STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155769	A. BUILDING 00 B. WING	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORRISON WOODS HEALTH CAMPUS	4100 N MORRISON RD MUNCIE, IN 47304

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00441163. This visit included a State Residential Licensure Survey Complaint IN00441163 - No deficiencies related to the allegations are cited. Survey dates: August 19, 20, 21, 22, and 23, 2024 Facility Number: 011596 Provider Number: 155769 AIM Number: 200901690 Census Bed Type: SNF/NF: 24 SNF: 31 Residential: 57 Total: 112 Census Payor Type: Medicare: 18 Medicaid: 20 Other: 17 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 29, 2024.	F 0000	The submission of this plan of correction does not indicate and admission by Morrison Woods Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Morrison Woods Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on interview and record review, the facility failed to ensure consistent documentation and communication related to a resident's choice for	F 0578	1. Resident 35's Code status was affected by the alleged deficient practice. The resident's code	09/14/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Crabill	Executive Director	09/24/2024

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	advance directives for 1 of 8 residents reviewed for advance directives (Resident 35). Finding include: Resident 35's record was reviewed on 8/21/24 at 2:26 p.m. Diagnoses included rhabdomyolosis, severe sepsis with septic shock, acute respiratory failure with hypoxia, type 2 diabetes mellitus with diabetic chronic kidney disease, and unspecified dysphagia. A physician order, dated 7/25/24, included a code status of Full Code (perform Cardiopulmonary Resuscitation or CPR). A current face sheet indicated he was a full code. A current electronic "Continuity of Care" document in the electronic health record indicated he had signed a Do Not Resuscitate (DNR) form. The resident's current code status care plan, dated 7/8/24, indicated that the resident/ resident representative had chosen his advance directives to include a code status of full code and those advance directives would be honored. Reviews to the advance directives were to be completed quarterly and as needed. A Nurse Practitioner's progress note, dated 7/8/24, indicated the resident's code status was reviewed with the resident. It indicated he was a full code and his code status was reviewed and updated. During an interview, on 8/21/24 at 2:51 p.m., the DON indicated when evaluating a code status for a resident in need of CPR, she looked for verification in the "Continuity of Care" document. This was the location where she educated nursing		status reviewed and updated with resident, Physician and family. No adverse reactions noted. 2. All residents have the potential to be affected. Social Services (SS) staff and the Interdisciplinary Team (IDT) have been educated on requirements for code status related to advanced directives and ensuring the facility is following resident wishes for their advance directives. A house wide audit has been completed as well to ensure the campus is following all guidelines and requirements related to advanced directives care planning. 3. As a measure of ongoing compliance, all new admissions will be reviewed weekly by SSD to ensure Code status is documented per order in residents EHR X's 4 weeks, On admission resident first meeting and quarterly in resident first meetings X's 3 months. 4. As a quality measure, the SS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	staff to look for a resident's code status. The DON verified Resident 35's "Continuity of Care" document, signed by the resident, indicated he did not want CPR and was a DNR. However, his face sheet and his physician's order both indicated a Full Code status. These discrepancies would make it difficult to assess the resident's wishes in the event of need for CPR and should all list the same status. During an interview, on 8/21/24 at 2:58 p.m., LPN 6 indicated he verified a resident's code status from the face sheet. Resident 35's face sheet listed him as a full code which meant if needed, staff would perform CPR on Resident 35. LPN 6 would initiate CPR on any resident until the code status was proven to be a DNR. A current facility policy, dated 12/31/23 and provided by the DON on 8/23/24 at 2:53 p.m., titled "Guidelines for Advance Directives," indicated the purpose of the care plan was "...to ensure facility staff obtains and follows resident's advance directives regarding end of life care....nursing staff will obtain an order from the attending physician for the desired code status....Designation of code status and obtainment of physician order will be part of the medical record...." 3.1-4(f)(8)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, interview, and record review, the facility failed to implement preventative measures following an injury of unknown origin for 1 of 1 residents reviewed for injuries of unknown origin (Resident 24).	F 0656	1. Resident 24 was affected by the alleged deficient practice. Resident 24's care plan was updated to reflect care plan approaches to reduce the risk of	09/14/2024

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	Findings include: Resident 24's clinical record was reviewed on 8/20/24 at 3:33 p.m. Current diagnoses included dementia and Parkinson's Disease. The resident had an order for one antiplatelet medication, aspirin 81 mg taken one time daily. A 5/8/24, quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired, had mobility impairment in both the upper and lower extremities, and required staff assistance for bed mobility. A 7/29/24, 12:18 p.m., progress note indicated, while providing care, a CNA had observed a 9.5 centimeter (cm) long by 12 cm wide bruise on the inside of the resident's right knee. The bruise was purple/black in color. The bruise was tender to touch. The charge nurse was informed of the bruise. A 7/29/24, "Wound Management Detail Report" indicated the resident had a 9.5 cm by 12 cm black and purple bruise. This document was completed by LPN 8. A 7/30/24, "Statement of Witness Form" indicated LPN 8 had stated she was informed of Resident 24's knee bruise the day before when she had been the nurse on duty for the resident's hall. The form indicated the LPN had identified the bruises most likely likely cause as the resident's legs were contracted (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement), and his knees were very knobby. Staff placed pillows between his knees when they laid him down, however due to		knee bruising due to knee contractures, and noncompliance with interventions. Resident profile updated. No adverse effects noted. 2. All residents have the potential to be affected. All resident care plans and profiles reviewed to ensure that Interventions to reduce risk of bruising is accurately reflected in both. Director of Health Services (DHS) and MDS Coordinator educated to ensure that care plan and resident profiles accurately reflect resident Interventions. 3. As a measure of ongoing compliance, the MDS or designee will audit Care plan interventions and Resident profiles to ensure appropriate interventions are accurately reflected. Audit to consist of 5 residents weekly x4 week, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met.	

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	his disease progression, he got restless in bed and kicked/pulled the pillow off. He also used a mechanical lift for transfers and the way the sling positioned with his legs, the sling could have contributed to the bruising. The resident had a current care plan problem/need regarding the potential for bleeding and bruising related to medication. This problem originated 4/1/23. No new approaches were added to this care plan problem following the 7/29/24 bruise. The record lacked care plan interventions or preventative approaches to reduce the risk for knee bruising due to knee contractures, removing the pillow from between his knees, and/or the bruising risk associated with using a full body mechanical lift. During an interview on 8/23/24 at 11:32 a.m., QMA 7 indicated the resident had contractures. She was aware the resident had experienced a recent bruise to his knee. The staff placed pillows between the resident's knees. The resident frequently removed the pillow. She did not know of any updates or changes that had made since the resident had developed a bruise on his knee. Staff just continued to place the pillow between his knees and he sometimes removed or displaced it. She had never received any new or specific information about transferring the resident with a full body lift in a manner to reduce bruising. During an interview on 8/23/24 at 11:23 a.m., the Administrator and Assistant Director of Nursing both indicated related to Resident 24's injury, the root cause analysis had identified the most likely cause to be contractures to the knees, restless leg, removing the pillow between his knees, and the use of an anticoagulant medication as the			

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	medically likely cause of the bruising. During an interview on 8/23/24 at 11:48 a.m., the Administrator indicated the facility had not developed and implemented new approaches to prevent recurrence of bruising after completing the root cause analysis identified contractors, rubbing knees together, and knees touching while transferring in a mechanical full body lift were the most likely causes of the bruising on the resident's legs. 3.1-35(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview, and record review, the facility failed to ensure physician's orders were followed regarding oxygen administration for 1 of 1 resident reviewed for respiratory care. (Resident 261) Findings include: During an observation, on 8/19/24 at 1:28 p.m., Resident 261 was lying in bed, eyes closed. He was wearing a nasal cannula. The oxygen concentrator was on at 3 liters per minute. During an observation, on 8/20/24 at 9:55 a.m., he was lying in bed. The head of the bed was elevated 90 degrees. He was wearing a nasal cannula. The oxygen concentrator was on at 3.5 liters per minute. During an observation, on 8/20/24 at 11:30 a.m., the resident was seated upright in bed. He was not wearing a nasal cannula. An oxygen mask was lying across his lap. During an interview, at the	F 0695	1 Resident 261 was affected by alleged insufficient practice. Resident 261 continues to reside on the short-term rehab unit of health campus. Following alleged insufficient practice, resident 261's orders were updated and no adverse effects noted. 2 All residents with orders for oxygen have the potential to be affected by the alleged insufficient practice. All resident's oxygen orders reviewed and updated as indicated per physician orders. All clinical staff educated on the monitoring oxygen use, maintaining oxygen equipment, and following physician orders for oxygen therapy. 3 As a measure of ongoing compliance, the DHS or designee to complete house wide audit on	09/14/2024

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	time of the observation, he indicated he had a heart attack earlier in the week and the doctor had him using oxygen for a few days. During an observation, on 8/21/24 at 10:19 a.m., Resident 261 was lying in bed. He was not wearing a nasal cannula. During an interview, at the time of the observation, he indicated he was a little short of breath. During an observation, on 8/21/24 at 3:35 p.m., the resident was seated upright in his bed visiting with family. He was not wearing a nasal cannula. During an interview, at the time of the observation, he indicated he did not feel well. During an observation, on 8/22/24 at 8:32 a.m., Resident 261 was lying in bed. He was not wearing a nasal cannula. The oxygen concentrator was off and against the wall by the head of bed. Resident 261's clinical record was reviewed on 8/21/24 at 4:05 p.m. Diagnosis included metabolic encephalopathy, unspecified atrial fibrillation, essential hypertension, and unspecified sepsis. The resident's admission dated was 8/16/24. A current physician's order, dated 8/19/24, indicated the following: send to emergency room if oxygen saturation is below 85 % on 4 liters per minute of oxygen or if mental status changes. A respiratory care plan, initiated 8/19/24, indicated to administer oxygen per physician's order and as needed and to elevate head of bed or place in upright position as needed. A vital sign record, on 8/19/24 at 11:31 p.m., indicated the resident's oxygen saturation was at 95%, and the resident was on 2 liters of oxygen		all residents for accurate oxygen orders. DHS or designee will also audit 5 residents with oxygen for proper equipment 2 times per day for 2 weeks, then daily for 2 weeks, then 3 times a week for 3 months, then 2 times a week for 2 months, or until 100% compliance is maintained. 4 As a quality measure, Executive Director or designee will review any findings and corrective actions at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	per minute. A vital sign record, on 8/20/24 at 11:36 p.m., indicated the resident's oxygen saturation was at 95%, and the resident was on 2 liters of oxygen per minute. A vital sign record, on 8/21/24 at 11:18 p.m., indicated the resident's oxygen saturation was at 96%, and the resident was on 2 liters of oxygen per minute. A physician's progress note, dated 8/21/24 at 9:56 p.m., indicated the resident had an acute hypoxia episode during breakfast on Monday, 8/19/24 and was started on oxygen at 4 liters per minute. The plan was to wean the resident off the oxygen as tolerated but to send to the emergency room if oxygen saturation is below 85 % on 4 liters per minute of oxygen or if oxygen saturation is below 90% on room air. During an interview, on 8/22/24 at 8:45 a.m., RN 5 indicated Resident 261 did not wear oxygen and she was aware of the order to send him to the emergency room if his oxygen saturation was below 85% on 4 liters per minute of oxygen. During an interview, on 8/22/24 at 8:47 a.m., the ADON indicated she would need to call the physician and get clarification for the order as the resident was not wearing oxygen at this time. During an interview, on 8/22/24 at 3:00 p.m., Corporate Nurse Consultant indicated the order for Resident 261 to wear oxygen should have been a one time order related to his cardiac event earlier in the week and needed discontinued. She was not able to locate a titration order for the resident.			

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	A current facility policy, reviewed 12/31/23 and titled, " Guidelines for Medication Orders," provided by the DON on 8/23/24 at 11:15 a.m., indicated the following: "...2. A current list of orders will be maintained in the electronic medical record or each resident.... 6. Oxygen orders a. When recording oxygen orders specify: 1. The rate of flow, route, and rationale (i.e: 02, 2L/min per nasal cannula PRN for SOB.)..." 3.1-47(a)(4)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to ensure narcotic reconciliation per facility policy for 2 of 3 medication carts reviewed for medication storage. (100 Hall and 300 Hall) Finding include: 1. During a medication storage observation of the 100 hall cart, accompanied by LPN 9 on 8/23/24 at 9:49 a.m., the "Narcotic Count Sheet" record was reviewed and the following dates lacked shift to shift reconciliation of controlled medications: In July 2024- 7/1/24- on day and night shifts, 7/6/24- on day shift, 7/7/24- on evening shift, 7/10/24- on day and evening shifts, 7/16/24- on night shift 7/17/24- on evening shift, 7/19/24- on evening shift, 7/20/24- on all three shifts, 7/25/24- on all three shifts, 7/26/24- on all three shifts,	F 0755	1. Narcotic reconciliation was incomplete on 2 of 3 medication carts. Facility wide audit was conducted to determine controlled drugs had been counted and coincided with controlled drug record. 2. All residents have the potential to be affected, however none were identified. Facility audits were conducted to identify correct documentation of administration related to controlled medication and a physical inventory of controlled medications was conducted. Any identified issues were immediately addressed. 3. As a measure of ongoing compliance, the DHS or designee will audit the Shift-to-shift 3x weekly to determine compliance with signage requirements for 3 months, 2 times a week for 2 months and then monthly until 100% compliance is achieved.	09/14/2024

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	7/27/24- on all three shifts, 7/28/24- on all three shifts, 7/29/24- on all three shifts, 7/30/24- on all three shifts, 7/31/24- on all three shifts. In August 2024- 8/2/24- on evening shift, 8/3/24- on evening shift, 8/4/24- on evening shift, 8/5/24- on evening shift, 8/7/24- on evening shift, 8/10/24- on all three shifts. 2. During a medication storage observation of the 300 hall cart, accompanied by LPN 10 on 8/23/24 at 11:04 a.m. the "Narcotic Count Sheet" record was reviewed and the following dates lacked shift to shift reconciliation of controlled medications: In July 2024- 7/4/24- on evening shift, 7/6/24- on day shift, 7/7/14- on night shift, 7/8/24- on evening shift, 7/12/24- on evening shift, 7/13/24- on night shift, 7/14/24- on day shift, 7/15/24- on day and evening shifts, 7/16/24- on day shift, 7/22/24- on evening shift, 7/23/24- on day and evening shifts, 7/29/24- on evening shift, 7/30/24- on evening shift, 7/31/24- on evening shift. In August 2024-		4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	8/1/24- on all three shifts, 8/3/24- on night and evening shifts, 8/4/24- on evening shifts, 8/5/24- on evening shifts, 8/13/24- on evening shifts, 8/14/24- on night and evening shifts, 8/15/24- on day and evening shifts, 8/16/24- on night and day shifts, 8/17/24- on evening shift, 8/18/24- on evening shift, 8/19/24- on evening shift. During an interview, at the time of the observation, LPN 10 indicated the narcotic sign in/sign out sheet was to be completed after the narcotic medication count and with the exchange of keys. During an interview, on 8/23/24 at 2:08 p.m., the DON indicated the expectation was for the narcotic count sheet to be completed at every shift change and at any time the medication cart keys change hands. The DON indicated she was not able to locate any additional count sheets. A current facility policy, reviewed on 12/31/23, titled, "Guidelines for Narcotic Count", provided by the DON on 8/23/24 at 11:15 a.m., indicated the following: "... 2. The narcotic book shall contain a sheet providing space for the off going and oncoming nursing staff to record their signature indicating the narcotics have been reviewed....5. Both staff members shall sign that the narcotic count is accurately reconciled...." 3.1-25(b)(3)			
R 0000 Bldg. 00				

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	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00441163. Survey dates: August 19, 20, 21, 22, and 23, 2024 Facility number: 011596 Residential Census: 57 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed August 29, 2024.	R 0000	The submission of this plan of correction does not indicate and admission by Morrison Woods Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Morrison Woods Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense Based on record review and interview, the facility failed to follow a physician ordered parameter for medication administration for 1 of 5 residents reviewed for nursing services. (Residents 49) Findings include: The clinical record review for Resident 49 was completed on 8/20/24 at 1:27 p.m. Diagnoses included a history of heart attack, atrial fibrillation, hypertension and cardiomegaly.	R 0241	1. Resident 49 was affected. Resident 49's EMAR was reviewed on 8/21/24 at which time Physician was contacted and notified that Metoprolol was given outside hold parameters on 07/20/2024, 07/23/2024, 07/29/2024, 08/09/2024, 08/14/2024, 08/15/2024, 08/18/2024. No new physician's orders were received.	09/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155769	A. BUILDING 00 B. WING	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORRISON WOODS HEALTH CAMPUS	4100 N MORRISON RD MUNCIE, IN 47304

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	An admission physician order, dated 7/4/24, indicated to administer metoprolol tartrate (to treat high blood pressure) 50 mg (milligram), one tablet two times daily. Special instructions included to hold for a systolic blood pressure (SBP) less than 110 or a heart rate (HR) less than 60 beats per minute. A review of Resident 49's electronic medication administration record (eMAR) for the month of July, indicated the following: The medication was administered for the morning dose on 7/6/24 with a SBP of 109; on 7/20/24 with a SBP of 91; on 7/23/24 with a SBP of 109; and 7/29/24 with a SBP of 109. The medication was administered for the morning dose on 8/9/24 with a SBP of 95; on 8/14/24 with a SBP of 108; 8/15/24 with a SBP of 104; and on 8/18/24 with a SBP of 95. The medication was administered for the evening dose on 8/15/24 with a SBP of 108; on 8/15/24 with a HR of 45, on 8/16/24 with a HR of 51 and a SBP of 107; and on 8/18/24 with a SBP of 95. During an interview on 8/21/24 at 11:18 a.m., the DON indicated the medication should have been held per physician's order when the HR and/or SBP were out of parameter. A current facility policy, revised 8/11/16, titled, "AL-Physician's Orders Guidelines," provided by the Administrator on 8/21/24 at 11:18 a.m., included the following: "Purpose. To provide guidelines for obtaining and follow through of physician orders."		2. All residents having hold parameters related to their blood pressure medications have the potential to be affected by alleged deficient practice. A hold parameter audit was completed on all residents who have hold parameters for the last 30 days to ensure they were followed. Audits were completed on 8/22/24 by DHS/designee. Education provided to all facility nurses and QMA's on following physicians orders related to hold parameters for blood pressure medication on 6/22/24. 3. As a measure of ongoing compliance, the Director of Health Services (DHS), or designee, will complete audits of all resident withhold parameters related to blood pressure medication to ensure they were followed accurately 3x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months or until 100% compliance is achieved. 4. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance	

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation and interview, the facility failed to store, prepare, and distribute foods under safe sanitary conditions regarding dating and labeling foods and cleaning equipment. This deficient practice had the potential to impact 25 of 25 facility residential residents. Findings include: During a kitchen tour on 8/19/24 at 10:01 a.m., the following concerns were observed: a. The upright refrigerator had an opened single serve can of soup covered with an unsecured piece of cellophane wrap and lacked an open date. b. On the bottom shelf of the upright freezer had a blue ceramic bowl with a scope of cream-colored ice cream. The bowl was uncovered and lacked a date. c. The microwave oven was observed with red splattered debris on all walls and upper and lower surfaces of the microwave. d. In the dry storage, a container with white powdered substance, unlabeled and undated. e. The exhaust hood over the stove had a thick layer of black sticky residue. On the floor below a shelving unit was a shoe sized spill of brown sticky appearing substance. f. A utensil drawer was observed with a amber, sticky substance covering the bottom of the drawer. Some utensils observed with a sticky residue covering part of the surface.	R 0273	1. All items found to be without dates and or labels were discarded, and kitchen disinfected per policy. 2. All residents had the potential to be affected by this practice. No residents had ill effects from this practice. 3. All dietary staff will be re-in-serviced by the Director of Food Services or designee on the guidelines titled "Food Labeling Guidelines" and kitchen cleanliness. The Director of Food Service or designee will randomly audit all dry, fridge and frozen food storage 4 times a week for 5 weeks to ensure items are dated and labeled. The Director of Food Service or designee will audit kitchen floors, walls, trash cans and lids 4 times a week for 5 weeks. 4. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	09/14/2024

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	During an interview at the time of the observation, Cook 1 indicated the food in the refrigerator and freezer should be dated and all foods covered. The evening staff probably heated up some tomato soup and had not covered the bowl with caused it to splatter on the internal surfaces. This should have been cleaned immediately after use. The brown sticky substance on the dry storage floor was maple syrup that had spilled from an uncovered syrup container. She had seen the spill upon entering for work but had not had time to clean it up. The white powder in the covered container on the dry storage shelf was white flour and should be labeled and dated. A current facility policy, approved January 2024, titled, "Storage Procedures," provided by the Corporate Nurse Consultant on 8/20/24 at 9:13 a.m., included the following: "Procedures ...Dry Storage of Food ...2. The storeroom is well-lighted, well-ventilated, dry, clean, and kept a room temperatures of below ...6. Open packages are labeled, dated, and stored in closed containers ....Refrigerated Storage ...5. Food is covered, dated and stored loosely to permit air circulation ....Frozen Storage ...3. All foods in the freezer are wrapped in moisture proof wrapping or placed in suitable containers, to prevent freezer burn. Items are labeled and dated." A current facility policy, revised 1/2023, titled, "Manual Sanitation," provided by the Corporate Nurse Consultant on 8/20/24 at 9:13 a.m., included the following: "Clean and Sanitize food-contact surfaces ...Anytime contamination has occurred."			