STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225117	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal of Fairhaven Nursing Center	184 Main Street Fairhaven, MA 02719

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 34145 Based on interviews and observations, the facility failed to promote residents' rights to be treated with dignity, respect and was provided equal access to services for all residents. Specifically, the facility failed to ensure: 1. all 46 residents residing on one unit (Dementia Special Care Unit (DSCU)-a specialized nursing home unit that provides care for people with dementia designed to support residents' independence and well-being) of two units in the facility were provided equal access to television sets for their personal use, while 18 residents on the first-floor unit were each provided televisions sets by the facility (at no cost) for their personal use; 2. staff did not stand while assisting residents to eat for three Residents (#25, #36, and #5), out of a total sample of 18 residents; and 3. staff maintained a dignified dining experience in two of three dining rooms observed and ensure meals were provided at the same time for residents seated at tables together resulting in residents having to sit and watch while others ate. Findings include: 1. On 2/25/25 at 7:30 A.M., the surveyor observed that 18 resident rooms on the first-floor unit had wall mounted televisions for each bed for 25 residents currently residing on the unit. On 2/25/25 at 7:26 A.M., the surveyor observed that all 17 resident rooms on the DSCU did not have wall mounted televisions for each bed for 46 residents currently residing on the unit. Of the 46 residents on the unit, only 16 residents had a television on a bureau/table in their room. During an interview on 2/27/25 at 9:40 A.M., the Therapeutic Activity Director (TAD) said for residents on the DSCU, families can bring in a television for them to watch or to play music. She said the DSCU is different than the first-floor unit in that the first-floor televisions are provided by the facility, and on the DSCU, families need to bring them in for their loved ones. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/27/25 at 11:04 A.M., the surveyor observed a television placed on a bureau in Resident #44's room (on the DSCU). The Resident's significant other (SO) said the facility did not provide the television and the Resident's son purchased the television and brought it in for his/her use. The SO said it is a Smart TV (a television that has built-in internet connectivity, allowing users to access online content like streaming services) and they use the facility's free internet to access channels. During an interview on 2/27/25 at 12:45 P.M., Resident #49, who resides on the first-floor unit, said the television mounted on the wall in his/her room is the facility's property and he/she did not need to purchase one to use. The Resident said everyone on the first-floor unit has a free television mounted to the wall. During an interview on 2/27/25 at 1:57 P.M., the Administrator said the facility provides televisions and free cable service for residents on the first-floor unit but has never provided televisions for DSCU residents. She said the former DSCU director didn't like televisions for the dementia residents and wanted them out of their rooms and participating in activities. She said they have free internet access and residents can use that with the Smart TVs their families bring in to watch what they like. 42742 2a. Review of the facility's policy titled Promoting/Maintaining Resident Dignity During Mealtimes, revised February 2025, included but was not limited to the following: -It is the practice of this facility to treat each resident with respect and dignity and care for each resident in a manner and in an environment that maintains or enhances his or her quality of life, recognizing each resident's individuality and protecting the rights of each resident. -Focus on the resident while talking to him/her and addressing him/her individually. -All staff will be seated, if possible, while feeding a resident. Resident #25 was admitted to the facility in August 2023. On 2/25/25 at 8:47 A.M., the surveyor observed Resident #25 lying in bed with the bed elevated from the floor. Certified Nursing Assistant (CNA) #5 was observed standing while assisting the Resident with eating his/her breakfast meal consisting of scrambled eggs, oatmeal, and a thickened red colored beverage. The breakfast tray was observed on top of a dresser next to the bed. No overbed tray table was observed in the room. An armed chair was observed right behind CNA #5, but it was not used. On 2/25/25 at 9:01 A.M., the surveyor observed CNA #5 remain standing and continue to assist the Resident with eating his/her breakfast meal until 9:12 A.M. (25 minutes total) when the tray was removed from the room. During an interview on 2/25/25 at 12:58 P.M., UM #2 said staff are supposed to be at eye level and should be sitting down while feeding residents and not standing. She said it should be a dignified experience. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/25 at 4:19 P.M., Nurse #1 said staff are expected to sit while feeding residents and be at eye level. During an interview on 2/27/25 3:53 P.M., CNA #5 said she did feed the Resident breakfast on Tuesday, 2/25/25. She said the process for physically assisting residents with meals is to engage the resident and sit at eye level when assisting them to ensure there is no risk of them feeling intimidated. She said she did not sit to feed the Resident on this day, but it was not intentional. She said she had a chair set up and didn't realize until after she had obtained the Resident's tray that there was no overbed table in the room to hold the tray while she fed the Resident. She said she decided that looking for a table may take a while and result in the food getting cold and the Resident getting hungry, so she placed the tray on the long bureau piece of furniture near the bed and then stood and fed the Resident with the tray on the bureau and her standing facing the resident. CNA #5 said this is not the regular way and she knows she should not have stood to feed the Resident, and the policy is to sit. She said the Resident takes about 30 minutes to eat and consumed about 100% of his/her meal and had no negative interaction with him/her or change in eating related to her standing so she thought this one time it would be okay. b. Resident #36 was admitted to the facility in December 2024. On 2/26/25 at 8:22 A.M., the surveyor observed Resident #36 sitting in the Daffodil dining room on the second floor. The MDS nurse was observed standing and physically assisting the Resident with eating his/her breakfast meal. On 2/26/25 at 8:30 A.M., the surveyor observed the MDS nurse walking around the dining room checking on all the residents. The MDS nurse returned to Resident #36's side, picked up his/her silverware, and physically assisted the Resident with eating his/her breakfast meal while standing to the Resident's left side. Five minutes later, the MDS nurse was observed standing to the Resident's left. She picked up the Resident's spoon and physically assisted him/her with another bite. During an interview on 2/27/25 at 8:07 A.M., the MDS Nurse said the process for the dining rooms is to serve all residents at the same table at the same time removing all the food from the trays and then assisting as needed. She said when staff physically assist the residents they are supposed to be seated. She said yesterday because she was in the Daffodil room alone for breakfast, she did not sit down to assist Resident #36 with his/her breakfast because she had two other residents in there she had to check on and intermittently assist. She said typically Resident #36 has supervision for meals and can feed him/herself, but she noticed a change yesterday and had to physically assist him/her. The MDS Nurse said she should have been sitting down to assist the Resident but was not. c. Resident #5 was admitted to the facility in June 2014. On 2/26/25 at 12:56 P.M., the surveyor observed Resident #5 in bed. CNA #2 was observed physically spooning food from the lunch meal into the Resident's mouth while standing over the Resident. CNA #2 provided a few bites to the Resident. No chair was observed in the room to be available for the CNA's use while assisting the Resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/25 at 1:03 P.M., CNA #2 said Resident #5 can feed him/herself if you hand him/her handheld foods but anything else would need to be fed. She said staff should be sitting while assisting residents with meals. When asked how they achieve this in resident rooms, she said if they cannot find a chair to bring in the room they can sit at the edge of the resident's bed. CNA #2 said she thought the Resident was done with his/her meal but the Resident asked for more so that was why she was standing over him/her when she was observed by the surveyor. She said staff should be sitting when physically assisting a resident with meals and standing over them could be intimidating. During an interview on 2/26/25 at 5:06 P.M., the Assistant Director of Nursing (ADON) and Administrator said staff are supposed to sit at eye level to the resident and provide dignity while feeding. They said staff are supposed to be sitting and not standing while assisting residents with eating. 3. On 2/26/25, the surveyor made the following dining observations: a. Daffodil Dining Room (second floor) 11:55 A.M. Lunch Service: -food truck #1 arrived at second floor at 11:54 A.M. to be delivered to dining room and long hall residents -16 total residents seated in the dining room Table 2: -Two residents seated at the table -At 11:59 A.M., the first resident received their lunch meal, a staff member assisted with set up while the other resident watched -At 12:07 P.M., the second resident received their lunch tray During an interview on 2/26/25 at 12:10 P.M., the Activities Director (AD), who was delivering meal trays to dining room residents, said the expectation is that all residents should be served at the same time, but the order of the trays is how they come up from the kitchen. She said there's no order to the trays and staff can only open one side of the food truck at a time so they'll pull what they can from that side, then will pull from the other side. b. Additional Dining Room (second floor) 8:07 A.M. Breakfast Service: Table 1 (left): -Two total residents seated at the table (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One resident eating his/her breakfast meal while the second Resident (#30) was observed falling asleep at the table without his/her breakfast meal -At 8:10 A.M., Resident #30 still without breakfast meal -At 8:12 A.M., Resident #30 observed getting restless, first resident finished their meal, Resident #30 pulling at his/her clothes and knocking on the table rocking from side to side, -At 8:19 A.M., Resident #30 is still without his/her breakfast meal, all other residents served. Resident restless and observed ringing his/her hands while rocking from side to side in the wheelchair -At 8:21 A.M., the Resident is assisted with eating his/her breakfast meal (14 minutes later) During an interview on 2/26/25 at 8:19 A.M., CNA #1 said Resident #30 is a feeder and his/her tray comes up on a later truck and the Resident would be fed by staff once they got to that tray. Table 2 (middle): -Two total residents seated at the table -At 8:08 A.M. one resident received his/her breakfast tray -Resident (#57) drinking tea, no breakfast tray observed, Resident said he/she had not eaten yet -At 8:10 A.M., Resident #57 still without breakfast meal, observed saying to the tablemate who was trying to speak to him/her to just eat their breakfast since they had some -At 8:15 A.M. Resident #57 received his/her breakfast tray Table 3 (on right): -One Resident (#27) seated at the table repeatedly asking if he/she can have coffee, if he/she is having food -At 8:10 A.M., Resident #27 asks staff if he/she is getting any breakfast -At 8:16 A.M., Resident #27 received his/her breakfast meal During an interview on 2/26/25 at 12:58 P.M., Unit Manager (UM) #2 said residents should be served together, but if they're in the wrong position or are at a different table it changes the way the trays are lined up. She said the trays should be removed together to accommodate the residents, so they're served together. UM #2 further said staff are supposed to be at the same level as the residents while assisting them to eat and be sitting, not standing. She said the expectation is that it should be a dignified dining experience. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/25 at 4:08 P.M., the Certified Food Manager (CFM) said nursing staff on the second floor give her a list of residents in order of how they would like them to be served for all three meals. She said the way it goes is the way nursing gives it to her and has no way of knowing who goes in the dining room by looking at the list. She said the resident list is numbered starting with number one, so she lines up the trays in the food trucks to accommodate the requested nursing order. For example, she would ensure the number one tray is in the front. The CFM said the trays are organized in order on one side of the truck, then the other side. The CFM said residents seated at the same table should be served together but the way nurses set it up is hard and she has no control of this. The CFM said the list nurses give her is how she does it. She said she wishes there was a seating chart but knows this could be hard. During an interview on 2/26/25 at 5:05 P.M., the Assistant Director of Nursing (ADON) and the Administrator said they try to provide a dignified dining experience for the residents. The Administrator said residents should be served at the same time, but sometimes there are instances where residents are in a different dining room, so their tray is on a different food truck. She said they do have a seating arrangement on the second floor and food trays should be in order per the table assignments. She said there are instances where residents don't want to sit in their assigned seat but usually do. She said the trays are organized in chronological order. The ADON and Administrator further said staff are supposed to sit, not stand, at the resident's eye level and provide a dignified experience while feeding the residents.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 34145 Based on records reviewed and interviews, the facility failed to ensure activity programs were offered consistently on weekends to meet the needs of residents residing on the first-floor unit in the facility. Findings include: On 2/26/25 at 1:30 P.M., the surveyor held a Resident Group Meeting with seven residents in attendance. During the meeting, six of seven residents (all representing the first-floor unit) said they enjoy the activity program during the week (Monday through Friday), but the weekends are long and boring with nothing to do. They said one activity assistant comes in every other Saturday, but otherwise there is nothing to do on the weekend. One resident said that Bingo is on the calendar every Saturday, but when the activity assistant is not in, there is no one to run the game and Bingo doesn't happen. They said there are some coloring materials and books in the dayroom, but they are not interested in those items. Review of the January 2025 and February 2025 Activity Staff Schedule and punch card detail report indicated activity staff working Saturday and Sundays on the first-floor unit as follows: -Saturday 1/4/25: 1 activity staff 9:00 A.M. to 4:00 P.M. -Sunday 1/5/25: 0 activity staff -Saturday 1/11/25: 0 activity staff -Sunday 1/12/25: 0 activity staff -Saturday 1/18/25: 1 activity staff 9:00 A.M. to 4:00 P.M. -Sunday 1/19/25: 0 activity staff -Saturday 1/25/25: 0 activity staff -Sunday 1/26/25: 0 activity staff -Sunday 2/2/25: 0 activity staff -Saturday 2/8/25: 0 activity staff -Sunday 2/9/25: 0 activity staff -Sunday 2/16/25: 0 activity staff -Saturday 2/22/25: 0 activity staff (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sunday 2/23/25: 0 activity staff Review of the January 2025 first floor activity calendar for days when no activity staff were present indicated: -Sunday 1/5/25: 9:30 A.M. Morning visits; 10:00 A.M. to 11:00 A.M. Televised Catholic Mass; 2:00 P.M. to 4:00 P.M. Afternoon movie. -Saturday 1/11/25: 9:30 A.M. Morning visits; 10:00 A.M. to 12:00 P.M. Open Rec Room; 2:00 P.M. Bingo; 3:30 P.M. Refreshments. -Sunday 1/12/25: 9:30 A.M. Morning visits; 10:00 A.M. to 11:00 A.M. Televised Catholic Mass; 2:00 P.M. to 4:00 P.M. Afternoon movie. -Sunday 1/19/25: Morning visits; 10:00 A.M. to 11:00 A.M. Televised Catholic Mass; 2:00 P.M. to 4:00 P.M. Afternoon movie. -Saturday 1/25/25: 9:30 A.M. Morning visits; 10:00 A.M. to 12:00 P.M. Open Rec Room; 2:00 P.M. Bingo; 3:30 P.M. Refreshments. -Sunday 1/26/25: Morning visits; 10:00 A.M. to 11:00 A.M. Televised Catholic Mass; 2:00 P.M. to 4:00 P.M. Afternoon movie. Review of the February 2025 first floor activity calendar for days when no activity staff were present indicated: -Sunday 2/2/25: Morning visits; 10:00 A.M. to 11:00 A.M. Televised Catholic Mass; 2:00 P.M. to 4:00 P.M. Afternoon movie. -Saturday 2/8/25: 9:30 A.M. Morning visits; 10:00 A.M. to 12:00 P.M. Open Rec Room; 2:00 P.M. Bingo; 3:30 P.M. Refreshments. -Sunday 2/9/25: Morning visits; 10:00 A.M. to 11:00 A.M. Televised Catholic Mass; 2:00 P.M. to 4:00 P.M. Afternoon movie. -Sunday 2/16/25: Morning visits; 10:00 A.M. to 11:00 A.M. Televised Catholic Mass; 2:00 P.M. to 4:00 P.M. Afternoon movie. -Saturday 2/22/25: Morning visits; 10:00 A.M. to 12:00 P.M. Open Rec Room; 2:00 P.M. Bingo; 3:30 P.M. Refreshments. -Sunday 2/23/25: Morning visits; 10:00 A.M. to 11:00 A.M. Televised Catholic Mass; 2:00 P.M. to 4:00 P.M. Afternoon movie. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/27/25 at 9:33 A.M., the Activity Director said she was aware that residents were bored on weekends because they told her this a while ago. She said there used to be no activity staff on weekends but started having one activity assistant come in every other Saturday to do activities. She said the weekend receptionist is available to do things for the residents, like call Bingo, when the activity assistant is not working every other Saturday. During an interview on 2/27/25 at 1:57 P.M., the Administrator said they have only one activity staff who come in for activities on the first floor every other Saturday and will need to hire someone to come in on weekends to meet the residents' needs.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48362 Based on observations, interviews, and meal test tray results, the facility failed to serve meals that were palatable and at appetizing temperatures on one (Dementia Special Care Unit - DSCU) of two units. Findings include: On 2/26/25 at 8:00 A.M., the surveyor made the following observations on the DSCU Unit: - At 8:00 A.M., the first meal truck arrived on the unit. - At 8:07 A.M., the first residents were served in the dining area. - At 8:16 A.M., the second meal truck arrived on the unit. - At 8:20 A.M., the third meal truck arrived on the unit. - Nursing staff were bringing breakfast meal trays to the resident rooms as well as into the dining room being observed. - At 8:21 A.M., the final resident in the dining area was delivered their breakfast tray, 21 minutes after the initial residents were served their meals. On 2/27/25 at 7:55 A.M., the surveyor requested a breakfast test tray to the DSCU Unit. The following observations were made: - The third meal truck arrived on the DSCU unit at 8:06 A.M. - The DSCU had three unit dining rooms in which residents were seated for the breakfast meal. - Nursing staff were still serving meals from the first and second trucks which had previously arrived on the unit. - Nursing staff were bringing breakfast meal trays to resident rooms as well as into the two of the three dining room areas. - At 8:22 A.M., nursing staff were observed to open the third meal truck and begin delivering trays to the unit, 16 minutes after it arrived on the unit. - At 8:27 A.M., nursing staff delivered the final tray from the third meal truck to a resident, 21 minutes after the meal truck arrived on the unit. On 2/27/25 at 8:27 A.M., a test tray was conducted with the Food Service Director (FSD) observing and confirming temperatures (in degrees Fahrenheit (F)) at 8:27 A.M. The results were as follows: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Scrambled Eggs: 98.0 F, cold to taste and lacking flavor - Oatmeal: 125.0 F, cold to taste - Orange Juice: 53.3 F, warm to taste/touch - Milk: 56.6 F, warm to taste/touch During an interview on 2/26/25 at 12:10 P.M., the DSCU Activities Director said the meal trays come up from the kitchen and there is no order. During an interview on 2/27/25 at 8:34 A.M., the FSD said the meal temperatures were not within appropriate ranges. The FSD said the eggs and oatmeal should be warmer when delivered to the residents. The FSD said her expectation was for hot food items to be served to residents at about 155 F. The FSD said the milk should be at a colder temperature, below 53 F. During an interview on 3/3/25 at 8:28 A.M., the Administrator and the surveyor reviewed the dining observations on the DSCU and the test tray results. The Administrator said she was unaware of the length of time it took for meal trays to be passed on the second floor. The Administrator said meal trucks should be organized to ease the delivery of trays to residents on the unit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742 Based on observation, interview, and document review, the facility failed to follow professional standards of practice for food safety to prevent the potential of foodborne illness to residents who are at high risk. Specifically, the facility failed to: 1. Ensure food was properly stored in the walk-in freezer in the main kitchen; 2. Properly label and date food products stored in the free-standing refrigerator and walk-in refrigerator in the main kitchen and/or discard food when past their use by date; and 3. Ensure food was properly labeled and/or discarded when past their manufacturer's expiration date in two of two resident nourishment kitchen refrigerators reviewed. Findings include: Review of the facility's policy titled Food Receiving and Storage, undated, indicated but was not limited to the following: -Foods shall be received and stored in a manner that complies with safe food handling practices. -All foods stored in the refrigerator or freezer will be covered, labeled of contents and date (use by date). -The freezer must keep frozen foods frozen solid. Wrappers of frozen foods must stay intact until thawing. -Food items and snacks kept on the nursing units must be maintained as indicated below: a. All food items to be kept below 41 degrees must be placed in the refrigerator located at the nurses' station and labeled with a use by date. b. All foods belonging to residents must be labeled with the resident's name, the item, and the use by date. 1. On [DATE] at 7:27 A.M., the surveyor reviewed the walk-In freezer in the main kitchen with the Certified Food Manager (CFM) and observed the following inside: -one cardboard box on a shelf opened, inside the box contained a plastic bag of frozen beef patties, bag not sealed potentially exposing the patties to environmental contaminants During an interview on [DATE] at 7:27 A.M., the CFM said the bag should have been sealed. 2. On [DATE] at 7:30 A.M., the surveyor reviewed the free-standing refrigerator in the main kitchen with the CFM and observed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225117	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal of Fairhaven Nursing Center	184 Main Street Fairhaven, MA 02719

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-one plastic container of Thick & Easy thickened orange juice, approximately ,d+[DATE] full, not labeled with open date or use by date, manufacturer expiration date [DATE], not disposed of when expired During an interview on [DATE] at 7:30 A.M., the CFM said the thickened beverage container should have been labeled when opened and when expired. She said once opened, they were only good for three days. On [DATE] at 7:41 A.M., the surveyor reviewed the walk-in refrigerator in the main kitchen with the CFM and observed the following: -one large rectangular pan with two clear plastic bags stored inside filled with raw chicken breasts, pan not labeled with content, date prepared, or the use by date During an interview on [DATE] at 7:41 A.M., the CFM said the pan should have been labeled with the content, the day it was pulled out, and the use by date. She said she knew she pulled it out on Friday but wasn't sure how long it was good for. She said it still should have been labeled. During an interview on [DATE] at 4:06 P.M., the CFM said the chicken was only good for four days and should have been labeled. 3. Review of the facility's policy titled Food Brought by Family/Visitors, dated [DATE], indicated the following: -Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name the item and the use by date. -The nursing staff if responsible for discarding perishable foods on or before the use by date. On [DATE] at 3:26 P.M., the surveyor reviewed the first floor resident nourishment kitchen with the CFM and observed the following: -one container of Activa probiotic yogurt, 7 oz, unopened, labeled with resident's name, labeled ,d+[DATE], manufacturer's expiration [DATE], item expired and not disposed of During an interview on [DATE] at 3:26 P.M., the CFM said the yogurt was expired. On [DATE] at 3:44 P.M., the surveyor reviewed the second floor resident nourishment kitchen with the CFM and observed the following: -One plastic bag stored inside the refrigerator with three plastic containers of food inside the bag, bag labeled with a resident's name, bag not labeled with the date received or the use by date During an interview on [DATE] at 3:44 P.M., the CFM said the resident's food stored inside the plastic bag was only good for three days once received by the family member. She said the bag should have been labeled with the date it came in and the use by date but wasn't.