STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155248	A. BUILDING 00 B. WING	01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BRENTWOOD CARE CENTER	30 E CHANDLER AVE EVANSVILLE, IN 47713

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 16, 17, 18, 22, and 23, 2024 Facility number: 000152 Provider number: 155248 AIM number: 100267510 Census Bed Type: SNF/NF: 86 Total: 86 Census Payor Type: Medicare: 2 Medicaid: 72 Other: 12 Total: 86 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on Janaury 29, 2024.	F 0000		
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure the MDS (Minimum Data Set) assessment was completed accurately for 1 of 1 resident reviewed for dialysis. (Resident 50) Finding includes:	F 0641	**F641 Accuracy of Assessments Date 1/24/2024** **F641---What corrective action was accomplished for the resident found to have been affected by the deficient**	01/24/2024

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

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	On 1/17/24 at 2:18 P.M., Resident 50's clinical record was reviewed. Diagnoses included, but were not limited to, muscle wasting and atrophy, legal blindness, type 2 diabetes mellitus, end stage renal disease, and long term (current) use of insulin. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 12/12/23, indicated Resident 50 had moderate cognitive impairment, received an insulin injection for 7 out of 7 days during the look back period (12/6/23 - 12/12/23), did not receive any hypoglycemic medication, had a weight loss of 5% or more in the past month or 10% or more in the past 6 months, and had a weight gain of 5% or more in the last month or 10% or more in the last 6 months. Current physician orders included, but were not limited to: Insulin Lispro (a fast-acting hypoglycemic medication) Subcutaneous Solution Pen-injector 100 unit/ml (units per milliliters) - Inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units if blood sugar > 400 mg/dl (milligrams per deciliter) give 10 units and notify MD/NP (medical doctor / nurse practitioner), subcutaneously before meals related to type 2 diabetes mellitus, dated 9/8/23 Monthly weights and vitals - every day shift every 1 month starting on the 1st for 5 day(s), dated 10/1/2023 Discontinued physician orders included, but were not limited to: Insulin Glargine Solostar (a long-acting hypoglycemic medication) 100 unit/ml - inject 30		**practice.** Resident 50's assessment was corrected on 1/22/2024 to accurately reflect his weight loss and insulin coding as hypoglycemic. **---How will other residents who may have the potential to be affected be identified?** ·All dialysis residents with weight loss and hypoglycemia have the potential to be affected. **---What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** ·Regional MDS coordinator educated MDS coordinators on accuracy of weight and insulin assessments. **---How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?** ·Lead MDS coordinator / designee will audit weight loss and insulin assessments to ensure accuracy. 3Xs /week x 4 weeks, 1x/ week x 4weeks and 1x per month x 4 months. Director of clinical education/designee will report findings to QAPI x 6 months. **---Systematic changes will be completed by 1/24/2024** **Requesting paper compliance for F641**	

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	units subcutaneously at bedtime related to type 2 diabetes mellitus, discontinued 12/16/23 The Medication Administration Record (MAR) for December 2023 indicated Resident 50 received Insulin Lispro on 12/6, 12/7, 12/8, 12/9, 12/11, and 12/12 and Insulin Glargine on 12/6, 12/7, 12/8, 12/9, 12/10, 12/11, and 12/12. Resident 50's weights for the past 6 months included, but were not limited to: 12/6/2023 - 171 lbs (pounds) 11/1/2023 - 177 lbs 6/12/2023 - 193 lbs The clinical record lacked documentation of a weight gain. A nutritional assessment, dated 12/1/23, indicated the resident had a weight loss greater than 7.5% in 90 days and was monitored for significant weight loss by the Registered Dietician. On 1/22/24 at 8:26 A.M., MDS Coordinator 5 indicated insulin should be coded as a hypoglycemic on the 12/12/23 MDS assessment. At that time, she indicated the resident did not have any weight gain and only weight loss should be indicated on the 12/12/23 MDS assessment. On 1/23/24 at 9:16 A.M., the Administrator provided a current "Conducting an Accurate Resident Assessment" policy, dated 2023, that indicated "appropriate, qualified health professional(s) correctly document the resident's medical, functional, and psychosocial problems...using the appropriate Resident Assessment Instrument".			

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F 0729 SS=D Bldg. 00	483.35(d)(4)-(6) Nurse Aide Registry Verification, Retraining §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. Based on record review and interview, the facility failed to ensure CNAs (Certified Nursing Aide)	F 0729	**F729 Nurse Aide Registry Verification, Retraining**	01/24/2024

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	had a current and valid certificate to work in the facility for 1 CNA whose certificate had expired at the time of hire. (CNA 7) Finding includes: On 1/22/24 at 12:10 P.M., the employee records were reviewed. CNA 7 started employment at the facility on 12/26/23. The facility's employee license binder lacked a record of CNA certification for CNA 7. On 1/22/24 at 12:54 P.M., an Indiana Professional Licensing Agency search indicated CNA 7's CNA certificate expired 6/11/23. On 1/22/24 at 2:38 P.M., the Administrator provided a valid CNA certificate for CNA 7 with a renewal date of 1/22/24. On 1/23/24 at 11:12 A.M., the Administrator indicated she was aware CNA 7 had been hired with an expired license, but assumed it had been taken care of and was unaware it hadn't been renewed until it was brought to her attention on 1/22/24. On 1/23/24 at 9:16 A.M., the Administrator provided a current "License Verification" policy, dated 2023, that indicated "any licensed/certified employee is responsible for submitting verification of licensure/certification renewal to Human Resources prior to expiration". 3.1-14(e)		**Date 1/24/2024 F729---What corrective action was accomplished for the residents found to have been affected by the deficient practice.·** C NA's 7 certificate was renewed without lapse in certification on 1/22/2024. A licensure audit was immediately completed, with no other deficiencies found. **--** **-How will other residents who may have the potential to be affected be identified?** All residents who have the potential to be affected. **---What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** Human Resource will ensure employees have a valid C NA certificate. If an employee or new a hire candidate doesn't have a valid C NA certificate, he or she will not be eligible to work until their certificate is valid. A licensure expiration date spreadsheet was created and will be audited indefinitely. **---How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?** Human Resources Consultant/ designee will audit C NA certifications for validity 3Xs /week x 4 weeks, 1x/ week x 4 weeks and 1x per month x 4 months. Director of clinical	

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			education/designee will report findings to QAPI x 6 months. **---Systematic changes will be completed by 1/24/2024Requesting paper compliance for F729**	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not			

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	to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, record review, and interview, the facility failed to post the actual hours worked of licensed and unlicensed nursing staff directly responsible for resident care per shift daily for 7 of 7 days reviewed. Finding includes: During an observation, on 1/16/24 at 2:35 P.M., the staff numbers posted on the hallway at the main entrance of the facility reflected the census was 86 residents. The form did not provide actual hours worked by nursing staff. On 1/22/24 at 1:00 P.M., staff posting sheets were provided by the Administrator for the following dates: 1/16/24 1/17/24 1/18/14 1/19/24 1/20/24 1/21/24 1/22/24 Each staff posting sheet included the date, census, and total hours each discipline was in the building. Disciplines included RN (Registered Nurse), LPN (Licensed Practical Nurse), and CNA (Certified Nursing Aide). The actual hours worked by each shift were not included on the sheets. During an interview on 1/22/24 at 2:35 P.M., the	F 0732	**F732 Posted Nurse Staffing Information** **Date 1/24/2024 F732---What corrective action was accomplished for the residents found to have been affected by the deficient practice.** Immediately nursing staff scheduler added actual hours worked for licensed and unlicensed staff to the posted nurse staffing information. **---How will other residents who may have the potential to be affected be identified?** All residents who have the potential to be affected. **---What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** Administrator/ designee will ensure nursing staff scheduler posted nurse staffing information reflects actual hours worked for licensed and unlicensed nursing staff. **---How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?**	01/24/2024

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	Administrator indicated she didn't realize the hours weren't listed on the posted nursing staffing sheet. On 1/12/24 at 9:11 A.M., a Nurse Staffing Posting Information policy, dated 2023, was provided by the Administrator and indicated "The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered Nurses ...Licensed Practical Nurses ...Certified Nursing Aides".		Administrator/ designee will audit actual hours worked for posted nurse staffing information 3Xs /week x 4 weeks, 1x/ week x 4 weeks and 1x per month x 4 months. Director of clinical education/designee will report findings to QAPI x 6 months. **---Systematic changes will be completed by 1/24/2024Requesting paper compliance for F732**	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review, the facility	F 0757	**F757 Drug Regimen is Free**	01/24/2024

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	failed to ensure proper interventions were in place for monitoring symptoms, side effects, and behaviors of medications used for dementia for 1 of 3 residents reviewed for dementia care. (Resident 80) Finding includes: On 1/17/24 at 2:38 P.M., Resident 80's clinical record was reviewed. Diagnosis included, but was not limited to, Alzheimer's Disease with late onset and unspecified dementia. The current quarterly MDS (Minimum Data Set) assessment, dated 12/24/23, indicated the resident was cognitively intact and needed limited assistance with mobility, transfers, and eating. The MDS assessment also indicated the resident received an antipsychotic medication during the 7 day lookback period. Current physician orders included but were not limited to: Rexulti (an antipsychotic medication) - 1 mg (milligram) in the evening for dementia with behaviors, dated 11/6/23. The clinical record lacked an order, care plan, and documentation for monitoring antipsychotic side effects and behaviors. The current MAR (Medication Administration Record) lacked monitoring for side effects and behaviors for antipsychotic drugs. During an interview on 1/22/24 at 10:02 A.M., LPN (Licensed Practical Nurse) 12 indicated residents who received antipsychotics were to have an order for monitoring side effects and behaviors.		**from Unnecessary Drugs** **Date 1/24/2024** **F757---What corrective action was accomplished for the residents found to have been affected by the deficient practice.** On 1/24/2024 Dementia Care Unit Manager added symptom monitoring and side effects for behavior medications used for dementia care residents. **---How will other residents who may have the potential to be affected be identified?** ·All residents who have dementia and take behavior medications have the potential to be affected. **---What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** ·Director of Nursing educated nurses to ensure proper symptom monitoring and side effects for behavior medications are in place for dementia residents. · **---How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?** ·Director of Nursing/designee will audit symptom monitoring and side effects for behavioral medications used for dementia residents 3Xs /week x 4 weeks, 1x/ week x 4weeks and 1x per	

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	On 1/22/24 at 2:45 P.M., the Administrator provided a current "Behavioral Health Services" policy that indicated "... the facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status...the staff will... accurately document the changes... in the resident's record...". 3.1-48(a)(3)		month x 4 months. Director of clinical education/designee will report findings to QAPI x 6 months. **---Systematic changes will be completed by 1/24/2024** **Requesting paper compliance for F757**	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			

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	Based on observation, record review, and interview, the facility failed to provide proper storage of medications and personal property in 3 of 5 medication carts reviewed. Loose pills, unlabeled medications, and resident's personal property were found in medication drawers and the narcotic box of medication carts. (200 Hall, 500 Hall, Alzheimer Unit) Findings include: 1. On 1/18/24 at 8:38 A.M., the upper drawer of the tan cart on the 200 hall was observed to have the following unlabeled medications: 1 box of antihistamine lacked a name and label. 1 box of antihistamine with [patient name] lacked a label. 1 bottle of acetaminophen with [patient name] lacked a label. 2. On 1/18/24 at 8:59 A.M., the medication cart on the 500 Hall was observed to have the following medications loose in 2 drawers of the cart: 1 bottle of Flonase with [patient name] 1 bottle of Calcitonin with [patient name] 1 large pill with KCL M20 1/2 large oblong pill 1/2 white circle pill 2 ½ medium white circle pill with no numbers 1 oblong yellow pill with no numbers 1 small round peach pill with number S 1P 1 small round yellow pill with R 158 1/2 small round blue pill with no numbers 2 ½ small round white pills with no numbers 1 small oblong pink pill 1 white capsule 3. On 1/18/24 at 9:27 A.M., the medication cart of the Alzheimer Unit was observed to have the following items in the upper drawer and narcotic	F 0761	**F761 Label/ Storage Drugs and Biologicals** **Date 1/24/2024** **F761---What corrective action was accomplished for the residents found to have been affected by the deficient practice.** Immediately unit managers ensured proper storage of medications and personal property by labeling/ discarding all unlabeled medications. Unit managers placed resident's personal property in residents locked nightstands. Loose pills were discarded. **---How will other residents who may have the potential to be affected be identified?** ·All residents have the potential to be affected. **---What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** ·Director of Nursing educated nurses and QMA's to ensure proper storage of all medications. All medications must be labeled and if any loose pills fall out of their package, to immediately pick up the loose pills from the drawer. Resident's personal property may not be stored in the narcotic box. · **---How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA**	01/24/2024

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	box: 1 hearing aid, not labeled 1 gold watch, not labeled 4 gold rings, not labeled 1 bag containing important papers, not labeled During an interview on 1/18/24 at 8:44 A.M., RN (Registered Nurse) 2 indicated the medications should be properly labeled with the resident's name, dose, frequency, route, and physician name. During an interview on 1/18/24 at 9:00 A.M., QMA (Qualified Medication Aide) indicated there should be no loose pills. At that time, she indicated a cart auditor cleaned the carts frequently and the loose pills should have been removed then. She also indicated she cleaned the cart as she was able. During an interview on 1/18/24 at 9:27 A.M., RN 6 indicated the evening nurse could have found the hearing aid when a resident passed over the weekend and placed it in the upper drawer for safe keeping. RN 6 also noted that the medication cart was the most accessible lock box. The unit manager had a lock box in her office, but she was not at the facility on the weekends in case the resident or family needed to access it. During an interview on 1/23/24 at 8:56 A.M., LPN (Licensed Practical Nurse) 4 indicated there should be nothing but narcotics in the locked box. The residents' bedside tables were equipped with locks so they could place items in there for safe keeping. On 1/23/23 at 9:16 A.M., the Administrator provided a current "Labeling of Medications and Biologicals" policy that indicated "all		**program will be put into place?** ·Director of Nursing/designee will audit medication carts for proper medication storage/ labeling to include checking for any loose pills and resident property 3Xs /week x 4 weeks, 1x/ week x 4weeks and 1x per month x 4 months. Director of clinical education/designee will report findings to QAPI x 6 months. **---Systematic changes will be completed by 1/24/2024** **Requesting paper compliance for F761**	

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	155248	A. BUILDING 00 B. WING	01/23/2024

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	medications...used in the facility will be labeled in accordance with current state and federal considerations...must include resident name ... Labels for over the counter medications must be labeled with the following: the original manufacturer's or pharmacy-applied label indicating the medication name; the strength, quantity, lot and control number; the expiration date when applicable; appropriate accessory and precautionary statements; and directions for use". 3.1-25(j)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure food was served at a palatable temperature for 1 of 1 tray tested for food temperature. Finding includes: On 1/16/24 at 11:30 A.M., Resident 79 indicated the food was not hot enough. On 1/16/24 at 11:38 A.M., Resident 1 indicated the food was cold. She lived in the last room served on her hall.	F 0804	**F804 Nutritive Value/ Appear, Palatable/ Prefer Temp** **Date 1/24/2024** **F804---What corrective action was accomplished for the residents found to have been affected by the deficient practice.** Immediately Dietary Manager ensured food was served at a palatable temperature. **---How will other residents who may have the potential to**	01/24/2024

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	On 1/18/24 at 12:03 P.M., 2 Certified Nursing Aides (CNA) were observed delivering meal trays on the 500 hallway. All but 4 trays were in a large, insulated cart. The other 4 trays were on a small pushcart, not insulated. At that time, CNA 11 indicated the larger insulated cart was too small to hold all the trays for the hall. On 1/18/24 at 12:15 P.M., a test tray was obtained from the 500 hallway. Food temperatures for that meal were as follows: Goulash - 120 degrees F (Fahrenheit) Cauliflower - 105 degrees F Milk - 43 degrees F A food serving temperature policy was requested and not provided. 3.1-21(a)(2)		**be affected be identified?** ·All residents have the potential to be affected. **---What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** ·Dietary Manager educated dietary staff that food must be served at palatable temperature. To further ensure palatable temperature, new insulated food tray carts were ordered. Insulated food tray carts were received and put into use on 2/5/2024. · **---How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?** ·Dietary Manager/ designee will audit food cart trays to ensure temperatures are palatable 3Xs /week x 4 weeks, 1x/ week x 4weeks and 1x per month x 4 months. Director of clinical education/designee will report findings to QAPI x 6 months. **---Systematic changes will be completed by 1/24/2024** **Requesting paper compliance for F804**	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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	§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. Based on observation, interview, and record review, the facility failed to store foods in accordance with professional standards and maintain the dishwasher with the proper equipment for 1 of 1 kitchens reviewed. Findings include: 1. On 1/16/24 at 10:20 A.M., a tour of the kitchen began. Two staff were present, a cook and the dishwasher. On 1/16/24 at 10:35 A.M., food packages were observed in the walk-in refrigerator labeled with a date in black marker. None of the marked dates differentiated between open date and use-by date. Outdated/expired food included: 1 angel food cake, cut, opened, in plastic wrap dated 1/5/24 1 angel food cake, in plastic wrap, not cut, no date	F 0812	**F812 Food Procurement Store/ Prepare/ Serve- Sanitary** **F812---What corrective action was accomplished for the residents found to have been affected by the deficient practice.** Immediately Dietary Manager labeled all unlabeled food items and discarded all expired food. Discarded expired dishwasher test strips and replaced with new dishwasher test strips that expire 12/1/2025. **---How will other residents who may have the potential to be affected be identified?** ·All residents have the potential to be affected. **---What measures will be put**	01/24/2024

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	1 gallon pickles, opened, manufacturer's use-by date was 10/14/23 1 5-lb (pound) container cottage cheese, opened, manufacturer's expiration date was 11/23/23 1 5-lb container sour cream, opened, manufacturer's expiration date was 12/23/23 2 large trays of ground beef thawing on the bottom shelf, not dated, in plastic bags open to air 1 16-ounce container of chicken base, opened not dated. 1 bag salad mix, opened, not dated, brown and slimy 1 bag salad mix, opened, dated 1/5/24, brown On 1/18/24 at 10:17 A.M., the following outdated/expired food was observed in the walk-in refrigerator: 1 bag salad mix, opened, dated 1/5/24, brown On 1/23/24 at 08:46 A.M., spice containers were observed to have dates written on them with a black marker. The dates failed to indicate whether that was an open date or use by date. The spices had no manufacturer expiration dates. The following spices were observed: onion powder, no date poultry seasoning, delivered 3/23/20. At that time, the kitchen supervisor gave the container to staff to throw away. At that time, the kitchen manager indicated they used pre-printed labels and also wrote on the packages in the walk-in refrigerator and freezer with a marker because the stickers came off. A sticker included a place to note the prepared and use-by dates. These labels were not observed in the walk-in refrigerator during the initial tour of the kitchen. 2. On 1/17/23 at 9:55 A.M., the kitchen supervisor		**into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** ·Dietary Manager educated dietary staff on proper food safety and storage to include dating and labeling and discarding expired food/ expired dishwasher test strips. · **---How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?** ·Dietary Manager/ designee will audit food storage to ensure food is properly dated and labeled and no expired food is present. Dietary Manager/ designee will audit dishwasher test strips to ensure test stripes are not expired. 3Xs /week x 4 weeks, 1x/ week x 4weeks and 1x per month x 4 months. Director of clinical education/designee will report findings to QAPI x 6 months. **---Systematic changes will be completed by 1/24/2024** **Requesting paper compliance for F812**	

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	was observed testing the chemical sanitization of the dishwasher. She obtained a test strip from a bottle and put it in the rinse water. The manufacturer label on the test strips indicated they expired 3/23/23. On 1/22/24 at 08:33 A.M., the kitchen supervisor indicated different test strips were used to check the sanitization buckets used for cleaning the food preparation surfaces than they use for the dishwasher. She removed a test strip from a bottle and demonstrated testing the sanitization buckets. The manufacturer's expiration date on the test strips indicated they expired on 11/20/23. On 1/23/24 at 9:16 A.M., the Administrator provided a current "Food Safety" policy, dated 2023, which indicated that "food facility staff shall inspect all food, food products, and beverages for ...timely and proper storage...labeling, dating, and monitoring refrigerated food...so it is used by its use-by date or frozen/discarded". 3.1-21(i)(2) 3.1-21(i)(3)			