

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

PRINTED: 06/10/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/28/2024
NAME OF PROVIDER OR SUPPLIER WINSTON COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 17560 EAST MAIN STREET LOUISVILLE, MS 39339		
(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 State Agency (SA) conducted an annual recertification survey at the facility from 3/26/24 through 3/28/24. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F578 for advance directives, F606 for not completing background checks, F691 for nephrostomy care, and F812 for food storage. The census at the time of the survey was 92 with a bed capacity of 96 beds.	F 000			
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578			4/25/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/12/2024

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 (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 staff interview, record review, and facility policy review, the facility failed to ensure a resident's choice for end of life care was indicated accurately on medical records for one (1) of 24 residents reviewed for advance directives. Resident #56 Findings include: Record review of facility's resident rights pamphlet titled, "A Matter of Rights", undated, revealed, "As a resident in a long term care facility, you have many rights guaranteed by law. ... Your rights include... freedom to make your own decisions. ... You have a right to expect care and a residential setting that: promotes your quality of life, and reflects your individual needs and preferences..." Record review of facility policy titled, "Policy for	F 578	Winston County Nursing Home provides the plan of correction (POC) without admitting or denying the validity or existence of the alleged deficiency. The POC is prepared and/or executed solely because it is required by the federal and state law. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. 1.The advance directive was clarified by the Licensed Social Worker and Resident #56's Responsible Party on 3/27/24. The inaccurate update form was removed from the chart on 3/27/24 and replaced with a corrected copy. 2.All residents have the potential to be affected.		

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F 578	Continued From page 2 Advanced Directives", undated, revealed, "(proper name of facility) and the Medical Staff will comply with the 1990 Patient Self Determination Act by: 1. Inquiring upon admission if the patient has an advance directive (Living Will or Durable Power of Attorney), 2. Providing information related to advance directives to the patient. Within the confines of medical/ethical practices, we will honor your advance directive with consultation with you and your family..." Record review of facility policy titled, "Understanding Advance Directives", undated, revealed, "You have the right to make health care decisions, including decisions about nursing home care, for yourself..." Record review of Resident #56's "Advance Directive Acknowledgement Review" dated 12/19/23, revealed, "This update on (proper name of Resident #56) took place on 12/19/2023 with the responsible party. This update documents that this resident will be: DNR (do not resuscitate)" and was signed by the Licensed Social Worker (LSW). This document was located in the resident's paper medical chart as the front page. Record review of "Advance Directive Acknowledgement" revealed on admission to the facility, Resident #56 chose a "full code" status. This document was signed by the resident and witnessed by the LSW and dated 12/2/22. This form was located in the resident's paper chart behind the "Advance Directive Acknowledgement Review" form that was dated 12/19/23. Record review of Resident #56's electronic "Physician Orders" dated 12/12/22, revealed an	F 578	3.The Licensed Social Worker was educated on 3/27/2024 on the facility policies for Resident's Rights and Advance Directives. The Licensed Social Worker completed an audit of all advance directives on 3/28/24 to ensure accuracy. In order to ensure the problem does not recur, the Advance Directive Acknowledgement Review form was updated on 3/28/24 to reflect that end of life decisions have been reviewed and whether or not the resident or resident representative wishes to make changes. The new form will not state what the wishes are so that care team will refer to the signed Physician's orders and signed advance directive. Code status for new admissions and changes in code status will be reviewed daily during department head meeting. 4.To monitor compliance the Risk Management Nurse will audit ten charts each week for eight weeks beginning 4/2/24, then five charts for four weeks to ensure code status information is congruent across all documentation. The Risk Management Nurse will report any findings to the Quality Assurance and Performance Improvement Committee monthly for three months beginning 4/25/24.		

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F 578	Continued From page 3 order for "full code". An interview and chart review with the Director of Nursing (DON) on 3/27/24 at 4:00 PM, revealed if Resident #56 experienced a cardio-pulmonary arrest, the staff would check the resident's medical record and would note the first page which indicated a DNR status, and if no additional review of medical records or orders was done, no life-saving measures would be initiated. She confirmed the advance directive signed by the resident on admission and the physician's electronic order indicated a full code status. She confirmed the facility failed to ensure the accuracy of documentation of the resident and/or the resident's representative choice for end of life care which could have led to the resident's wishes not being honored. During an interview on 3/27/24 at 4:05 PM, the Administrator confirmed the electronic physician's order as well as the initial advance directive signed by the resident on admission indicated a full code status, but the "Advance Directive Review" dated 12/19/23 indicated a "Do Not Resuscitate" status. She confirmed the facility failed to accurately indicate the resident and/or resident's representative choice for end of life care in the medical record which could have led to the resident's wishes not being honored. An interview with the LSW on 3/27/24 at 4:40 PM, revealed she was responsible for discussing the advance directive with the residents and/or resident representatives annually. She revealed if a resident or representative had no request for change from the previous advance directive acknowledgement, the acknowledgement review would be signed to indicate this information was	F 578			

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F 578	Continued From page 4 reviewed but no changes were made. If the resident or representative requested a change from the previously made choice, a new "Advance Directive Acknowledgement Review" form would be completed to indicate the decision made and would be signed by the resident or representative to indicate this new decision. She and Resident #56's representative discussed this during the annual review, but no decision to change from the full code status was determined. The LSW confirmed she mistakenly marked DNR rather than full code on the review form, which was not indicative of the resident's or the representative's wishes. She stated it is important for this information to be accurate since it does determine what end of life care would be provided for the resident. Record review of Resident #56's "Face Sheet" revealed the resident was admitted to the facility on 12/2/22, with medical diagnoses that included chronic obstructive pulmonary disease with acute exacerbation, heart failure, type 2 diabetes mellitus, atrial fibrillation, and congestive heart failure. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/17/23, revealed a Brief Interview for Mental Status (BIMS) score of 6 which indicated the resident was severely cognitively impaired.	F 578			
F 606 SS=E	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who-	F 606		4/25/24	

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F 606	Continued From page 5 (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to submit criminal background checks on four (4) of five (5) new employee personnel records reviewed during survey. Employee #1, #2, #3, and #5. Findings include: Review of the facility policy titled, "Hiring" with no revision date revealed under "Comments #3e. If the drug test is negative, a Criminal History Record Check (CHRC) will be performed. Employees will be fingerprinted, and fingerprints will be submitted to the (Proper Name State Agency)..." An interview on 03/28/24 at 12:45 PM, with the Administrator confirmed that background checks	F 606	Winston County Nursing Home provides the plan of correction (POC) without admitting or denying the validity or existence of the alleged deficiency. The POC is prepared and/or executed solely because it is required by the federal and state law. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. 1.Fingerprint cards on all new staff members including, Employee #1, #2, #3 and #5, were sent off to be returned for their criminal background checks on 3/28/24. 2.All residents have the potential to be		

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F 606	Continued From page 6 were completed with the Human Resource Director who also oversees the hospital. The Administrator confirmed that she was not aware that the fingerprint letters were not on the employee files. An interview on 03/28/24 at 12:55 PM, with the Human Resource Director and the Administrator revealed that criminal background checks have not been performed on any employee that has been hired since the first week of January 2024. The Human Resource Director stated, "I'm just going to be honest with you, I don't have any background letters. I have the fingerprint cards filled out, but I haven't sent them in to be checked. I got behind on them and I just haven't managed to catch up". The Human Resource Director confirmed that the purpose of the background checks is to make sure the residents are safe and that nobody is hired with a criminal background. A record review of License Verification for the five (5) employee files that did not have a background check letter did not reveal any discipline activity on their license. Employee #1, #2, #3 and #5 were all hired within the last four (4) months and serve in the role of Certified Nursing Assistant (CNA) and Registered Nurse (RN). The employees have had a Nurse Aid Registry search that showed no disqualifying events, but they do not have a fingerprint letter from the state that would show any criminal charges in the last two years. An interview on 03/28/24 at 1:40 PM, with the Chief Executive Officer (CEO) of the hospital/nursing home confirmed that he was not aware that the Human Resource Director had not	F 606	affected. 3.The Human Resources Director was educated on the facility's hiring policy on 3/28/24. The Human Resources Director completed an audit on all employee files to ensure that criminal background checks were performed and that their letters were placed in their chart as required by policy. A New Employee Checklist was implemented for all new hires to provide oversight between departments. When new staff members are hired the Human Resources Director will have fingerprint cards sent in to Mississippi State Department of Health immediately upon return. Human Resources will provide a copy of background check to Director of Nurses when returned. 4.To monitor compliance the Director of Nurses will maintain constant communication with Human Resources and keep an ongoing record of new hires and their background checks completion date. The Director of Nurses will check for compliance weekly x4 weeks beginning 4/1/24 and then monthly. The Director of Nurses will report any findings for review by the Quality Assurance Committee on 4/25/24 and then monthly for three months.		

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F 606	Continued From page 7 been submitting the fingerprint cards for a criminal background check. The CEO confirmed that not submitting and receiving the background check information could result in someone being hired and working with the residents that could put the residents at risk.	F 606			
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, record reviews, and facility policy review, the facility failed to ensure a resident received the necessary care and treatment of a nephrostomy for one (1) of three (3) residents with urinary catheter systems. Resident #78 Findings include: Record review of the facility policy titled "Application of Urostomy pouch and bedside drainage bag" with a revision date of 2/1/23, revealed, "Purpose: Care of a Resident with a urostomy and pouch system for collection of urine. To promote the dignity and cleanliness of a Resident who has a urostomy...." Record review of Progress note, (Proper name of facility) dated 03/19/2024 at 4:03 AM, revealed,	F 691	Winston County Nursing Home provides the plan of correction (POC) without admitting or denying the validity or existence of the alleged deficiency. The POC is prepared and/or executed solely because it is required by the federal and state law. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. 1. Notified Primary Care Physician and Urologist that Resident #78's nephrostomy bag was leaking. Received return call from Urologist office on 3/28/24 that new supplies would be shipped to facility with orders to replace. Resident #78 was admitted for inpatient care at on outside facility on 4/2/24 prior to supplies	4/25/24	

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F 691	Continued From page 8 "This nurse received report from Emergency Room (ER)Resident also needs a new bag ordered since his is leaking." An interview and observation on 3/26/24 at 10:57 AM, Resident #78 revealed his urinary catheter bag leaks, and he has to put the catheter bag inside of a zip-lock bag, so it doesn't leak into his privacy bag. An observation of a clear zip-lock bag with the nephrostomy bag inside of it with approximately 75 cc of yellow urine in the bottom of the zip-lock bag. The resident revealed the urinary bag had been leaking for quite some time. An interview and observation on 3/27/24 at 2:00 PM, Resident #78 revealed he had told the nurses that his catheter bag leaked and that's what he is using the zip-lock bags for, they just give me more zip-lock bags. He revealed I just want this fixed, so I don't have to use these extra bags. An interview and observation on 3/27/24 at 2:45 PM, the Registered Nurse (RN) Supervisor revealed it is the responsibility of the nurses to inspect Resident #78's catheter bag each shift and to notify her or the Director of Nurses (DON) if there is a problem. She revealed she had not been notified of any issues with his urinary bag. The RN Supervisor confirmed that Resident #78's urinary catheter bag was inside a zip-lock bag and revealed it looked like there was approximately 75-100 cc of urine in the bottom of the zip-lock bag. She revealed the ball was dropped and confirmed he did not have a new catheter bag ordered at this time and stated, "I feel like we failed the resident for this." An interview on 3/27/24 at 3:05 PM, RN #1	F 691	being received in the mail. Resident #78 is due to return to our facility on 4/16/24. 2. All residents with urinary catheter systems have the potential to be affected. 3. The facility policy Application of Urostomy Pouch and Bedside Drainage Bag was updated to include nephrostomy definition and care on 3/27/24. The Quality Assurance and Performance Improvement nurse educated all nursing staff on 3/28/24 on the updated facility policy for Application/Care of Urostomy/Nephrostomy/Cystostomy Pouch and Bedside Drainage Bag, the importance of notifying Registered Nurse Supervisor or Director of Nurses when a resident is found to have defective supplies or equipment, and urinary diversion. 4. The monitor compliance the Nurse Supervisor will visually assess all urinary catheter systems daily for 4 weeks beginning 3/26/24 and then weekly ongoing for proper function and use and document any adverse findings. The Quality Assurance and Performance Improvement nurse will audit all nurses notes entered into the Electronic Health Record the prior 24 hours beginning 4/1/24, 3 times a week for 2 weeks, then twice a week for 2 weeks, the weekly on Mondays for 4 weeks for records of defective equipment or supplies to ensure that all protocols were followed and properly reported. The Quality Assurance and Performance Improvement nurse will report any findings for review by the Quality Assurance Committee on 4/25/24 and then monthly for three months.		

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F 691	Continued From page 9 revealed Resident #78 asked for a zip lock bag a few days after he came back from the ER and I gave him two or three zip-lock bags to use to put his catheter bag in. RN #1 revealed she looked at the catheter bag and it looked as if the seam on the catheter bag was leaking. She confirmed she did not notify anyone about ordering the resident a new catheter bag and confirmed the resident's primary physician had not been notified about the leaking nephrostomy bag. An observation and interview on 03/27/24 at 3:45 PM, the DON revealed she was unaware of any issues with Resident #78's nephrostomy catheter needing to be replaced. Resident #78 stated to the DON that his "bag had been leaking before he went to the ER last week and he has been using zip-lock bags for quite some time." An interview on 3/27/24 at 3:55 PM, the DON confirmed the issue of his catheter bag leaking has gone through several staff members and it should have been taken care of immediately. She confirmed they failed to address the necessary care needed for the resident's nephrostomy. Record review of Resident #78's Face Sheet with an admission of 3/15/23 revealed medical diagnoses that included Retention of urine, and Benign Neoplasm of Prostate. Record review of Resident #78's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/18/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #78 is cognitively intact.	F 691			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		4/25/24	

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F 812	Continued From page 10 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review, the facility failed to ensure items in the kitchen refrigerator, freezer and dry good spices were labeled and dated on one (1) of two (2) kitchen tours during survey. Findings include: A review of the facility policy revised on 1/22, titled "Food and Supply Storage" revealed: "Procedures: Cover, label and date unused portions and open packages..." An interview on 03/26/24 at 10:15 AM, with the Assistant Dietary Director (ADD) revealed that the Dietary Director is off this week, and she oversees the kitchen.	F 812	Winston County Nursing Home provides the plan of correction (POC) without admitting or denying the validity or existence of the alleged deficiency. The POC is prepared and/or executed solely because it is required by the federal and state law. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. 1.Facility disposed of all items that were not labeled and/or not dated on 3/26/24. 2.All residents have the potential to be affected by this deficient practice.		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/28/2024
NAME OF PROVIDER OR SUPPLIER WINSTON COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 17560 EAST MAIN STREET LOUISVILLE, MS 39339		
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F 812	Continued From page 11 An observation and interview on 03/26/24 at 10:18 AM, of the walk-in freezer in the kitchen with ADD revealed four (4) clear gallon size Ziploc bags with some type of meat inside them. The ADD confirmed that it was fish inside two (2) of the gallon Ziploc bags and some type of red meat inside of the other 2 gallon size Ziploc bags. The ADD confirmed that the Ziploc bags should have been labeled and dated when the meat was placed in the bag and stored in the refrigerator. An observation on 03/26/24 at 10:35 AM, of the spice rack located on the stainless steel preparation table revealed an opened 28 ounce container of Nutmeg that was unlabeled, a 28 ounce container of Montréal Steak seasoning, a 28 ounce container of Cinnamon, a 28 ounce container of Onion Powder, a 28 ounce container of Garlic Powder, a 28 ounce container of Rubbed Sage, a 28 ounce container of Rotisserie Chicken Seasoning, a 28 ounce container of Lemon Pepper Salt, and a 28 ounce container of Ground Cumin that were all opened and unlabeled. There was a stainless steel four (4) inch container with a creamy white substance inside of it with a piece of clear plastic wrap over the top of it with no label or date. An interview on 03/26/24 at 10:45 AM, with the cook confirmed that the creamy white substance in a 4-inch stainless steel container was bacon grease that she used it to season the food with sometimes and that she did not know how old it was. The cook confirmed that when any item was opened that it was supposed to have a label identifying what was inside and when it was opened but she was busy and didn't have time to do it.	F 812	3.Dietary Team was educated on 4/10/24 by Dietary Manager on labeling and dating and facility policy B003 Food and Supply Storage. Dietary Manager and/or supervisor will monitor dating and labeling protocols are being followed daily x 2 weeks, biweekly x 2 weeks, and then monthly. 4.To monitor compliance Dietary Manager and/or supervisor will monitor dating and labeling protocols are being followed beginning 4/8/24, daily for 2 weeks, twice a week for 2 weeks, and then monthly. Dietary Manager will report any findings for review to the Quality Assurance Committee on 4/25/24 and then monthly for 3 months.		

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F 812	Continued From page 12 An interview on 03/26/24 at 10:50 AM, with the ADD confirmed that there were nine (9) 28-ounce seasoning containers opened without dates on the labels. The ADD stated "All the staff knows to label anything that they open with the contents and the date opened on a sticker". An observation on 03/26/24 at 11:05 AM, of the kitchen in Oak Cottage revealed a tray with eight (8) 8-ounce glasses of a brown liquid and three (3) 8-ounce glasses of a white liquid that did not have a label on them. An interview on 03/26/24 at 11:35 AM, with the Dietary Aide confirmed that all items prepared and placed in the refrigerator or stored as dry goods should be labeled and dated. Dietary worker confirmed that not labeling food and drink items could result in someone getting sick. An interview on 03/27/24 at 2:15 PM, with the Administrator confirmed that any food or drink that is opened is supposed to be labeled and dated. The Administrator confirmed that not labeling and dating food items could result in someone getting something that they might have an allergy to or someone getting sick if the food item is old.			F 812			