for. Resident #19 expressed no pain control concerns and that she receives her all of medications in a timely manner.</p> <p>Others at Risk: An 100% audit was conducted of all facility narcotic count sheets and EMAR administration records to ensure no further discrepancies occurred. No other discrepancies were identified.</p> <p>Systemic Changes: Director of Nursing, in collaboration with Pharmacy Consultant reviewed and updated the facility policy and procedure for Handling Controlled Substances. All facility licensed nurses were in-serviced by Director of Nursing regarding the policy and procedures for handling of controlled substances and the urgency of reporting discrepancies to facility leadership upon identification. Facility orientation material for agency staff was reviewed and updated to include a signed acknowledgment of policies and procedures for the Handling of Controlled Substances.</p> <p>Evaluation & Monitoring: The Director of Nursing, or designee will perform audits of all facility narcotic count sheets weekly x 4 weeks, then monthly x 2 months, and then as needed to monitor for compliance. Any findings will be reported at the Monthly QA meeting. After this time frame, the QAA Committee may determine to discontinue reporting if sustained compliance has been demonstrated.</p> <p>Responsible Party: Director of Nursing</p> <p>Completion Date: 10/23/2023</p>		

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

PRINTED: 09/19/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495373	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/08/2023
NAME OF PROVIDER OR SUPPLIER BRANDON OAKS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 755	<p>Continued From page 4</p> <p>administration records (MARs) for 07/2023 revealed that no nursing staff had documented that they had administered Oxycodone to Resident #19 until 07/20/23 when Licensed Practical Nurse (LPN) #1 documented they had administered 5 mg of Oxycodone for pain in their legs at 2:32 p.m. LPN #1 documented the medication was effective. LPN #1 was an agency nurse.</p> <p>The facility staff provided the surveyor with 2 controlled drug records for this medication. Drug record #1 indicating the pharmacy had delivered 16 tablets of Oxycodone on 05/13/23. LPN #6 had signed as the receiving nurse. This form was crumpled and torn. The Administrator stated LPN #1 had taken this form from the facility after their shift but had later returned it. Drug record #2 revealed that the pharmacy had delivered 16 tablets of Oxycodone 5 mg to the facility on 07/14/23. LPN #3 had signed for receiving the medication.</p> <p>07/20/23, LPN #1 documented on controlled drug record #1 that they had removed 1 tablet of Oxycodone 5 mg at 8:00 a.m. LPN #1 documented the word "dropped" beside of this entry and made a second entry at 8:00 a.m. indicating they had removed a second tablet. LPN #1 did not document they had administered this medication on Resident #19's MAR. LPN #1 documented on the MAR they had administered Resident #19 1 tablet of 5 mg Oxycodone at 1432 (2:32 p.m.) on 07/20/23. However, the count went from #16 to #14 on the controlled drug record (#2) instead of #16 to #15.</p> <p>A review of Resident #19's progress notes revealed LPN #1, or any other nurse had not</p>	F 755			

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

PRINTED: 09/19/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495373	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/08/2023
NAME OF PROVIDER OR SUPPLIER BRANDON OAKS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 755	<p>Continued From page 5</p> <p>documented Resident #19 had complained of any pain on 07/20/23.</p> <p>The discrepancy on sheet #2 was identified by LPN #4 when counting narcotics with another nurse on Saturday 07/22/23. LPN #4 left a note and did not immediately report the discrepancy to the administrative staff.</p> <p>09/07/23 10:35 a.m., during a meeting with the Administrator they stated LPN #1 came to the facility and returned controlled record sheet #1 it was crumpled up and torn. They did not ask this nurse to complete a drug test, the agency the nurse worked for was notified, stated they would do an investigation, but they had never reached back out to this facility.</p> <p>LPN #1 had provided the facility with a signed written statement (no date) indicating they had dropped a medication in the residents room on the floor, wasted it in the sharps box but did not have a witness (another nurse) to sign for the disposal of the medication. LPN #1's statement read in part, "I dropped a medication in a Patients room on the floor, wasted it in sharps box. I did not have a witness sign it with me. I gave the same women her medication later in the shift, I signed it in the MAR and in the book towards the end of my shift. I made an error by doing so because I gave the medication twice by accident..." LPN #1 also wrote that they accidentally took the narcotic sheet home because it was mixed in with other papers on their clipboard.</p> <p>During this interview the surveyor reviewed camera footage with the Administrator, Administrator in Training, and Director of Nursing.</p>	F 755			

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

PRINTED: 09/19/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495373	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/08/2023
NAME OF PROVIDER OR SUPPLIER BRANDON OAKS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 755	<p>Continued From page 6</p> <p>On the day of 07/20/23 LPN #1 (identified by facility staff) was observed entering a resident room at approximately 8:12 a.m. The administrative staff identified this room as belonging to Resident #19. LPN #1 was not observed returning to the medication cart and obtain a second dose of Oxycodone to administer to Resident #19. At approximately 2:25 p.m. LPN #1 was observed in the nurses station, observed to open a drawer of the medication cart, leave the nurses station, and walk a few steps down the hallway, turn around and reentered the nursing station. LPN #1 was not observed to enter any residents room(s) prior to turning around and re-entering the nurses station. During the video footage LPN #1 was observed to place a clipboard in their bookbag/backpack.</p> <p>09/07/23 1:23 p.m., during an interview with Resident #19 they stated staff would knock on their door and ask them if they needed anything for pain. Resident #19 voiced no complaints to the surveyor regarding their stay at this facility.</p> <p>09/07/23 2:20 p.m., during an interview with LPN#3 they stated they had counted narcotics with LPN #1 on 07/20/23 they had looked at the paperwork but did not actually look at the medications. A review of the nursing schedule for 07/20/23 indicated an agency nurse (no name) and LPN #3 had both worked this unit on different shifts.</p> <p>09/07/23 4:10 p.m., during an interview with LPN #4 they stated they had noticed the discrepancy when counting medications on Saturday (07/22/23) when they arrived at work. There should have been a line for #15 and #14 and there was not a line for #15. The count was</p>	F 755			

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

PRINTED: 09/19/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495373	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/08/2023
NAME OF PROVIDER OR SUPPLIER BRANDON OAKS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 755	<p>Continued From page 7</p> <p>correct, but it didn't match up and they had left a note.</p> <p>The administrative staff provided the surveyor with a copy of their policy titled, "CONTROLLED SUBSTANCES." This policy read in part, "...Accurate accountability of the inventory of all controlled drugs is maintained at all times..."</p> <p>09/08/23 8:47 a.m., during an interview with LPN #5 (unit manager) they stated they were notified on Monday 07/24/23 between 6:30 a.m. and 7:00 a.m. by LPN #6 that there was a discrepancy with Resident #19's narcotic medications. They had tried to contact the Administrator but were unable to reach them. They had informed the Administrator when they arrived at work on the same day.</p> <p>09/08/23 8:57 a.m., during an interview with LPN #6 they stated when they arrived to work on Sunday night (07/23/23) they completed a count of the narcotics with LPN #4. When they got to the narcotic page for the Oxycodone LPN #4 had put a sticky note on the narcotic sheet because the numbers were not matching. LPN #4 had asked them what they should do. LPN #6 stated the only thing I could think to do was to tell the unit manager on Monday morning (next morning). The numbers actually matched up but went from #16 to #14 not #16, #15, #14. LPN #6 stated they did not have any complaints from this resident and stated Resident #19 rarely asked for anything.</p> <p>The Administrator provided the survey team with information to indicate Resident #19 was not charged for the medications.</p>	F 755			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495373	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/08/2023
NAME OF PROVIDER OR SUPPLIER BRANDON OAKS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 755	Continued From page 8	F 755			
F 812 SS=F	<p>No further information regarding this issue was provided to the survey team prior to the exit conference.</p> <p>Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements. The facility must -</p> <p>§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.</p> <p>§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, facility staff failed to ensure food was stored under safe and sanitary conditions in the main kitchen.</p> <p>The findings included:</p> <p>The facility staff failed to dispose of out of date carnation sweetened condensed milk. The box containing the cans of milk included a best before date of August 2023.</p>	F 812	<p>F812</p> <p>Corrective Action: The expired sweetened condensed milk that was found in the production kitchen's dry storage room was discarded by the Dietary Manager on 9/7/2023. Others at Risk: A survey was conducted of all other cooking and storage facilities in the building and no other sweetened condensed milk or expired product was found. The survey was conducted by the Dietary Management Team.</p> <p>Systemic Changes: All perishable food product brought into the facility will be stocked according to "First In, First Out" guidelines and will comply with the Food Product Shelf Life Guidelines found in Sodexo Document #2.1.9. Shelf stable products will be labeled with the date of arrival in the facility, as well as the disposal date. Product will not be accepted if the disposal date is within two months of delivery.</p> <p>Evaluation & Monitoring: The Executive Sous Chef, Dining Supervisor, or designee will monitor the arrival and stocking of new deliveries on Mondays and Thursdays of each week. The Dietary Operations Manager, Dietary General Manager, or designee will conduct spot surveys, monitor stocking, and review practices every two weeks. Findings and compliance will be discussed and monitored with the facility Administrator and QA committee once a month for at least three months, or until deemed unnecessary.</p> <p>Responsible Party: Dietary Operations Manager Completion Date: 10/23/2023</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495373	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/08/2023
NAME OF PROVIDER OR SUPPLIER BRANDON OAKS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 812	Continued From page 9 09/07/23 8:15 a.m., the surveyor toured the main kitchen area with dietary employee #1 and #2. During this observation the surveyor along with dietary employee #1 observed an opened box of carnation sweetened condensed milk (cans) with a best before date of August 2023. Dietary employee #1 removed this box from the food supply and stated they would dispose of the items. 09/07/23, the Administrator was notified that the kitchen included a box of carnation milk with best before date of August 2023. The administrative staff provided the surveyor with a copy of their policy titled, "Food Safety management System." This policy read in part, "...Food stock rotation consists in using products with an earlier use-by-date first and moving products with a later sell-by date to the back of the shelf. This ensures that food is used within date...Locate products with the soonest best before or use-by dates. Remove items that are past these dates..." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 812			