STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255072	A. BUILDING _____ B. WING _____	10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON COUNTY NURSING HOME	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 re-certification survey at the facility from 10/11/22 to 10/13/22. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited F606, F656, F695, and F812. The census at the time of the survey was 89 and the facility was licensed for 96 beds.	F 000		
F 606 SS=D	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- (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:	F 606		11/14/22

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

Electronically Signed | 10/27/2022

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 606	Continued From page 1 Based on staff interviews, record review and facility policy review the facility failed to submit criminal background checks on three (3) of five (5) new employee personnel records reviewed. 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. Employee will be fingerprinted, and fingerprints will be submitted to the MS State Department of Health." An interview on 10/12/22 at 9:45 AM with the Human Resources (HR) Director confirmed that the background checks had not been completed on Certified Nursing Assistant (CNA) #1, CNA #2, and Registered Nurse (RN) #1. She revealed she is the only one in her department and she covers the hospital new hires as well and stated that she just got behind. She revealed she did not realize how behind she had gotten until the State Agency (SA) asked for the records of the latest new employees hired in the last 120 days and it revealed that these employees did not have their criminal background check. She stated they were all direct care employees and that if an employee was working here they were required to have a criminal background completed. She revealed the facility has a policy that all employees will be fingerprinted and a criminal background check will be completed on every employee that works at the facility. An interview on 10/12/22 at 10:00 AM with the Administrator and the Director of Nurses (DON) confirmed it is the policy of the facility that all	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 staff members, Certified Nursing Assistant (CNA) #1, CNA # 2 and Registered Nurse (RN) # 1, were submitted on 10/12/22 to the MS State Department of Health for their criminal background check to be complete and filed in employee record. 2.All residents have the potential to be affected. 3.The Human Resources Director was educated on 10/12/22, by Director of Nurses (DON) on the facility Hiring policy and protocol for submitting fingerprints for new hires and receiving criminal background check. The Human Resource Director completed an audit on all employee files to ensure that criminal background checks were performed and that their letters were placed in their file as required by policy. When new staff members are hired, the Human Resource Director will have fingerprint cards sent in to MS State Department of Health within 10 days of hire. Human Resource Director	

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F 606	Continued From page 2 employees have a criminal background check. The DON confirmed that allowing someone to work here without a criminal background check being completed puts the resident at risk for the potential for abuse if that employee had a disqualifying factor on their criminal background check. Record review of new hire personnel records revealed that no criminal background check had been completed on CNA #1, CNA #2, and RN #1 that were hired in the last 120 days.	F 606	will provide a copy of background check to Director of Nurses (DON) when returned. A copy will be kept in DON employee files, as well. 4.The Director of Nursing (DON) will maintain constant communication with Human Resource Director and keep an ongoing record of new hires and their criminal background checks. An audit tool was developed and implemented by DON on 10/12/22. DON will continue to check for compliance weekly for four weeks and then monthly. The DON will report any findings for review by the Quality Assurance (QA) Committee on 11/11/22 and then every other month starting in December.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		11/14/22

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F 656	Continued From page 3 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, record review and facility policy review the facility failed to implement a comprehensive care plan for three (3) of 18 care plans reviewed. Resident #2, Resident #42 and Resident #184. Findings Include: Record review of the facility policy titled "Care Plan" with a revision date of 09/04/2014 revealed under "Purpose...To direct resident care from admission to discharge". Resident #184	F 656	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. Resident # 184: O2 signage was placed outside room and the O2 tubing was	

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F 656	Continued From page 4 An observation on 10/11/22 at 11:03 AM, revealed Resident #184 lying in bed receiving Oxygen (O2)via biprong nasal cannula at five (5) Liters Per Minute (LPM). O2 tubing was not dated or labeled and there was no O2 signage on the resident's room door. Record review of Resident #184's care plans revealed the following care plan: I am at risk of respiratory complications related to the diagnosis of Asbestos exposure and I receive O2 @ 5 L/M (liters/minute) via nasal bi prong (NBP) with a goal of I will be free of signs and symptoms of respiratory distress and maintain optimal functioning within limitations imposed by disease process through next review and interventions that include Administer O2 as ordered @ 5 l/m via NBP. Change setup weekly and as needed (PRN). An observation and interview on 10/12/22 at 1:30 PM, with Licensed Practical Nurse (LPN) #1 confirmed that Resident #184's O2 tubing was not labeled and dated and there was no O2 signage on the door. She confirmed and revealed there was a plastic bag with new O2 tubing with a date of 10/10/22 lying on top of the air conditioner in the resident's room. She revealed the nurse was supposed to have changed the resident's tubing on Sunday 10/10/22 so it must have not been done and stated it is the policy of the facility that resident's O2 tubing has to be changed once per week, labeled, and dated and O2 signage needs to be put on the door. She confirmed the resident has a care plan that indicated that the O2 tubing needs to be changed weekly and as needed. An interview on 10/12/22 at 4:00 PM, with the	F 656	replaced, dated, labeled and placed in a plastic bag on 10/12/22. Comprehensive Care plan was reviewed on 10/12/22 and no revisions were necessary. Resident #2: O2 signage was placed outside room and the O2 tubing was replaced, dated, labeled and placed in a plastic bag on 10/12/22. Water humidifier bottle was replaced and dated on 10/12/22. Comprehensive Care plan was reviewed on 10/12/22 and no revisions were necessary Resident #42: O2 signage was placed outside room and the O2 tubing was replaced, dated, labeled and placed in a plastic bag on 10/12/22. Comprehensive Care plan was reviewed on 10/12/22 and no revisions were necessary 2. All residents have the potential to be affected. 3. All staff members were educated by Quality Assurance Performance Improvement nurse on 10/13/22 on the importance following and implementing the comprehensive care plan. 4. To monitor compliance the Quality Assurance Performance Improvement Nurse began auditing the comprehensive care plan on all residents on 10/17/22 and began performing daily checks on all new physician□s orders to ensure that the proper care plans were implemented on 10/17/22. Quality Assurance Performance Improvement nurse implemented an audit log for daily checks times two weeks, then twice a week for two weeks, and then	

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F 656	Continued From page 5 Licensed Practical Nurse (LPN) Minimum Data Set (MDS) #2 and LPN-MDS #3 revealed they are responsible for putting care plans on the resident's record on admission and after their MDS assessments if needed. LPN-MDS #3 revealed that the purpose of the care plan was to provide a guide for care to meet the resident's needs. LPN-MDS #2 revealed that the care plans go on the resident's paper chart and in the computer, which all nurses have access to and she confirmed that Resident #184's care plan was not followed related to changing the O2 tubing weekly. Resident #2 An observation and interview on 10/11/22 at 11:00 AM, Resident #2 revealed that he uses his oxygen every night. There was no date noted on the oxygen tubing, nasal cannula, or water humidifier bottle and there was no oxygen signage on the door. Record review of Resident #2's Care Plan with start date of 1/27/22 and review date of 10/20/2022, revealed the goal, "I will be free of signs/symptoms of respiratory distress and maintain optimal functioning within limitations imposed by disease process through next review". The interventions in this Care Plan included the following: "Administer Oxygen at 2 Liters per minute via nasal biprong as needed as ordered. Change setup weekly and as needed." On 10/12/22 at 1:30 PM, an interview with Licensed Practical Nurse (LPN) #4, revealed that the night shift nurses take care of changing the	F 656	weekly on Mondays. The Quality Assurance Performance Improvement Nurse will report any findings for review by the Quality Assurance (QA) Committee on 11/11/22 and then every other month starting in December.	

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F 656	Continued From page 6	F 656		

oxygen tubing, cannulas, and water humidifier bottles. She revealed that the tubing, cannulas, and the humidifier bottles are supposed to be dated and that the nasal cannulas are to be placed in a plastic bag. She also revealed that oxygen signs are to be on the wall outside of the resident's room as well. LPN #4 confirmed that there was no date on the oxygen tubing, nasal cannula, or humidified water bottle and that there was no oxygen sign outside the resident's door.

Record review of Electronic Treatment Record for the months of September 2022 and October 2022, revealed that the oxygen tubing, nasal cannula, and humidified water bottle was not being changed and dated as ordered and care planned.
Resident #42

An observation and interview on 10/11/22 at 3:45 PM, Resident #42 stated she wears oxygen at night. There was no date on the oxygen tubing or bag for tubing storage and there was no oxygen signage on the entry door.

Record review of Resident #42's Care Plan with a start date of 1/27/22 and review date of 12/1/2022, revealed the goal, "I will be free of signs/symptoms of respiratory distress and maintain optimal functioning within limitations imposed by disease process through next review". The interventions in this Care Plan included the following: "Administer Oxygen at 4 Liters per minute via nasal biprong as ordered. Change setup weekly and as needed."

An interview on 10/12/22 at 1:20 PM, with LPN #5 revealed the oxygen tubing and storage bags are to be changed weekly on Sunday night. She

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F 656	Continued From page 7 revealed the O2 tubing is supposed to be labeled and dated and placed in a plastic bag and she confirmed that it was not changed for Resident #42. An interview on 10/12/22 at 4:10 PM, with the Director of Nursing (DON) revealed that the importance of the care plans was to ensure the care is provided as needed. She revealed that if the staff did not implement the care plan, then a resident with O2 could have respiratory infections from the oxygen not being changed weekly.	F 656		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review and facility policy review the facility failed to change, date, and label and store oxygen tubing and to post oxygen signage at the entrance to residents' rooms for three (3) of four (4) residents reviewed with oxygen. Residents #2, Resident #42 and Resident #184. Findings Include: Review of facility policy "Oxygen Therapy" with revision date of 02/09/18 revealed under "Policy	F 695	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.	11/14/22

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F 695	Continued From page 8 Explanation and Compliance Guidelines: ...4. NO SMOKING and/or OXYGEN IN USE signs will be posted at the entrance of the resident's room." Facility Policy also revealed under "Oxygen Concentrator" the following: ".3. Change humidified bottle and tubing weekly." Resident #184 An observation on 10/11/22 at 11:03 AM, revealed Resident #184 lying in bed with Oxygen (O2) via biprong nasal cannula at 5 (five) Liters Per Minute (LPM), O2 tubing was not dated or labeled and there was no O2 signage on the resident's room door. An observation on 10/11/22 at 2:00 PM, revealed Resident #184 lying in bed receiving O2 via nasal cannula at 5 LPM, O2 tubing was not dated or labeled and there was no O2 signage on the resident's room door. An observation on 10/12/22 at 9:00 AM, revealed Resident #184 was in her bed receiving O2 via nasal cannula at 5 LPM, the O2 tubing was not labeled or dated and there was no O2 signage on the resident's door. An observation and interview on 10/12/22 at 1:30 PM, with Licensed Practical Nurse (LPN) #1 confirmed that Resident #184's O2 tubing was not labeled and dated and there was no O2 signage on the door. She revealed there was a plastic bag with new O2 tubing with a date of 10/10/22 lying on top of the air conditioner in the resident's room and that the nurse was supposed to have changed the resident's tubing on Sunday 10/10/22 so it must have not been done. She revealed it is the policy of the facility that	F 695	1. Resident # 184: O2 signage was placed outside room and the O2 tubing was replaced, dated, labeled and placed in a plastic bag on 10/12/22. Resident #2: O2 signage was placed outside room and the O2 tubing was replaced, dated, labeled and placed in a plastic bag on 10/12/22. Water humidifier bottle was replaced and dated on 10/12/22. Resident #42: O2 signage was placed outside room and the O2 tubing was replaced, dated, labeled and placed in a plastic bag on 10/12/22. 2. All residents receiving as needed (PRN) or continuous oxygen therapy have the potential to be affected. 3. All staff members were educated by Quality Assurance Performance Improvement nurse on the importance of universal precautions and discarding contaminated items and replacing them with new, initialed, and dated oxygen supplies per policy on 10/13/2022. 4. To monitor compliance the Quality Assurance Performance Improvement Nurse began auditing on 10/17/22, 3 times a week for 2 weeks, then twice a week for 2 weeks, then weekly on Mondays for 4 weeks and then monthly to ensure that the O2 signage is in place and O2 tubing is new, initialed, dated and in a plastic bag per policy. The Quality Assurance Performance Improvement Nurse will report any findings for review by the Quality Assurance (QA) Committee on 11/11/22 and then every other month starting in December.	

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resident's O2 tubing has to be changed once per week, labeled, and dated and O2 signage needs to be put on the door. She revealed that if a resident's O2 tubing is not labeled and dated then no one knows when it was changed and that could lead to an infection for the resident.

An interview on 10/12/22 at 1:45 PM, with the Director of Nurses (DON) confirmed it is the policy of the facility that O2 tubing is changed, dated, and initialed on Sunday's each week. She revealed that if the O2 tubing is not dated then you can assume it was not changed. She revealed the reason the resident's O2 tubing would need to be changed is to prevent the buildup of bacteria.

Record review of Resident #184's Physician Orders revealed an order dated 9/23/22 for "O2 @ (at) 5 L/M per NC (nasal cannula) cont. (continuous) decrease O2 levels" and an order dated 9/23/22, "Change NEB(nebulizer)/O2 tubing q (every) Sunday, date tube and storage bag, clean NEB/O2 concentrator and filter @ (at) this time".

Record review of Resident #184's Face Sheet with an admission date of 9/23/22 and medical diagnoses that included Anxiety disorder and Contact with and (suspected) exposure to asbestos.

Record review of Resident #184's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/29/22 revealed a Brief Interview for Mental Status (BIMS) score of 05, which indicates the resident is severely cognitively impaired,

Resident #2

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An observation and interview on 10/11/22 at 11:00 AM, with Resident #2 revealed that he used his oxygen every night and that he put it on and removed it himself. The oxygen tubing and water humidifier bottle were not labeled and dated and there was no oxygen signage on the door.

An observation on 10/11/22 at 3:00 PM, revealed that there was no date on the oxygen tubing or on the humidified water bottle and there was no oxygen signage on the door outside of his room.

An interview with Licensed Practical Nursing (LPN) #1 on 10/13/22 at 8:30 AM, revealed that the oxygen tubing and humidified water bottles are supposed to be changed every seven days and that the nurses on night shift are responsible for this.

An interview with Licensed Practical Nurse (LPN) #4 on 10/12/22 at 1:30 PM, revealed that the night shift nurses take care of changing the oxygen tubing and water humidifier bottles. She revealed that the tubing and the humidifier bottles are supposed to be dated and that the nasal cannulas are to be placed in a plastic bag. She also revealed that oxygen signs are to be on the wall outside of the resident's room as well. LPN #4 confirmed that there was no date on the oxygen tubing, nasal cannula, or humidified water bottle and that there was no oxygen sign outside the resident's door. She also revealed that this could cause issues including being unable to determine the last time this tubing was changed which could lead to infection.

On 10/13/22 at 9:45 AM, an interview with Registered Nurse (RN) #2, revealed that the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON COUNTY NURSING HOME	17560 EAST MAIN STREET LOUISVILLE, MS 39339

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F 695	Continued From page 11	F 695		

oxygen tubing and humidified bottles are scheduled to be changed every Sunday and as needed. She also revealed that the nurses on night shift are responsible for getting them changed and dated.

Record review of Resident #2's Physician Orders revealed orders dated 6/19/20 for "Oxygen at 2 L/M Per NC (nasal cannula) PRN (as needed). SOB (shortness of breath)" and an order dated 6/22/20 to "Change NEB/O2 Tubing every Sunday, Date Tube and Storage Bag...".

A record review of the Face Sheet revealed that Resident #2 was admitted to the facility on 11/19/19, with diagnoses of Myocardial Infarction, Essential Hypertension, Heart Failure, unspecified, Atrial Fibrillation, unspecified, and Anemia.

Record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/12/2022, for Resident #2, revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #2 is cognitively intact.

Record review of the September and October 2022 Electronic Treatment Administration Records (E-TARs), revealed in the description column to Change Nebulizer/Oxygen Tubing Every Sunday, Date Tube and Storage Bag. There were no initials or check marks by staff present on the E-TAR that would indicate that this task was completed.

Resident #42

An observation and interview with Resident #42 on 10/11/22 at 3:45 PM, revealed the resident

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F 695	Continued From page 12	F 695		

sitting in her wheelchair with an oxygen concentrator at her side. There was no date on the tubing or bag for tubing storage and there was no oxygen signage on the resident's room door. Resident #42 revealed she wears oxygen every night.

An observation of Resident #42 on 10/12/22 at 9:26 AM and at 9:55 AM, revealed no date on the oxygen tubing, no storage bag, and no oxygen signage on the entry door.

An observation and interview on 10/12/22 at 1:20 PM, with LPN #5 revealed the oxygen tubing and storage are to be changed weekly on Sunday night. She revealed the oxygen tubing is also supposed to be labeled, dated, and placed in a plastic bag. LPN #5 confirmed there was no tubing storage bag in the room and that it should be. LPN #5 confirmed there was no oxygen signage on the door.

An interview on 10/12/22 at 2:00 PM, with the Infection Control Nurse revealed the oxygen tubing is to be changed out each Sunday night and kept in a bag when not in use. She revealed it must be labeled and dated each week and oxygen signage should be on the resident's door.

Record review of the Face Sheet for Resident #42 revealed that she was admitted to the facility on 10/30/19 with diagnoses that included Pneumonia, Simple chronic bronchitis, and Heart failure.

Record review of Physician Orders revealed the following orders dated 2/22/22 for O2 at 4 L/M Per NC Cont. SOB" and an order dated 10/31/19 "Change NEB/O2 Tubing every Sunday. Date

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F 695	Continued From page 13 Tube and Storage Bag..." Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/21/22, revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 12, indicating that the resident is moderately impaired.	F 695		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review the facility failed to ensure items in the kitchen refrigerator and refrigerated cooler were labeled and dated, expired food items were removed and that food bins were covered for one (1) of two (2) kitchen tours.	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	11/14/22

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F 812	Continued From page 14 Findings include: A review of the facilities' policy titled, "Food and Supply Storage." Policy #BOO3, revised 1/22, revealed, "All food, non-food items, and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption ...Dry Storage ...Foods that must be opened must be stored in approved containers that have tight-fitting lids...Hang scoop. The food level must be no closer than one inch below the handle of the scoop ...Refrigerated storage life of foods ...Use the manufacturer's expiration date for products before they are opened ...Label when the product is opened. The initial brief tour of the kitchen on 10/11/22 at 10:20 AM with the Dietary Manager (DM) revealed: 1. Kitchen refrigerator #1 an observation and interview revealed three (3) metal containers not labeled, and not dated. The Dietary Manager revealed that one container was pimento and cheese, the second was pears, and the third was lettuce and tomato. The Dietary Manager was unsure of how long the items had been in the refrigerator. A large gallon-sized bag of ham was not labeled or dated. A large gallon-sized bag of turkey was not labeled or dated. The Dietary Manager revealed it is everyone's responsibility to keep things labeled and expired items discarded. She confirmed this had not been done. 2. Refrigerated cooler observation and interview with the DM revealed three (3) five-pound white plastic containers with a manufactured label of	F 812	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, not dated, uncovered, expired, and/or contaminated on 10/11/22. 2. All residents have the potential to be affected by this deficient practice. 3. Dietary Team was educated on 10/18/22 by previous Dietary Manager and 11/2/22 by current Dietary Manager on receiving and stocking protocol, storage of dry goods, labeling, dating, and discarding of expired items. 4. Dietary Manager and/or supervisor will complete a monitoring log to ensure that protocols are being followed beginning 11/2/22 daily x 2 weeks, biweekly x 2 weeks, and then monthly. Dietary Manager will report findings to the Quality Assurance committee for review and recommendations of changes as needed on 11/11/22 and then every other month beginning in December.	

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F 812	Continued From page 15	F 812		

sweet potatoes. Each container was labeled with today's date 10/6/22, good through 10/9/22. Observed a plastic 7.6-ounce container of red liquid substance with no label or date and a brown, opened box, with no date or label. The Dietary Manager stated, "These are omelets, I think they opened these this morning." There were three white 12 lb. plastic containers labeled baked potato salad with an expiration date of 10/04/22 and a white 11 lb. plastic container labeled coleslaw with an expiration date of 9/29/22. An oblong metal container which the dietary manager revealed was spaghetti with an expiration date of 10/06/22. The Dietary Manager confirmed a white container was sliced strawberries with an expiration date of 9/27/22.

3. An observation of the storage shelf revealed four (4) 5 lb boxes of "Butter flake artificially flavored buttermilk biscuit mix" with a manufactured expiration date of July 12, 2022.

4. An observation and interview with the Dietary Manager revealed the sugar storage bin lid was off and the scoop was lying inside on the sugar. The flour bin revealed a square plastic container lying down in the flour. The third bin used for storing brownie mix was noted with the lid off. The Dietary Manager stated the lid is to always be kept on and the scoop is not to be stored inside the bins on the food. She revealed this could cause contamination and could make someone sick.

An interview on 10/11/22 at 11:05 AM, with the Dietary Manager revealed that all food was supposed to be labeled and dated when opened. She revealed it is everyone's responsibility to ensure that expired foods are discarded and she

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F 812	Continued From page 16 confirmed that the dietary department has failed to complete this task. An interview on 10/12/22 at 2:10 PM, with the Infection Control Nurse confirmed that any expired foods or uncovered foods could cause an infection or food poisoning in a resident if food is not discarded timely.	F 812		