STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255215	A. BUILDING _____ B. WING _____	06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF COLLINS	1315 SOUTH FIR AVE COLLINS, MS 39428

(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 and two (2) Complaint Investigations CI MS# 18383 and CI MS #18764 at the facility from 6/05/22 through 6/08/22. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA did not substantiate CI MS #18764 for an unknown injury. The SA substantiated CI MS #18383 regarding safety/falls and cited F610. The SA also cited F636, F657, F686 and F812 related to the survey. The facility held a license for 60 beds with a census of 57.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision.	F 636		7/5/22

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

Electronically Signed | 06/30/2022

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F 636	Continued From page 1	F 636		

(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.

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F 636	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to complete the comprehensive Minimum Data Set (MDS) for one (1) of 38 residents reviewed for comprehensive assessments, with the potential to affect 57 residents. Resident #3 A record review of the facility's policy "MDS Process", with a latest revision date of 12/20, revealed, "The Assessment Nurse/ Nurse Case Manager will set the Assessment Reference Date on an allowable date with input from the interdisciplinary team and communicate scheduled assessments to the interdisciplinary team. The RAI (Resident Assessment Instrument) manual is the source document to be used for further MDS coding guidelines, time schedules and requirements..." A record review of Centers for Medicare and Medicaid (CMS) RAI Version 3.0 Manual, dated October 2019, revealed, "...The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days)..." A record review of the "Face Sheet" revealed the facility admitted Resident #3 on 03/20/2014. A record review of Resident #3's last comprehensive annual MDS assessment revealed a date of 05/24/2021, which is greater than 366 days. On 06/08/22 at 9:30 AM, during an interview with Registered Nurse (RN) #1, she confirmed Resident #3's last annual assessment was	F 636	-Resident #3 comprehensive Minimum Data Set was completed and transmitted on 06/10/2022 by Director of Nursing. -All residents have the potential to be affected by the deficient practice. -An in-service was initiated on 06/07/2022 with facility Assessment Nurse, Nurse Case Manager and Director of Nursing by Quality Improvement Nurse. Topics reviewed included Resident Assessment Instrument Manual regarding assessment completion timelines as well as facility policies titled Resident MDS Assessment and MDS Process. An audit was completed on 06/10/2022 by Director of Nursing and Nurse Case Manager of active resident's minimum data set schedule. All resident assessments audited on 06/30/2022 by Director of Nursing were completed timely. -The facility Director of Nursing and/or Facility Administrator will review residents minimum data set schedule weekly for three weeks beginning on 06/17/2022 then monthly times two months until substantial compliance is attained to ensure timely completion of resident minimum data set assessments. A quality Assurance Committee meeting was held on 06/27/2022 to review this corrective action plan. The Quality Assurance Committee members present on 06/27/2022 were Facility Administrator, Facility Director of Nurses, Facility	

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F 636	Continued From page 3 completed on 05/24/2021. On 06/08/22 at 9:45 AM, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed Resident #3's last annual MDS assessment had an Assessment Reference Date (ARD) of 05/24/2021 and she verified it had been over 366 days since an annual MDS assessment had been completed. On 06/08/22 at 10:30 AM, during an interview with the Director of Nursing (DON), she explained Resident #3 had an annual assessment that was open (not completed). She had not been made aware previously that the annual assessment was open and had been missed. She was trying to complete the MDS assessments that were due for April and May 2022 and she must have missed Resident #3's assessment. She confirmed that she was aware that some MDS assessments were behind because two (2) MDS nurses had quit in April 2022. The facility used the RAI manual for guidance in completing MDS assessments.	F 636	Medical Director, Facility Infection Preventionist, Dietary Manager, Environmental Services Supervisor, MDS Nurse, Accounts Manager, Admission Coordinator, Social Services, and Medical Records Nurse. The facility Quality Assurance Committee Meeting shall be held monthly for 2 months until substantial compliance is attained. Areas of concern will be carried the the Quality Assurance Committee for corrective action to include in-service training, and/or disciplinary action.	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		7/5/22

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F 657	Continued From page 4 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure the comprehensive care plan was reviewed timely for one (1) resident, Resident #39, and revised for two (2) residents, Resident #39 and Resident #103, out of four (4) residents sampled for falls. Findings Include: Review of the facility's policy, "Care Plan Process" with a revision date of 08/17 revealed, "...The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive person-centered plan of care...Re-evaluates the resident's status at prescribed intervals (i.e. quarterly, annually, or if a significant change in status occurs)...Interventions are actions that should promote meeting the established goal..."	F 657	-Resident #34 comprehensive care plan was reviewed and revised on 06/09/2022 by Nurse Case Manager. Resident #103 was discharged from the facility on 12/08/2022. -All residents with falls have the potential to be affected by the deficient practice. -An in-service was initiated on 06/07/2022 with facility Assessment Nurse and Nurse Case Manager by Director of Nursing. Topics reviewed included Care Plan Process with review and revision of resident comprehensive care plans. An audit was completed on 06/09/2022 by Director of Nursing and Nurse Case Manager of resident care plans for revisions and fall interventions. Care plans were reviewed and updated on 06/09/2022 to include interventions.	

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F 657	Continued From page 5 Review of the facility's policy "Fall Prevention and Management Program" with the latest revision date of 09/18 revealed, "...will be used to develop interventions after each fall and for care plan revisions...Management...The resident's care plan is updated to reflect the new intervention(s). Resident #103 A record review of Resident #103's "Face Sheet" revealed the facility admitted him on 11/26/21, with diagnoses including Muscle Weakness, Lack of Coordination, and Need for Assistance with Personal Care. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/2/21 revealed Resident #103 had a Brief Interview of Mental Status (BIMS) score of nine (9), which indicated he had moderate cognitive impairment. A record review of "Departmental Notes" for Resident #103, dated 12/2/2021 at 7:27 AM, revealed, "Resident noted on floor on his bottom by CNA (Certified Nursing Assistant)..." A record review of Resident #103's "Baseline Care Plan And Summary" reflected actual falls dated 11/30/21 and 12/7/21, along with the interventions. There was no fall with an intervention for the fall that occurred on 12/2/2021. A record review of the medical record revealed there was no comprehensive care plan developed related to falls for Resident #103. On 6/8/22 at 1:50 PM, in an interview with the	F 657	-The facility Director of Nursing and/or Facility Administrator will review comprehensive care plans for fall interventions weekly for three weeks beginning on 06/09/2022 then monthly times two months until substantial compliance is attained to ensure timely reviews with fall interventions. A quality Assurance Committee meeting was held on 06/27/2022 to review this corrective action plan. The Quality Assurance Committee members present on 06/27/2022 were Facility Administrator, Facility Director of Nurses, Facility Medical Director, Facility Infection Preventionist, Dietary Manager, Environmental Services Supervisor, MDS Nurse, Accounts Manager, Admission Coordinator, Social Services, and Medical Records Nurse. The facility Quality Assurance Committee Meeting shall be held monthly for 2 months until substantial compliance is attained. Areas of concern will be carried the the Quality Assurance Committee for corrective action to include in-service training, and/or disciplinary action.	

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F 657	Continued From page 6	F 657		

DON, she stated the care plan should have been updated on 12/2/21 to include Resident #103's fall. The care plan is used by staff to give care to the residents.

Resident #34

Record review of the "Face Sheet" revealed Resident #34 was admitted by the facility on 10/2/2019 with diagnoses including Hyperlipidemia, Chronic Obstructive Pulmonary Disease with Acute Exacerbation, and Chronic Respiratory Failure with Hypoxia.

Record review of the Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 4/25/22 revealed Resident #34 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated she is cognitively intact.

Record review of Resident #34's "Incident Log" dated from 12/6/21 through 6/6/22 revealed she had falls that occurred on 12/15/21, 2/4/22, 3/26/22, 3/29/22, 4/10/22, 5/10/22.

Record review of Resident #34's care plan revealed a "Problem/Need" listed as "Resident is at risk for falls" with dates of actual falls listed as 11/12/19, 3/6/21, and 2/4/22". There were no actual fall dates listed for the falls that occurred on 12/15/21, 3/26/22, 3/29/22, 4/10/22, and 5/10/22. The "Goal & Target" date was listed as "Resident will be free of injury and complications

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F 657	Continued From page 7 through the next review 8-25-21" and "Resident will have no falls through next review 8/25/21", which indicated Resident #34's status had not been re-evaluated with the results of the latest MDS assessment dated 4/25/22. Care plan approaches related to the falls corresponded with the date of the actual falls on 3/6/21 and 2/4/22. There were no approaches listed for the actual falls that occurred on 12/15/21, 3/26/22, 3/29/22, 4/10/22, and 5/10/22. On 06/07/22 at 11:17 AM, in an interview with Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1, RN #1 confirmed Resident #34's care plan was not reviewed timely and that typically the care plan is reviewed with each assessment. The care plans are located in each resident's chart and updates are handwritten until the next comprehensive MDS assessment, in which the entire care plan is reprinted and placed on the chart. She confirmed the care plan should be revised with each fall to include the date the fall occurred and the corresponding intervention. On 06/08/22 at 10:09 AM, in an interview with the Director of Nursing (DON), she stated that it is her expectation that the care plan be reviewed with each MDS, which is at least quarterly. She stated falls are reviewed daily in morning meeting and interventions are discussed. The care plan should be updated at that time with the intervention. The interventions discussed in the morning meetings for Resident #34 "did not make it to the resident's care plan in the chart". She acknowledged that the care plan is used by the staff to know how they are to provide care to the residents.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		7/5/22

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F 686	Continued From page 8 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to prevent the development of an avoidable pressure ulcer on a resident with an immobilization brace for one (1) of three (3) facility acquired pressure ulcers reviewed. Resident #30 Findings Include: Review of the facility's policy, "Prevention and Treatment of Skin Issues" with a latest review date of 8/21 revealed, "Policy: It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care ...C. monitoring of skin integrity. The skin will be observed daily during care by the nursing	F 686	-Resident #30 splint was discontinued on 03/24/2022 by Treatment Nurse. Resident #30 was re-assessed on 06/08/2022 by Director of Nursing and a body audit completed with no additional skin issues or concerns noted. -All residents with splints have the potential to be affected. -An in-service was initiated on 06/07/2022 with facility Registered Nurse, Licensed Practical Nurses, Certified Nursing Assistants and Temporary Nurse Aides by Staff Development Nurse. Topics reviewed included Prevention and Treatment of Skin Issues. Body audits were completed on residents with splints on 06/08/2022 by Director of Nursing. No new skin issues were identified at time of audits on 06/08/2022. Orders were	

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F 686	Continued From page 9 assistants. If any skin concerns are noted, they are to be reported immediately to the designated nurse verbally and via the kiosk in electronic facilities ..." On 06/06/22 at 11:33 AM, the State Agency (SA) observed wound care for Resident #30 performed by the Director of Nursing (DON). The SA observed two wounds to the resident's right heel. Record review of Resident #30's "Departmental Notes" dated 3/21/22 at 2:44 PM revealed, "Pressure Ulcer//Right Heel// ...New DTI (Deep Tissue Injury), which appears to be from the brace resident must wear on her leg. The metal part was under the heel and medial side where the DTI was located." Record review of the facility's "Pressure Ulcer Evaluation for Unavoidable/Avoidable Status" dated 3/21/22 revealed Resident #30 was evaluated for clinical conditions and pressure ulcer risk factors with formal and clinical assessments on 3/18/22. Risk factors for development and or delayed healing of pressure ulcers were indicated as "cast or non-removable device". Record review of the "Wound Assessment Report" dated 3/18/22, revealed an "Assessment Occasion" as "New Wound." The stage and the type of pressure area was indicated as "Unstageable" and "Suspected Deep Tissue Injury". The location of the pressure injury was the right heel and measurements were recorded as 5.50 CM X 2.80 CM. The wound report "Notes" revealed, "New DTI appears to be from the brace resident has to wear on her leg. The metal part was under the heel and on the medial	F 686	received for all active residents with splints on 06/08/2022 by Medical Records Nurse to check under splint for signs of skin breakdown. There were no non-removable devices ordered for residents at time of audit on 06/08/2022. -The facility Director of Nursing and/or Treatment Nurse will complete an additional body audit weekly times four weeks on residents with splints beginning on 06/08/2022 until substantial compliance is attained. A quality Assurance Committee meeting was held on 06/27/2022 to review this corrective action plan. The Quality Assurance Committee members present on 06/27/2022 were Facility Administrator, Facility Director of Nurses, Facility Medical Director, Facility Infection Preventionist, Dietary Manager, Environmental Services Supervisor, MDS Nurse, Accounts Manager, Admission Coordinator, Social Services, and Medical Records Nurse. The facility Quality Assurance Committee Meeting shall be held monthly for 2 months until substantial compliance is attained. Areas of concern will be carried the the Quality Assurance Committee for corrective action to include in-service training, and/or disciplinary action.	

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side where the DTI is located".

During an interview on 06/06/22 at 12:15 PM, with Resident #30, she said she fell at home, fractured her knee, and came to the facility to receive therapy. She did not know her foot was pressing against the medal on the brace and had caused a wound.

On 06/06/22 at 11:34 AM, the SA conducted a telephone interview with Registered Nurse (RN) #2, a former employee who was the wound care nurse. She said she was told by another nurse that Resident #30's right heel was "boggy" which possibly meant the resident's heel had underlying tissue damage. RN #2 said she monitored the area for a few days and notified the doctor, but she was unable to recall the exact date this occurred. RN #2 commented that the resident's immobilizer brace kept sliding down her leg causing the metal bar in the brace to apply pressure to her right heel. RN #2 confirmed the Certified Nursing Assistants (CNAs) could not remove the brace per doctor's order and only the nurse that provided care to the surgical site could remove the device. RN #2 believed Resident #30 developed the pressure injury on her heel from the metal bar on the brace. She stated that as the wound care nurse, she should have requested a physician order to check the pressure points to ensure the resident did not develop a wound from the brace.

During an Interview on 06/07/22 at 11:00 AM, with Licensed Practical Nurse (LPN) # 2, revealed she assisted RN #2 during wound care by holding Resident #30's right foot. LPN #2 said she was holding the residents' foot and noted the resident's right heel was red and boggy. LPN #2

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F 686	Continued From page 11	F 686		

said she reported her findings related to the heel to RN #2 and was told that RN #2 was going to monitor the heel for a while. LPN #2 said that approximately one week later, Resident #30's right heel continued to be boggy and had developed a purple discoloration. LPN #2 advised RN #2 that something needed to be done to prevent the resident from having skin breakdown. By the third week, Resident #30's right heel had opened, and wound care orders were received. LPN #2 said she was responsible for the weekly body audits, but she did not document there were any skin issues because she had already told RN #2 and the DON about the condition of Resident #30's heel.

During an Interview on 6/07/22 at 1:00 PM, with the Medical Doctor (MD), he confirmed he was notified that Resident #30 had developed a deep tissue injury on her right heel. He was unaware that the resident's heel was pressing against the metal bar of the brace as it would slide down. He had thought the facility had padded all the pressure points on the resident's leg and heel to prevent pressure ulcers and friction, and he thought the facility was assessing the pressure areas daily.

An interview on 6/7/22 at 1:30 PM, with the Physical Therapy Assistant (PTA) revealed he was asked on 3/28/22 by RN #2 to look at Resident #30's brace to see why it kept sliding down. The PTA said he adjusted the brace which kept the brace in place until it was removed.

Record review of the facility's "Timeline for (Proper Name of Resident #30) Wounds" given to the SA by the DON revealed, "3/7/22 External Fixator with pins was removed and immobilizer

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	255215	A. BUILDING _____ B. WING _____	06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF COLLINS	1315 SOUTH FIR AVE COLLINS, MS 39428

(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 686	Continued From page 12	F 686		

was placed. 3/14/22 clarification from ortho (Orthopedics) on removal/placement of brace due to pain voiced by resident. Ortho states only loosen for wound care. 3/18/22 Deep tissue injury to right heel developed ..."

During an Interview on 6/7/22 at 2:30 PM with the DON, she confirmed the resident acquired both the unstageable pressure ulcer and the Stage 2 pressure ulcer to the right heel because it had been one (1) wound that developed into two (2) separate wounds. The wound occurred from the metal bar on the brace. She acknowledged there is no documentation showing the facility was monitoring the pressure points daily for pressure injury development underneath the brace. She confirmed it was the wound care nurse's responsibility to make sure the resident's pressure points were checked daily to prevent skin breakdown.

Record review of the "Face Sheet" revealed the facility admitted Resident #30 on 11/10/21, with the diagnoses that included Unspecified Fracture of Right Femur, Muscle Spasm, Muscle weakness, and Diabetes Mellitus.

The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/3/22 revealed Resident #30 had a Brief Interview of Mental Status (BIMS) score of 15 that indicated she was cognitively intact. Review of Section M revealed Resident #30 is at risk of developing pressure ulcer injury and had more than one (1) unhealed pressure injuries.

Review of RN #2's, "Licensed Nurses Orientation Checklist", revealed on 12/8/21 information was covered related to "Policies/Procedures,

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F 686	Continued From page 13 schedules, documentation" on the Skin Program/Wound Care which included body audits, treatments/orders	F 686		
F 812 SS=D	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: Based on observation, interviews, record review and facility policy review, the facility failed to discard expired food items, ensure daily temperature logs for the freezer were completed, and failed to label and date refrigerated items for one (1) of four (4) kitchen observations. Findings Include: A record review of the facility's policy" Food Storage Labeling", with a revision date of 05/18,	F 812	-The facility dietary freezers and cooler were cleaned on 06/05/2022 by dietary staff and expired food discarded accordingly. All food was stored and labeled appropriately on 06/05/2022 by Facility Administrator. Cooler and Freezer temperatures were checked on 06/05/2022 and temperature logs updated accordingly by dietary staff. -All residents have the potential to be	7/5/22

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F 812	Continued From page 14 revealed, Policy: The facility will ensure the safety and quality of food by following good storage and labeling procedures Procedure: 1. Labeling ... a. All temperature controlled foods and ready to eat foods that are prepared in the facility and held for longer than twenty-four hours will be labeled. Information included on the label: Name of the Food Date of storage ...3. Rotation ...b. Foods stored in storage units will be surveyed routinely to identify and discard foods that have passed its manufactured use-by date or expiration date... 4. Monitoring storage temperatures ...b. Temperatures in food storage units are monitored daily. C. Documentation of time and temperature is recorded on a Temperature Monitoring Log ..." On 6/5/22 at 10:22 AM, during an initial kitchen tour and interview with the Head Cook (Dietary #1), the State Agency (SA) observed that the temperature logs for the Milk Box and Ice Cream Box freezers had missing documentation. The SA observed an 8-ounce container in the refrigerator that contained a white liquid substance and was not labeled with the name of the food or the date of storage. The SA observed a 32-ounce container of McCormick Culinary egg shade food color with an open date of 5/28/20 and an expiration date of 12/20. The SA observed an undated clear container with potato salad and coleslaw that had no label containing the name of the food or the date of storage. Dietary #1 commented that she had informed the staff that it is important to check all refrigerators, and freezers for labeled food items and to complete the documentation of the temperature logs daily. She confirmed the food should have been labeled and the temperatures logs should have been completed because this information lets the staff	F 812	affected. -An in-service was initiated on 06/07/2022 with facility Dietary staff by Administrator. Topics reviewed included Food Storage Labeling, discarding expired foods, and maintaining temperature logs. -The facility Director of Dietary Services and/or Facility Administrator will check dietary cooler/freezer for appropriate food storage, labeling and discarding of expired food three times per week for three weeks beginning on 06/09/2022 then weekly for 2 weeks until substantial compliance is attained. The facility Director of Dietary Services and/or Facility Administrator will check dietary temperature logs three times per week for three weeks beginning on 06/09/2022 then weekly for 2 weeks until substantial compliance is attainted. A quality Assurance Committee meeting was held on 06/27/2022 to review this corrective action plan. The Quality Assurance Committee members present on 06/27/2022 were Facility Administrator, Facility Director of Nurses, Facility Medical Director, Facility Infection Preventionist, Dietary Manager, Environmental Services Supervisor, MDS Nurse, Accounts Manager, Admission Coordinator, Social Services, and Medical Records Nurse. The facility Quality Assurance Committee Meeting shall be held monthly for 2 months until substantial compliance is attained. Areas of concern will be carried to the Quality Assurance Committee for corrective action to include	

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F 812	Continued From page 15	F 812		

know that the food is good to serve to the residents. Dietary #1 explained that all expired foods should be thrown away so that staff will not use them. She further acknowledged that although the egg shade color had not been used for a long time, it should not have been in the kitchen.

On 6/8/22 at 2:45 PM, in an interview with the Administrator, he confirmed that Dietary #1 is in charge of the kitchen while the Dietary Manager is on leave. He acknowledged that staff should be checking for expired food, logging temperatures daily, and labeling and dating foods in the refrigerator so that the residents will not be served expired food. He said that dietary staff should check and record temperatures on the refrigerators and freezers to make sure that the food does not spoil.

A record review of the "Daily Freezer/Refrigerator Temperature Log" for the "Month/Year" of 6/2022 with a "Location/Unit Description" listed as "Milkbox Dietary" revealed there was no temperature recorded for 6/4/22.

A record review of the "Daily Freezer/Refrigerator Temperature Log" for the "Month/Year" of 6/2022 with a "Location/Unit Description" listed as "Ice Cream Box Dietary" revealed there was no temperature recorded for 6/4/22.

A record review of the facility's "In-Service Attendance" revealed Dietary #1 received training on the "Topic" of "Storage Temperatures" on 4/6/22.

in-service training, and/or disciplinary action.