MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79CH	A. BUILDING: _____ B. WING _____	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKINSON COUNTY SENIOR CARE	116 SOUTH LAFAYETTE STREET CENTREVILLE, MS 39631

(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
M 000	Initial Comments During an annual recertification survey, conducted by Healthcare Management Solutions (HMS), on behalf of the Mississippi State Department of Health, conducted 5/6/19-5/9/19, the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm licensure requirements, with deficiencies cited at M605, M655, M815 and M855. The census at the time of survey was 86 and the facility held a license for 105 beds.	M 000		
M 605	45.21.1 Service Beyond Capability of the Home Service Beyond Capability of the Home. Whenever a resident requires hospitalization or medical, nursing, or other care beyond the capabilities and facilities of the home, prompt effort shall be made to transfer the patient/resident to a hospital or other appropriate medical facility. This Statute is not met as evidenced by: Level II Based on observation, record review and interview the facility failed to ensure the residents were provided routine dental services, inside or outside of the facility, in an attempt to prevent any dental issues or assess the need for dentures. The facility also failed to ensure there was a policy in place that addressed dental care and dentures. This affected five residents (Resident #53, #73, #65, #3, and #75) reviewed regarding dental care, of 23 sampled residents. Findings include:	M 605	How the corrective action(s) will be accomplished for those Residents found to be affected by the deficient practice: Dental appointments have been scheduled for resident #53, #73, #65, #3, #75 to have an oral inspection completed, as well as an estimate for dentures, if appropriate. How the facility will identify other Residents having the potential to be affected by the same deficient practice: All Residents could have been affected by	6/21/19

Mississippi State Department of Health

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

Electronically Signed | 06/14/19

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M 605	Continued From page 1 In response to a request for a policy regarding dental services, the facility submitted documentation that stated the facility did not currently have a "Dental Service Policy and Procedure." The statement was dated 5/8/19. Resident #53 Review of Resident #53's medical record revealed the resident had diagnoses that included Brain Disorder, Paralytic Gait, Osteoarthritis, Dysphagia, Aphasia, Vitamin Deficiency and Spastic Paraplegia. The current order form revealed the resident was to have a regular diet, mechanical soft texture, regular liquids. The weight records indicated the resident had no significant weight loss. The care plan dated 7/17/12 indicated the resident was at risk for impaired oral hygiene related to the fact there were some natural teeth and required extensive assistance with personal hygiene. The interventions included to observe oral cavity for abnormalities and obtain dental consult as needed and oral care three (3) times a day. The care plan dated 3/15/16, revealed the resident had impaired cognitive function or impaired thought processes related to Organic Brain Syndrome due to carbon monoxide poisoning. The annual Minimum Data Set (MDS) assessment, dated 3/4/19, revealed the resident was cognitively intact. The assessment revealed the resident required extensive assistance with brushing teeth and there were obvious or likely cavity or broken natural teeth. The resident was observed on 5/6/19 at 2:30 PM, with missing bottom teeth and no upper teeth. An observation on 5/7/19 at 10:15 AM, revealed a	M 605	this deficient practice. What measures will be put into place or what systemic changes will the facility will make to ensure that the deficient practice does not recur: This facility has implemented a corporative approved dental services policy and procedure, effective 5/8/2019, to assist Residents in obtaining routine and emergency dental services, to include denture estimates, if appropriate. Between 5/8/2019 and 5/10/2019, the Director of Nursing services in-serviced all current licensed nursing staff, regarding the new policy and procedure related to dental services. All Resident s oral status will be assessed upon admission and well documented in the clinical record. Initial dental appointments will be made upon admission, and then annually thereafter. In the event of an emergency, an appointment will be made immediately. If a Resident does not wish to be referred for dental services, the physician will be notified, the Registered Dietician will be consulted to assess for any necessary changes in diet, and the Resident s plan of care will be revised to accurately reflect current status and preferences. This nursing facility is in the process of contracting an in-house dental service. As of 5/10/2019, all residents have been assessed for dental needs by the Director of Nursing, Register Nurse Minimum Data Set Coordinator and the Registered Nurse Unit Manger. On 5/13/2019, the Director of Nursing and Assistant Director of Nursing	

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M 605	Continued From page 2 thick film on the bottom teeth. An interview with the resident at the time of the observation revealed the resident would like to have dentures. He stated the staff assisted him with brushing his teeth. On 5/7/19 at 10:40 AM, an interview with Registered Nurse (RN) #1 revealed the resident had not been seen by a dentist. She verified there was no documentation in the chart that indicated the resident had ever been seen by a dentist while at the facility. On 05/07/19 at 11:00 AM, an interview with RN #1 verified there was no policy that addressed dental services. She verified the resident's bottom teeth had thick film build up. She verified the resident was dependent on staff for personal hygiene. Resident #73 Review of Resident #73's medical record revealed the resident had diagnoses that included Parkinson's Disease, Unspecified Dementia with Behavioral Disturbance, Diabetes, Adult Failure to Thrive, Abnormal Weight Loss, Vitamin Deficiency and Functional Dyspepsia. The weight record from November 2018 through April 2019 revealed there was no significant weight loss. The care plan dated 1/15/19, indicated the resident had an activities of daily living deficit related to Parkinson's Disease. The interventions included the resident required extensive staff participation with personal hygiene and oral care. The care plan dated 4/2/19, revealed the resident had cognitive deficit and memory problems related to Dementia/Alzheimer's Difficulty, recalling after short period of time.	M 605	began scheduling dental appointments, based on greatest to least great need, according to the findings of the oral assessments completed on 5/10/2019. All current Residents are expected to be seen by 10/7/2019. How the facility plans to monitor its performance to make sure that solutions are sustained: A Quality Assurance Performance Improvement tool has been created and implemented to ensure compliance with state and federal regulations. The Director of Nursing Services, or her designee, will maintain a log of Resident admissions, to include dates of initial dental appointments, and annual dental appointments thereafter. The Director of Nursing or Assistant Director of Nursing will oversee the scheduling and logging of appointments, to ensure that all residents are examined by a dentist in a timely manner. Beginning on 5/17/2019, the Director of Nursing, or her designee, will audit the dental log weekly, times four months, to assure compliance. Any noted concerns or noncompliance will be reported to the Quality Assurance Performance Improvement committee for review and recommendations, monthly, for six months. Responsible: Director of Nursing, or her designee.	

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M 605	Continued From page 3 The annual MDS assessment, dated 3/18/19, revealed the resident had severe cognitive impairment. The assessment revealed the resident was totally dependent with brushing his teeth. The assessment indicated the resident had no natural teeth On 5/6/19 at 1:30 PM, the resident was observed in bed. Certified Nurse Aides (CNA) #3 and CNA #1 were interviewed at 1:40 PM, and revealed the resident rarely ate his food. They stated he would drink two (2) Ensure with each meal and eat ice cream. On 5/6/19 at 2:15 PM, the resident was observed with missing teeth on the bottom and no top teeth. During an interview the resident, he indicated he had no dentures and thought that might help him with eating. On 5/7/19 at 10:00 AM, an interview with CNA #3 revealed the resident never had any dentures. She verified, once again, the resident had a poor appetite. On 5/7/19 at 10:40 AM, an interview with RN #1 verified the resident had no documentation that he was seen by a dentist. She verified the resident had no teeth, no dentures and a poor appetite. An interview with RN #1 on 5/0/19 at 11:00 AM, revealed there was no policy related to dental services. Resident #65 Review of Resident #65's medical record revealed he had diagnoses that included Dementia, Diabetes, Vitamin Deficiency, Hypertension, Nausea and Vomiting, Unspecified	M 605		

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M 605	Continued From page 4 Psychosis, Anxiety Disorder, Major Depression and bipolar disorder. The annual MDS assessment, dated 7/2/18, revealed the resident had severe cognitive impairment. The assessment revealed the resident required extensive assistance with personal hygiene, which included brushing teeth. The assessment indicated the resident had no broken/loose teeth. The quarterly MDS assessment, dated 3/11/19, revealed no changes. The care plan dated 8/14/14, revealed the resident was at risk for impaired oral hygiene related to being edentulous [no teeth] and the need for assistance with activities of daily living. Interventions included observe oral cavity for abnormalities and obtain dental consult as needed. The interventions also included oral care three (3) times a day. On 5/6/19 at 1:50 PM, the resident was observed with no teeth and no dentures. On 5/7/19 at 11:15 AM, an interview with RN #1 verified the resident never had any dentures while he had been in the facility. She verified there was no documentation that the resident had seen a dentist while in the facility. She verified the resident required assistance for personal hygiene. She stated the facility did not have any policy regarding routine dental services or residents who had no dentures or no teeth. On 5/9/19 at 11:00 AM, an interview with the MDS Coordinator verified the resident had no teeth. Resident #3 Review of Resident #3's medical record revealed the resident had diagnoses that included	M 605		

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M 605	Continued From page 5 Alzheimer's Disease, Dementia, Schizophrenia, Diabetes, Peripheral Vascular Disease, Anxiety Disorder, Disassociative and Conversion Disorders and Generalized Arthritis. The annual MDS assessment, dated 1/14/19, indicated the resident had moderate cognitive impairment, and required limited assistance for personal hygiene. The MDS did not indicate the resident had no teeth. On 5/6/19 at 11:40 AM the resident was observed with no teeth and no dentures. The resident stated she had no dental visits. The resident stated she wanted dentures. An interview with the licensed practical nurse (LPN) #5, at the time of the observation, revealed the resident did not have teeth when admitted and no one checked into her having dentures On 5/7/19 at 10:40 AM, an interview with RN #1 verified the resident had no documentation that she was seen by a dentist. She verified the resident had no teeth, no dentures and no weight loss. An interview with RN #1 on 5/7/19 at 11:00 AM, revealed there was no policy related to dental services. Resident #75 Review of Resident #75's medical record revealed the resident had diagnoses that included Heart Failure, Bipolar Disorder, Abnormal Weight Loss, Hypertension, Vascular Dementia without Behavioral Disturbance, Persistent Mood Disorder, Anorexia and Osteoarthritis. The admission MDS assessment, dated 3/25/19, revealed the resident had severe cognitive	M 605		

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M 605	Continued From page 6 impairment, the resident required extensive assistance with personal hygiene, and had no natural teeth. The care plan dated 03/19/19, revealed the resident required assistance with activities of daily living (ADL) related to Dementia with Alzheimer's and neglected self-care. The interventions included the staff was to provide extensive assistance of one for personal hygiene & oral care daily. On 5/7/19 at 10:30 AM, the resident was observed sitting up in a chair in the dining room during an activity. The resident had no teeth and no dentures. An interview, at that time with CNA #6, revealed the resident did not have any dentures when she came to the facility. The resident was not able to answer any questions related to dentures. On 5/7/19 at 11:00 AM, an interview with RN #1 verified the resident had not seen a dentist. The RN verified residents did not see a dentist for routine care or no teeth or dentures. She verified there was no policy related to residents seeing a dentist. An interview with the Administrator on 5/9/19 at 3:50 PM, verified there was no policy implemented by the facility regarding dental services. She stated the last documented dental service was May of 2017, by a contract company. She stated the contract company had quit servicing the facility. She stated the corporation was leery of hiring another dental service. Further interview with the Administrator on 5/9/19 at 5:20 PM, revealed there had not been any resolution to another contract for dental services until March 2019, at the weekly Quality Assurance (QA)	M 605		

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M 605	Continued From page 7 meeting, as evidenced by the meeting minutes. The minutes revealed the facility was in the process of looking for a dental service company. The Administrator stated the facility had "dropped the ball" regarding follow up with getting routine dental services for the residents.	M 605		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on policy review, observation, and interview, the facility failed to ensure the oxygen (O2) tubing had been changed weekly for one (1) of five (5) sampled residents who were received for oxygen therapy, Resident #27. This deficient practice had the potential to affect 10 of 86 current resident in the facility who were receiving oxygen therapy at the time of the survey. Findings include: Review of the policy dated April 2007 and titled, "Nebulizer and Oxygen Tubing Storage Policy" indicated, "It is the policy of this facility to decrease the risk of potential and/or direct exposure to infectious diseases, air contaminants, and bacterial exposure. We will provide our residents with the proper storage and	M 655	How the corrective action(s) will be accomplished for those Residents found to be affected by the deficient practice: The oxygen tubing and humidifier bottle for Resident #27 were both changed, labeled and dated on 5/6/2019. The Director of Nursing assessed Resident #27 for potential signs and/or symptoms of respiratory infection. No signs or symptoms of respiratory infection were present. How the facility will identify other Residents having the potential to be affected by the same deficient practice: All Residents who are prescribed oxygen therapy have the potential to be affected by this deficient practice. Currently there	6/21/19

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M 655	Continued From page 8 cleaning of respiratory equipment. Procedure: The facility will replace all respiratory tubing weekly. These tubing's will be dated and stored in a dated plastic bag when not in use. The plastic bags will also be changed out weekly ...Documentation will be placed on the residents treatment record (TAR) of the weekly changing of tubing." During an observation on 5/6/19 at 12:11 PM, Resident #27's O2 tubing was observed dated as last changed on "4/22/19 at 1500 (3:00 PM)." The O2 humidifier bottle was also observed without water. The resident was receiving oxygen therapy per nasal cannula. At that time, Resident #27 told the surveyor the bottle had been "without water in it for a while." Resident #27 said the facility had run out of water to put into the humidifier bottle a few days earlier. During an observation on 5/6/19 at 2:14 PM, the old tubing dated 4/22/19 had been changed and now was dated 5/6/19, and the concentrator was full of water. The medication administration report (MAR) dated April 2019, for O2 tubing change, indicated the tubing had been changed on 4/29/19, by licensed practical nurse (LPN) #2 who had worked the 3-11 shift on 4/29/19. A review of the quarterly MDS with an ARD date of 2/4/19 revealed a BIMS of 13 out of 15, which indicates good cognition, active diagnoses of CHF, Anxiety, and Chronic Lung Disease, and is on O2 therapy. Resident #27's care plan dated May 2019, indicated the O2 tubing was to be changed weekly on Mondays. The night shift staff were to	M 655	are thirteen Residents prescribed oxygen therapy. On 5/6/2019 all thirteen Residents were reviewed to ensure oxygen tubing and humidifier bottles were properly labeled, dated and stored per facility policy and procedure. What measures will be put into place or what systemic changes will the facility will make to ensure that the deficient practice does not recur: On 5/13/2019 the Director of Nursing in-serviced and re-educated all current licensed nurses regarding the facilities policy and procedure for properly changing, labeling, dating and storing oxygen tubing and humidifier bottles weekly. Licensed Practical Nurse #2 was given a one-on-one in-service, by the Director of Nursing on 5/13/2019, regarding the facilities policy and procedure related to completing electronic charting documentation only after administration of medication, or treatment order, has been completed. How the facility plans to monitor its performance to make sure that solutions are sustained: In addition to the review and re-education noted above, a Quality Assurance Performance Improvement tool has been created and implemented to ensure compliance with state and federal regulations. All Residents receiving oxygen therapy have been reviewed. The Director of Nursing, or her designee, will	

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M 655	Continued From page 9 date the tubing and clean the oxygen concentrators at that time. "The resident has O2 via nasal cannula PRN (as needed), SOB (shortness of breath), humidified." In response to an interview on 5/8/19 at 1:25 PM, with LPN #4, regarding Resident #27's O2 tubing dated 4/22/19, and no water in the concentrator which the resident said was due to the fact the facility had been without tubing and water, LPN #4 responded, the 3-11 shift changes the O2 tubing but she did not know anything about the facility being without tubing or water for the concentrator. In an interview on 5/8/19 at 1:44 PM, the Director of Nurses (DON) was asked about Resident #27's O2 tubing dated as changed two weeks earlier on 4/22/19, and then had not been changed for two (2) weeks until 5/6/19. The DON was also informed about the concentrator being dry without any water. The DON said she had no answer for the tubing not being changed on the 29th, but she said the water concentrator could have run out of water anytime because it was on continuously. The DON laughed and said they had never run out of water for the concentrators. The DON said every Monday the tubing is changed by the 3-11 shift and she doesn't know what happened on the 29th. A telephone interview on 5/9/19 at 2:05 PM, with LPN #2 who had been responsible for the O2 tubing being changed on 4/29/19, said she had not changed Resident #27's O2 tubing on 04/29/19, but had initialed she had changed the tubing. She said she had been in the process of starting to change the tubing for Resident #27, but had been distracted and then had forgotten to go back and change the O2 tubing for the	M 655	conduct quality assurance audits to ensure oxygen tubing and humidifier bottles have been properly changed, labeled, dated and stored weekly, according to the facilities policy and procedure. This will be done by direct observation and documentation starting on 6/11/2019. These observations will occur weekly until 100% compliance is achieved, times four weeks, then reduced to monthly for one quarter, then re-evaluated. Noncompliance will be corrected and addressed immediately. Results of audits, noncompliance, along with corrective action taken, will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations. Responsible: The Director of Nursing Services, or her designee.	

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M 655	Continued From page 10 resident.	M 655		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on policy review, observation, and interview, the facility failed to ensure there was safe food handling for prevention of foodborne illness by the facility kitchen staff. The failure to ensure safe food handling has the potential to cause serious illnesses to all residents. The facility's census at time of survey was 86. Findings include: The facility's policy, "Purpose and Objectives for the Food and Nutrition Service Department" no date, stated, "The department will follow policies and procedures developed in accordance with local, state and federal regulations and will plan, organize, and evaluate all aspects of food and nutrition services ...The director of food and nutrition services: Directs the food and nutrition services department. Is ultimately responsible for assuring safe, wholesome, high quality food and patient/resident satisfaction." The facility's staff was not following their policy by providing safe food handling by dating food when opened and put in storage. Observation during the initial tour of the kitchen	M 815	*This facility will follow its Purpose and Objective to Food and Nutrition Service Department policy and procedure. Dates were immediately placed on items found not dated by the Dietary Manager. The opened turkey breast and lemons were thrown away by the Dietary Manager. **All Residents who received food from the kitchen were potentially affected by this deficient practice. ***The Administrator in-serviced the Dietary Manager on 5/10/2019 regarding the Food Labeling and Dating policy and procedure as well as the Safe Food Handling policy and procedure. On 5/10/2019, the Dietary Manager in-serviced and re-educated all dietary staff on the Food Labeling and Dating Safe Food Handling. ****Beginning 5/13/2019, the Dietary Manager will perform food receiving, labeling and storage audits five days per week, for one month, then three days per week, for one month, then reduced to two days per week, indefinitely. The	6/21/19

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M 815	Continued From page 11 on 5/6/19 at 10:30 AM, revealed in a cooler containing an opened gallon of milk that was not dated when opened. In the cooler next to the milk contained apple, grape, and orange juice concentrate opened and not dated. Next in the walk-in cooler was found an opened box of 17 spoiled lemons, with a black mold-like substance on them. Also, a package of sliced turkey breast that had a large open slit in the side of the package that was not dated. Under the counter was a baked Chest Pie with two (2) extra quarter slices on top wrapped in cellophane that was not dated. Interview on 5/6/19 at 10:35 AM, Dietary Worker (DW) #1 confirmed the milk, juices, and pie had not been dated when opened, and immediately place the date opened on the items found. Interview on 5/6/19 at 11:00 AM, with the Dietary Manager (DM), revealed she was unaware of the lemons and opened turkey breast. The DM threw them immediately away. The DM stated the items need to be thrown away. The DM knew that the items should not have been in the cooler. The food service department failed to follow the facility undated policy "Purpose and Objectives for the Food and Nutrition Service Department."	M 815	Administrator will monitor for compliance by direct observation and documentation. Any deficiencies will be documented and corrected immediately. Audit logs will be maintained in the dietary department and will be reviewed by the Quality Assurance Performance Improvement Committee weekly for review and recommendations, times four weeks, then monthly thereafter.	
M 855	45.30.7 Food Preparation Food Preparation. Foods shall be prepared by methods that conserve optimum nutritive value, flavor, and appearance. Also, the food shall be acceptable to the individuals served. A file of tested recipes shall be maintained to assure uniform quantity and quality of products.	M 855		6/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	79CH	A. BUILDING: _____ B. WING _____	05/09/2019

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M 855	Continued From page 12 This Statute is not met as evidenced by: Level II Based on policy review, observation, verbal residents' complaints, and food taste testing, it was determined the facility failed to provide each resident with nourishing, palatable diet by providing adequate food temperatures and palatability. Failure to provide adequate dietary needs has the potential to cause complaints and discontent by not meeting the residents needs. This had the potential to affect all residents who received food from the kitchen. There were 86 residents in the facility and the facility documented seven (7) residents, who received tube feedings, leaving 79 residents with the potential to be affected. Findings include: The facility's policy, "Purpose and Objectives for the Food and Nutrition Service Department" no date, documented, "The purpose of the food and nutrition services department is to provide high quality, nutritious, palatable and attractive meals in a safe, sanitary manner. Food will be prepared in a form to accommodate patient/resident allergies, intolerance's, and personal, religious, and cultural preferences, based on reasonable efforts ... Objectives of the food and nutrition services department are to: 1. Provide food and drink that is nutritious, palatable, attractive, and at a safe and appetizing temperature to meet individual needs." The facility's staff was not following their policy by providing palatable or appetizing temperature to meet the resident's needs. Participation/observation of resident council meeting on 5/7/19 at 12:10 PM, revealed that	M 855	*This facility will follow its Purpose and Objectives to the Food and Nutrition Service Department policy and procedure to provide food and drink that is nutritious, palatable, attractive and is a safe and appetizing temperature to meet individual needs. On 5/10/2019, the Dietary Manager in-serviced and re-educated all dietary staff on the facilities policy Safe Food Handling Practices/Food Temperatures and Food Sampling. Included in that in-service was the proper usage of the plate warmer. **All Residents receiving food from the kitchen were potentially affected by this deficient practice. ***ON 5/13/2019, the Dietary Manager began to do meal service audits that included food temperatures and food taste. These audits will be done at random meal times, five days per week, for one month, then three days per week, for one month, then reduced to two days per week, indefinitely. Audit logs will be maintained in the dietary department and will be submitted to the Quality Assurance Improvement Committee for review and recommendations. Audit reports will also be shared monthly with the Resident and Family Council Group for comments and suggestions. ****The Administrator will monitor for compliance by direct observation and documentation. Any deficiencies will be corrected immediately and reported to the Quality Assurance Improvement	

MSDH - Health Facilities Licensure and Certification

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M 855	Continued From page 13 Resident #11 and Resident #14 complained that their food was cold when served. They stated they ate in the dining room and were the last residents served. They said they never formally reported the complaint but had been previously discussed in Resident Council meetings. Observation of Resident #23 and Resident #43 on 5/8/19, as they were served lunch service, revealed that each resident tasted each item on their trays and stated the food was warm and good. During a sample taste test on 5/8/19 at 12:30 PM, in the activity room with the Dietary Manager (DM) participating, the surveyor sampled the main menu tray, pureed tray, and alternate tray. The menu tray consisted of crab cakes, black-eyed peas, and carrots: The crab cakes were measured at 122 degrees Fahrenheit (F) on the line and were luke-warm when tasted. The black-eyed peas were measured at 116 degrees F and were warm when tasted. The pureed tray had fish, brown beans, and carrots: The fish was measured at 138 degrees F on tray line but when tasted upon delivery of the test tray revealed no taste at all, tasted just like starch with no flavor, and was a luke-warm temperature. The alternative tray had crumbed crab cakes, brown beans, and mixed veggies: The crumbled crab cakes measured 90 degrees F and tasted luke-warm. The mixed veggies measured 130 degrees F and were luke-warm to taste. Interview on 5/8/19 at 12:30 PM, after all trays were served, the Dietary Manager (DM) tasted all the foods but the seafood. The DM did not like	M 855	Committee for review and recommendation. These observations will occur weekly for four weeks, beginning on 5/13/19, then reduced to monthly for one quarter. Direct observations will be complete by 9/13/19.	

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M 855	Continued From page 14 seafood, but did taste the pureed fish. The DM confirmed there was no fish taste and it had no flavor. The DM confirmed the temperature findings and taste were not acceptable. Observation in the kitchen, above the tray line was posted, "135 degree F Minimum temperature on the steam table. 145 degree F Fish, seafood, pork, raw shell eggs for immediate service. 155 degree F Ground beef, ground meat, raw eggs not prepared for immediate service 165 degree F Poultry, stuffed fish/meat/pasta; stuffing containing fish, meat, or poultry ..." The facility's staff was not following their guidance by maintaining the appropriate tray line temperatures.	M 855		