STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175126	A. BUILDING _____ B. WING _____	05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW SENIOR LIFE	1417 W ASH ST JUNCTION CITY, KS 66441

(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 The following citations represent the findings of a Health Licensure Resurvey and Complaint Investigation # 170137. The 2567 was electronically sent to the facility on 05/09/22.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility had a census of 61 residents. The sample included 16 residents, with five reviewed for activities of daily living (ADLs). Based on observation, record review, and interview, the facility failed to provide consistent bathing services for three sampled residents, Resident (R) 38, R49, and R9 . This placed the residents at risk for complications related to poor hygiene. Findings included: - The electronic medical record (EMR) for R38 recorded diagnoses of hypertension (high blood pressure), cognitive decline (memory loss), and chronic kidney disease (kidneys are damaged and cannot filter blood the way they should). R38's "Quarterly Minimum Data Set" (MDS), dated 03/29/22, documented the resident had severely impaired cognition and required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. The	F 677		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/09/2022

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MDS documented R38 required extensive assistance of one staff for bathing.

The "ADL Care Plan," dated 03/14/22, documented R38 preferred a whirlpool for bathing and directed staff to assist the resident on his scheduled bath days.

The "March and April 2022 Bathing Record" documented R38 requested whirlpool baths on Wednesday and Saturday evenings and documented the resident had not received a bath during the following days:
03/27/22-04/08/22 (13 days)
04/17/22-04/29/22 (13 days)

The EMR lacked evidence R38 refused any baths.

On 04/28/22 at 12:17 PM, observation revealed R38 unshaven and eating lunch in the dining room.

On 05/02/22 at 09:40 AM, observation revealed R38 unshaven and lying in his bed.

On 05/03/22 at 11:48 AM, Certified Nurse Aide (CNA) M stated R38 sometimes refused his showers, staff continued to ask him, and if he continued to refuse, staff filled out a shower sheet that stated he refused and gave it to the charge nurse.

On 05/03/22 at 01:40 PM, Licensed Nurse (LN) H stated when a resident refused a shower or bath, they are asked again and a shower sheet with refusal was marked and given to the care coordinator.

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On 05/04/22 at 09:16 AM, Administrative Nurse D verified R38 had not received his whirlpool baths as requested and staff should document any refusals.

The facility's "Activities of Daily Living" policy, dated 03/01/22, documented the facility provided each elder with care, treatment, and services according to the elders individualized care plan. Based on the individual elder's comprehensive assessment, facility staff would ensure that each elder's abilities in activities of daily living do not diminish unless circumstances of the elders clinical condition demonstrated that the decline was unavoidable, including bathing, dressing, grooming, transferring, locomotion, ambulation, toileting, and eating.

The facility failed to provide consistent bathing for R38, placing the resident at risk for complications related to poor hygiene.

- The electronic medical record (EMR) reported R49 had diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), hypertension (high blood pressure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

R49's "Admission Minimum Data Set" (MDS), dated 04/08/22, documented the resident had intact cognition and required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS documented R49 required extensive assistance of one staff for bathing.

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F 677	Continued From page 3	F 677		

The "ADL Care Plan," dated 04/25/22, documented R49 preferred showers for bathing and requested two showers per week. The "Care Plan" directed staff to offer the resident a choice between a shower or bath on her bath days.

The "April 2022 Bathing Record" documented the resident requested bathing twice per week and documented R49 had not received a bath or shower during the following days: 04/05/22-04/13/22 (9 days)

The EMR lacked evidence R49 refused any bath or shower.

On 04/28/22 at 09:59 PM, observation revealed R49 resting on top of the covers in bed watching television.

On 05/03/22 at 11:48 AM, Certified Nurse Aide (CNA) M stated, when staff got to work, they looked in the EMR tasks to see which resident was to receive a bath for that day, and a list was given to staff for bathing.

On 05/03/22 at 01:40 PM, Licensed Nurse (LN) H stated when a resident refused a shower or bath, they are asked again and a shower sheet with refusal was marked and given to the care coordinator.

On 05/04/22 at 09:16 AM, Administrative Nurse D verified R49 had not received her showers as requested.

The facility's "Activities of Daily Living" policy, dated 03/01/22, documented the facility provided each elder with care, treatment, and services according to the elders individualized care plan.

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F 677	Continued From page 4	F 677		

Based on the individual elder's comprehensive assessment, facility staff would ensure that each elder's abilities in activities of daily living do not diminish unless circumstances of the elders clinical condition demonstrated that the decline was unavoidable, including bathing, dressing, grooming, transferring, locomotion, ambulation, toileting, and eating.

The facility failed to provide consistent bathing for R49, placing the resident at risk for complications related to poor hygiene.

- Resident (R) 9's "Physician's Order Sheet," dated 04/18/22, recorded diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and dementia with behavioral disturbances (progressive mental disorder characterized by failing memory, confusion with agitation including verbal and physical aggression, wandering and hoarding).

R9's "Admission Minimum Data Set" (MDS), dated 01/25/22, recorded R9 had a Brief Interview for Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS recorded she required staff supervision with personal hygiene and bathing.

The "Activities of Daily Living (ADL) Care Plan," dated 01/18/22, directed one staff to provide R9 assistance with hygienic cares. The "ADL Care Plan" recorded the resident recently moved from her family member's house and R9 did not like to bathe. The "Care Plan" directed staff to continue to offer encouragement for compliance and if R9 refused, set up a bath kit in her room, and assist her with completing her hygienic cares with one

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F 677	Continued From page 5	F 677		

staff assist.

The "January Bathing Report" documented R9 received a shower/bath on the following day:
01/25/22

The "February Bathing Report" documented R9 received a shower/bath on the following days:
02/13/22 (no bath for 19 days)
02/15/22

The "March Bathing Report" documented R9 received a shower/bath on the following days:
03/01/22 (no shower/bath for 14 days)
03/22/22 (no shower/bath for 20 days)

The "April Bathing Report" documented R9 received a shower/bath on the following day:
04/29/22 (no shower/bath for 39 days)

On 04/28/22 at 10:25 AM, observation revealed R9 sat in the doorway of her room with her shoes off. Her hair appeared uncombed and disheveled.

On 05/03/22 at 03:30 PM, Administrative Nurse D verified the residents had scheduled bath/shower days including a skin assessment. The aides documented in the electronic health records when the resident received a shower/bath, and if it was not documented, it was not completed. Administrative Nurse D verified R9 was diagnosed with Alzheimer's and dementia and it was a struggle to get her to take a bath.

The facility's "Activities of Daily Living (ADLs) " policy, dated 03/01/22, documented the facility would provide each elder with care, treatment and services according to the elder's individualized care plan, based on the individual

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elder's comprehensive assessment, facility staff will ensure that each elder's ability in activities of daily living do not diminish unless circumstance of the elder's clinical condition demonstrates that the decline was unavoidable, including bathing, dressing, grooming, transfers, locomotion, ambulation, toileting, eating and communication.

The facility failed to provide the necessary care and bathing services for R9, placing the resident at risk for poor hygiene, and skin breakdown.

- Resident (R) 9's "Physician's Order Sheet," dated 04/18/22, recorded diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and dementia with behavioral disturbances (progressive mental disorder characterized by failing memory, confusion with agitation including verbal and physical aggression, wandering and hoarding).

R9's "Admission Minimum Data Set" (MDS), dated 01/25/22, recorded R9 had a Brief Interview for Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS recorded she required staff supervision with personal hygiene and bathing.

The "Activities of Daily Living (ADL) Care Plan," dated 01/18/22, directed one staff to provide R9 assistance with hygienic cares. The "ADL Care Plan" recorded the resident recently moved from her family member's house and R9 did not like to bathe. The "Care Plan" directed staff to continue to offer encouragement for compliance and if R9 refused, set up a bath kit in her room, and assist her with completing her hygienic cares with one staff assist.

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The "January Bathing Report" documented R9 received a shower/bath on the following day:
01/25/22

The "February Bathing Report" documented R9 received a shower/bath on the following days:
02/13/22 (no bath for 19 days)
02/15/22

The "March Bathing Report" documented R9 received a shower/bath on the following days:
03/01/22 (no shower/bath for 14 days)
03/22/22 (no shower/bath for 20 days)

The "April Bathing Report" documented R9 received a shower/bath on the following day:
04/29/22 (no shower/bath for 39 days)

On 04/28/22 at 10:25 AM, observation revealed R9 sat in the doorway of her room with her shoes off. Her hair appeared uncombed and disheveled.

On 05/03/22 at 03:30 PM, Administrative Nurse D verified the residents had scheduled bath/shower days including a skin assessment. The aides documented in the electronic health records when the resident received a shower/bath, and if it was not documented, it was not completed. Administrative Nurse D verified R9 was diagnosed with Alzheimer's and dementia and it was a struggle to get her to take a bath.

The facility's "Activities of Daily Living (ADLs) " policy, dated 03/01/22, documented the facility would provide each elder with care, treatment and services according to the elder's individualized care plan, based on the individual elder's comprehensive assessment, facility staff

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F 677	Continued From page 8 will ensure that each elder's ability in activities of daily living do not diminish unless circumstance of the elder's clinical condition demonstrates that the decline was unavoidable, including bathing, dressing, grooming, transfers, locomotion, ambulation, toileting, eating and communication. The facility failed to provide the necessary care and bathing services for R9, placing the resident at risk for poor hygiene, and skin breakdown.	F 677		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility had a census of 61 residents. The	F 757		

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F 757	Continued From page 9	F 757		

sample included 16 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to monitor and provide the physician ordered interventions for bowel management for one sampled resident, Resident (R) 38. This placed the resident at risk for constipation and decline.

Findings included:

- The electronic medical record (EMR) for R38 recorded diagnoses of hypertension (high blood pressure), cognitive decline (memory loss), chronic kidney disease (kidneys are damaged and cannot filter blood the way they should) and constipation (difficulty passing stools).

R38's "Quarterly Minimum Data Set" (MDS), dated 03/29/22, documented the resident had severely impaired cognition, required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene, and was always incontinent of bowel.

The "Pain Care Plan," dated 03/14/22, directed staff to monitor and document for side effects of pain medication and monitor for constipation.

R38's "Incontinence Assessment," dated 03/10/22, documented the resident did not have hard or difficult bowel movements, had several bowel movements daily, and did not use laxatives (stimulates or facilitates bowel movements) or suppositories (medication inserted into the rectum [the final section of the large intestine, terminating at the anus] to treat constipation) for regulation.

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The "Orders" tab revealed the following medications which could contribute to constipation:
3/10/22 fentanyl (narcotic pain medication) patch 72hr 25 micrograms/hr-apply one patch one time a day every three days for pain and remover per schedule.
3/10/22 hydrocodone (narcotic pain reliever) tab 10-325 milligrams give one tab every six hours as needed for pain.
3/16/22 hydrocodone tab 10-325 milligrams give one tab daily for pain.

The "Orders" tab recorded the following medications for bowel maintenence:
3/9/22 dulcolax (medication used to treat constipation) suppository. Give one suppository rectally every 24 hours as needed for constipation

The "Bowel Monitoring Record," dated March 2022, revealed R38 did not have a bowel movement for the following days:
03/25/22-03/31/22 (7 consecutive days)

The "Treatment Administration Record" (TAR), dated March 2022, lacked documentation the staff provided interventions during the lack of bowel elimination on the above dates.

The "Bowel Monitoring Record," dated April 2022, revealed R38 did not have a bowel movement for the following days:
04/14/22-04/20/22 (7 consecutive days)

The "Treatment Administration Record" (TAR), dated April 2022, lacked documentation the staff provided interventions during the lack of bowel elimination on the above dates.

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On 04/21/22, the "orders" tab was updated with the following orders:
4/21/22 colace (stool softner) cap 100 milligrams by mouth twice daily for constipation.
4/21/22 milk of magnesia (laxative) 1200 milligrams in15 milliliters, give 30 milliliters every 24 hours as needed for constipation for three days.
On 04/28/22 at 12:17 PM, observation revealed R38 ate lunch in the dining room.

On 05/03/22 at 11:48 AM, Certified Nurse Aide (CNA) M stated bowel movements are documented in the computer and was unaware if R38 had concerns with constipation.

On 05/03/22 at 01:40 PM, Licensed Nurse (LN) H stated she looked in the computer daily for residents who had not had a bowel movement and if R38 had not had a bowel movement in three days, she would look at the facility standing orders and administer Milk of Magnesium (a laxative) to the resident. LN H further stated, she relied on the nurse aides to also tell her if R38 had not had a bowel movement as R38 was too confused to be able to tell staff if he had or had not had a bowel movement.

On 05/04/22 at 09:16 AM, Administrative Nurse D verified R38 had not had interventions provided for the resident during the above dates he had not had a bowel movement and stated staff are to follow the bowel management protocol.

The facility's "Bowel Habits" policy, dated 03/10/22, documented each elder were assessed by shift for bowel patterns per CNA reporting in the charting system. The LN on each shift would generate a bowel report from the system at the

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F 757	Continued From page 12 beginning of the shift and initiate the bowel protocol as appropriate. If the elder had no bowel movement in the previous six-eight-hour shift, a laxative would be ordered by the physician. The policy documented the LN would document follow up on the intervention within eight hours after a laxative had been administered. The LN and CNA were responsible for following the bowel protocol document and all attempts to assist the elder in having a bowel movement with prune juice, power pudding, increased fiber laxatives and notification of the physician. The facility failed to monitor bowel movements and provide interventions for R38, who had multiple days without a bowel movement, placing the resident at risk for constipation and decline.	F 757		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: The facility had a census of 61 residents. The sample included 16 residents. Based on observation, record review, and interview the facility failed to ensure one of six residents reviewed during medication administration pass, remained free of medication error. This placed the resident at risk for adverse reaction from the medication. Findings included:	F 759		

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- Resident (R) 39's "Physician Order Sheet," dated 04/18/22, recorded diagnoses of dementia with behavioral disturbances (progressive mental disorder characterized by failing memory, confusion with agitation including verbal and physical aggression, wandering and hoarding), hallucinations (sensing things while awake that appear to be real, but the mind created), major depressive disorder (major mood disorder), and epilepsy (brain disorder characterized by repeated seizures).

R39's "Physician Order," dated 04/12/22 instructed staff to administer, Pristique (antidepressant) ER (extended release), 25 milligrams (mg) 1 tablet a day, Potassium Chloride (potassium supplement) ER, 10 milliequivalents (mEq) 1 tablet a day, and Depakote (anticonvulsant and mood stabilizer) DR (Delayed Release), 1 tablet in the morning.

On 05/03/22 at 07:20 AM, observation revealed License Nurse (LN) I crushed R39's pills, including the Pristique ER, Potassium Chloride ER, and the Depakote DR and mixed the medication with strawberry jello. LN I administered two spoons full of the medication and the resident ingested all of the medications.

On 05/03/22 at 07:20 AM, LN I stated R39 did not like to take her medications, so staff crushed them, and mixed the medication into strawberry jello.

On 05/04/22 at 09:30 AM, Administrative Nurse D verified the extended release medication should not be crushed, should be administered whole due to the extended release of the medication over time, and would get the medications in a

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liquid if available.

The Wed MD recommended Pristique ER, Potassium Chloride ER and Depakote DR should be administered whole, and not crushed, chewed or sucked, as it can release all the medication at once, increasing the risk for side effects.

The facility's "Medication Crushing Guidelines" policy, dated October 2017, documented most crushed tablets or emptied capsules may be mixed with applesauce, pudding, or jelly immediately prior to administration if necessary, to improve their palatability (Check compatibility before mixing). Water may also be used. Juice should only be used when so ordered by the physician. No other products should be mixed with food or beverages other than water unless a physician specific order is obtained. Medication should not be mixed with eternal feeding solutions unless ordered by physician. Medication that should not be crushed or chewed when a resident's condition prohibits the administration of solid dosage forms (tablets, capsules, etc) the nurse administering the medication should check to see that there is no contradiction to crushing the medications in question in liquid form, if possible. The rationale for not crushing some medications include-timed released tablets are designed to release medication over a sustained period usually 8-24 hours. These formulations are utilized to reduce stomach irritation in some cases and to achieve prolonged medication action in other cases. In either case these tablets should not be crushed.

The facility failed to ensure staff administered the extended release medication whole to R39, which placed the resident at risk for adverse reaction

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F 759	Continued From page 15 from the medication.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility had a census of 61 residents. The sample included 16 residents. Based on observation, interview, and record review, the facility failed to label Resident (R) 36's insulin (hormone which allows cells throughout the body to uptake glucose) pen with the opened and expiration date, and discard expired stock	F 761		

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medications on one of three medication carts. This placed the residents at risk for ineffective medications.

Findings included:

-On 05/02/22 at 01:30 PM, observation of the Sunshine medication cart, revealed the following: R36's Lantus (long acting insulin) flex pen lacked a date opened, and a date of expiration.
One bottle of Thiamin (Vitamin B1), 100 milligrams (mg), 100 count tablets, expired 03/22.

On 05/02/22 at 01:35 PM, Licensed Nurse (LN) G, verified the stock medication in the Sunshine cart had expired, the nurses are to look at the bottles before administering the medications to the residents, and discard expired medications. LN G stated the nurses dated the insulin pens/vials when opened and expired and discarded expired medications.

The facility's "Medication Storage in the Facility," dated 01/10/22, documented medication and biologicals are stored safely, securely, and properly following the manufacture or supplier recommendations. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will be immediately withdrawn from the stock. They will be disposed according to drug disposal procedures, and reordered from the pharmacy if a current order exists. Expiration dates of dispensed medications shall be determined by the pharmacist at the time of dispensing. Certain medications or package

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F 761	Continued From page 17 types, such as IV solutions, multiple dose injectable vials, ophthalmic, nitroglycerine tablets, blood sugar testing solutions and strips, once opened, require expiration date shorter than the manufacture's expiration date to ensure medication purity and potency. The nurse will check the expiration date of each medication before administering it. The facility failed to label and date R36's Lantus insulin flex pen with an opened and expiration date, and discard expired stock medications, placing the residents at risk for ineffective medications.	F 761		
F 812 SS=F	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:	F 812		

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The facility had a census of 61 residents. The sample included 16 residents. Based on observation, record review, and interview the facility failed to distribute and serve food in accordance with professional standards for food service safety for the 61 residents who resided in the facility and received their food from the facility kitchen, when the facility failed to ensure clean and sanitary food prep areas, and failed to dispose of expired food items. This placed the 61 residents at risk for foodborne illness.

Findings included:

- On 04/28/22 at 09:02 AM, observation in the kitchen revealed the following:

The kitchen ceiling had three areas of peeling paint, one approximately 12 inches (jn) x 12 in and two with approximately 8 in diameter, above the three-compartment sink.
An area of bubbling paint, approximately 8 in x 12 in above the preparation table.
Two of 28 fluorescent lights with gray fuzzy particles.
Three box air/heat units on the ceiling with grease coated filters and lint on the pipes.
The cord to the electrical box, on the ceiling, over the taller preparation table, with two dead flies.
The windowsill beside the clean dishracks had numerous dead bugs.
The wall behind the soiled dish/sprayer area had an area, approximately two foot by one foot, with a black substance.
Two of the five drawers by the steam table, with serving utensils, had a small amount of dried food particles.
The large uncovered mixer had dried pink and cream-colored food on the machine over the

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bowl.

The walk-in refrigerator had the following undated opened or expired food items:
One-gallon bag of shredded mild cheddar cheese.
Two packages (one-gallon bag) sliced cheese.
One (two gallon) bag of shredded mozzarella cheese.
A small jar of pickles
One-gallon pitcher of thickened juice.
Two (one gallon) pitchers of thickened water.
Three (five-pound (lb.) containers of sour cream
Two (five lb.) containers of cottage cheese.
One-gallon bag of tater tots.
One-gallon bag of onion rings.
One-gallon partial bag of bacon toppings dated 03/29/22

On 04/28/22 at 02:10 PM, Certified Dietary Manager (CDM) BB verified the above issues in the kitchen.

The facility's "Food Receiving and Storage" policy, revised March 2022, documented all foods stored in the dry storage, refrigerator or freezer would be covered, labeled and dated with "open date".

The facility's "Daily Kitchen and Hallway Cleaning Logs" policy, revised January 2022, documented it would be the facility's practice all kitchen and dining areas would always be cleaned and remained presentable.

The facility failed to store, prepare and serve food in accordance with professional standards for food service safety. This placed the 61 residents who resided at the facility and received food from

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F 812	Continued From page 20 the facility kitchen at risk for receiving a foodborne illness.	F 812		