STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225540	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
German Center for Extended Care	2222 Centre Street Boston, MA 02132

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on interview and policy review the facility failed to ensure that all written grievance decisions included the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; the facility failed to maintain evidence demonstrating the results of all grievances for a period of no less than three years from the issuance of the grievance decision. Findings include: Centers for Medicare and Medicaid Services (CMS) defines a grievance as: an expression of dissatisfaction (other than an organization determination) with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers, regardless of whether remedial action is requested. Review of the undated facility policy, titled Grievance Policy, indicated, but was not limited to, the following: -The facility adheres to the DPH's (Department of Public Health's) regulation 483.10 about Grievances. Resident #101 was admitted to the facility in December 2022 with a diagnosis of Parkinson's Disease. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #101 scored a 9 out of a possible 15 on a Brief Interview for Mental Status (BIMS), indicating the Resident had moderate cognitive impairment. During an interview on 8/29/24 at 2:01 P.M., Resident #101 said he/she had voiced a complaint to staff regarding other staff speaking a different language in front of him/her four to five weeks ago. (continued on next page)

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.

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

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's 2024 Grievance binder failed to indicate that a grievance was filed or maintained regarding Resident #101's complaint about staff speaking in a foreign language. During an interview on 8/28/24 at 3:13 P.M., Unit Manager #3 said that if a resident voices a complaint that she will look into it, and that if the complaint is not resolved within seven days that the complaint will become a formal written grievance; Unit Manager #3 said that after seven days a form will be filled out and the grievance will be documented. Unit Manager #3 said the complaint will be discussed at the interdisciplinary team meeting and that this process is verbal unless the complaint is not settled within seven days, at which point it becomes a written process. Unit Manager #3 said that Resident #101 had voiced a complaint about staff speaking in a foreign language earlier this month. The Unit Manager said that she had completed an investigation, educated her staff, and followed up with the Resident about resolution but that this was all verbal, not documented/written, as it was resolved within seven days. During an interview on 8/28/24 at 11:43 A.M., the Administrator said that Resident #101 had voiced a complaint about overhearing staff speaking a foreign language. During a follow-up interview on 8/28/24 at 2:04 P.M., the Administrator said that when a resident voices a concern to staff the staff are expected to communicate the concern up to the supervisor. The Administrator said that if the resident concern/complaint isn't able to be resolved by the supervisor that it will then be escalated to the department head, and that all unresolved concerns made in the last 24 hours were discussed in the interdisciplinary meeting. The Administrator said that those complaints will be logged in a soft log, not the grievance binder, for tracking. The Administrator said not all resident complaints are necessarily documented if they are resolved within seven days. The Administrator said a complaint will only be formally documented as a grievance and entered into the grievance binder if the complaint was not resolved within seven days. During an interview on 8/28/24 at 2:59 P.M., Social Worker (SW) #1 said that if a resident complaint is not resolved within seven days that it becomes a grievance, and that if a complaint is resolved before seven days it would not be documented as a grievance. During a follow-up interview on 8/29/24 at 2:04 P.M., the Administrator said that there is nothing in writing regarding Resident #101's complaint of staff speaking a foreign language. While flipping through the soft-log the Administrator showed the surveyor multiple examples of resident complaints, as denoted by the resident room number, including complaints regarding resident activities and requests of room transfers. The Administrator said that these complaints in the soft log are informal and do not include date, a summary statement of the grievance or a summary of the pertinent findings or conclusions as they are not considered grievances until they have remained unresolved for seven days.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to review and revise the plan of care for one Resident (#107) out of a total of 24 sampled residents. Findings include: Review of the facility's Care Plans - Comprehensive Policy, undated, indicated: 3. The Resident's comprehensive care plan is developed within seven days of the completion of the resident's comprehensive assessment (Admission, Annual or Significant Change in Status). 5. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to the MDS(Minimum Data Set Assessment). 11. The care planning/interdisciplinary team is responsible for the review of updating of care plans: when there has been a significant change in the resident's condition; when the resident has been readmitted to the facility from a hospital stay and changes in care and, at least quarterly. Resident #107 was admitted to the facility in March 2024 with diagnoses including dementia and psychotic disorder. Review of Resident #107's Significant Change MDS dated [DATE] indicated he/she was severely cognitively impaired, dependent on staff for activities of daily living and had daily physical and verbal behaviors. On 8/27/24 at 8:49 A.M., Resident #107 was observed seated in a wheelchair with his/her right leg extended forward, elevated and in a cast. Resident #107 appeared agitated and was continuously shifting in the chair. Review of Resident #107's clinical record indicated he/she was hospitalized on [DATE] after a fall and diagnosed with a closed displaced trimalleolar fracture (a fracture of the lower leg sections that form the ankle joint and help move the foot and ankle) of the right ankle. Due to swelling, Resident #107 was placed in a soft cast with the plan to follow up with orthopedic services for a hard cast. Review of the hospital paperwork indicated Resident #107 required a 1:1 and wore mitts (a restraint on his/her hands) as he/she would remove his/her soft cast. The clinical record indicated Resident #107 had a follow up appointment to replace his/her soft cast with a hard cast on 7/16/24 but due to transportation issues, he/she was not able to attend. Resident #107 was not seen by orthopedic services for a replacement cast until 7/31/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nurse progress note dated 7/18/24 indicated: Pt (pt) verbally responsive no change in MS (mental status) at baseline confusion, pt removed his/her RLE (right lower extremity) half cast and dsg (dressing). Pt RLE assessed dsg and cast replaced. Physician notified. Review of the physician's note dated 7/18/24 indicated: Last night, he/she removed his/her soft cast, but didn't put weight on his/her leg, staff re-applied it and add ace wrap. He/she continues to be confused and impulsive. Unfortunately, Resident #107 has a challenging situation, it's difficult to redirect him/her and he/she is at higher risk for falls and injuries now. Will encourage redirect him/her as possible. Review of Resident #107's behavioral care plan indicated the following: Focus: Resident exhibits behavioral issues may include but not limited to intrusiveness, wandering on unit inappropriate behavior, paranoid behavior, yelling at others, (3/22/24) trying to remove cast/sutures (8/22/24). Interventions: Administer medications as ordered. Approach resident in a calm manner at all times. Encourage resident to participate in activities. Monitor resident behaviors and document as needed. Notify HCP/Guardian as needed. Pysch consults as needed. Redirect resident as necessary, 3/22/24. The care plan was not updated to include behaviors of attempting to remove his/her cast/sutures until 8/22/24 and no updated interventions were initiated. (Resident #107 had a Significant Change MDS completed on 7/19/24.) During an interview with Occupational Therapist (OT) #1 on 8/28/24 at 12:20 P.M., she said that Resident #107 was on rehab services when he/she returned from the hospital in July 2024. OT #1 said that although his/her cast was always wrapped when she worked with him/her, she was told Resident #107 removed it many times. During an interview with Nurse #4 on 8/28/24 at 2:13 P.M., she said that staff had been instructed to not remove the cast as Resident #107 was supposed to go to an orthopedic services appointment to have the soft cast replaced with a hard cast once the swelling improved. Nurse #4 said that Resident #107's soft cast was wrapped with ace bandages and he/she had behaviors of trying to remove it. Nurse #4 said she did not know if interventions for monitoring Resident #107 were documented. During an interview on 8/29/24 at 7:14 A.M., Certified Nursing Aide (CNA) #2 said she works the overnight shift and Resident #107 would sometimes remove his/her soft cast. CNA #2 said when he/she would remove the cast, she would alert the nurse to re-apply the cast and ace wrap. During an interview on 8/29/24 at 8:24 A.M., CNA #1 said Resident #107 was always pulling on his/her soft cast and ace wrap and if it was off, she would alert the nurses to put it back on. During an interview with Health Care Proxy (HCP) #1 on 8/29/24 at 10:03 A.M., he said that Resident #107 was very confused and can be agitated. HCP #1 said he was not surprised that Resident #107 had behaviors of attempting to remove his/her cast. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/30/24 at 11:29 A.M., the Director of Nursing (DON) said that residents exhibiting new behaviors should be examined and assessed to determine the cause of behaviors. The DON said she was unaware that Resident #107's care plans were not updated until 8/22/24 to address his/her behavior of removing the leg cast, which had been ongoing since his/her re-admission to the facility in July 2024.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095 Based on observation, policy review, record review, and interviews, for one Resident (#120) of 24 sampled residents, the facility failed to ensure nursing provided services in accordance with the comprehensive care plan that met professional standards of quality. Specifically, for Resident #120 the facility failed to ensure nursing implemented a physician's ordered dressing change to his/her left foot. Findings include: Review of [NAME], Manual of Nursing Practice 11th edition, dated 2018, indicated the following: - The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following: - Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Review of the facility policy titled, dressings, dry/clean, undated, indicated the purpose of this procedure is to provide guidelines for application of dry clean dressings. 17. Apply the ordered dressing and secure with tape or bordered dressing per order. Label with date and initials to top of the dressing. Resident #120 was admitted to the facility in August 2024 with diagnosis including diabetes mellitus with foot ulcer. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/18/24, indicated that Resident #120 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS indicated Resident #120 had a surgical wound and received surgical wound care. On 8/27/24 at 8:55 A.M., the surveyor observed a dressing on Resident #120's left foot dated 8/25/24 with the initials of the Nurse who worked on 8/25/24. Resident #120 said that nursing is supposed to change his/her dressing every day, but the dressing was not done on 8/26/24. Review of Resident #120's plan of care related to actual skin break down, dated 8/14/24, indicated: - perform treatment as ordered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #120's physician's order, dated 8/14/24, indicated: - wound incision left great toe - dry clean dressing (DCD) daily, every day shift. Review of Resident #120's Treatment Administration Record (TAR), dated August 2024, indicated that Nurse #1 completed the dressing as ordered on 8/26/24. Review of Resident #120's nursing note, dated 8/26/24 at 3:24 P.M., indicated: - Wound to left great toe intact and dressing in place. No infection or drainage noted. During an interview on 8/28/24 at 12:12 P.M., Nurse #1 said she thinks she completed the wound treatment as ordered on 8/26/24 but she was not certain. Nurse #1 said she would date and label the dressing with the correct date and her initials. Upon further review of the dressing observation on 8/27/24 at 8:55 A.M., the dressings initials were not those of Nurse #1. The initials on the dressing dated 8/25/24 were of the nurse who completed the treatment as ordered on the TAR on 8/25/24. During an interview on 8/29/24 at 12:11 P.M., with Unit Manager #1, the surveyor made Unit Manager #1 aware of the observation of the dressing on 8/27/24 that was dated 8/25/24 and that this dressing did not have Nurse #1's initials on it. Unit Manager #1 said that Nurse #1 should have completed the dressing as ordered and Nurse #1 should have dated and initialed the dressing per facility policy. During an interview on 8/30/24 at 8:12 A.M., the Director of Nursing (DON) said that during dressing changes nursing should include the date and initial the dressing. The DON was made aware that Resident #120 said the dressing was not completed on 8/26/24. The DON said she is familiar with Resident #120, and she has changed his/her dressing and the DON said that Resident #120 is alert and oriented and nursing should document the dressing change once that dressing change is complete.

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident’s preferences and goals.

44095

Based on record review, policy review and interview the facility failed to provide care and treatment in accordance with professional standards of practice for one Resident (#43) out of a total sample of 24 Residents.

Specifically, for Resident #43 the facility failed to ensure nursing followed up on coumadin (warfarin - anticoagulant) dosing and nursing failed to obtain repeat laboratory work (a prothrombin time PT/INR test measures how fast a blood sample forms a clot. A high PT/INR means the body takes longer than normal to form blood clots) as recommended by Nurse Practitioner.

Findings include:

Review of the facility policy titled, Anticoagulation - Clinical Protocol, undated indicated but was not limited to the following:

1. The physician will order appropriate lab testing to monitor anticoagulant therapy and potential complications; for example, periodically checking hemoglobin/hematocrit, platelets, PT/INR, and stool for occult blood.

a. The staff should use a warfarin flow sheet or comparable monitoring tool to follow trends in anticoagulant dosage and response.

2. The physician will help review the progress of individuals who are being anticoagulated; for example, to see whether recent-onset atrial fibrillation has resolved.

3. The physician will periodically identify individuals whose anticoagulant can be discontinued or reduced, and will document a rationale for continuing anticoagulation over time, including the medication and current dosage.

5. Physician will be notified for all abnormal PT/INR results for further order.

Resident #43 was admitted to the facility in June 2024 with diagnoses including heart failure, atrial fibrillation, and pulmonary embolism.

Review of the most recent Minimum Data Set (MDS) assessment, dated 7/2/24, indicated that Resident #43 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. This MDS indicated Resident #43 did not reject care and received an anticoagulant. The MDS indicated he/she had a health care proxy, and his/her health care proxy was not invoked.

Review of Resident #43's hospital discharge summary, dated 6/25/24, indicated:

3.) Your warfarin dose has been adjusted several times during your stay. Please closely work with the facility to keep your INR at goal (2-3).

Review of Resident #43's physician's order, dated 6/26/24, indicated:

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Coumadin - monitoring dosing, give one unspecified (dose) by mouth every evening for coumadin monitoring per INR. Review of Resident #43's plan of care related to anticoagulation use, dated 7/3/24, indicated: - administer anti-coagulation as ordered - Check INR - as ordered. - Check lab as ordered. Review of Resident #43's laboratory results tab, indicated the following: 8/12/24 INR was 2.6. 8/19/24 INR was 4.0 High. 8/21/23 INR was 3.4 High. 8/22/24 INR was 3.3 High. Review of Resident #43's physician's order, dated 8/22/24, indicated: - hold coumadin today 8/22/24, recheck INR on 8/23/24. Review of Resident #43's nursing progress note written by Nurse #2, dated 8/23/24 at 5:38 P.M., indicated: - Had INR today, lab called to report the blood that they have drawn from the Resident was not enough, to run the test. The physician (MD) was made aware, and an order was given to hold coumadin until further notice. During an interview on 8/28/24 at 12:50 P.M., Nurse #2 said that he notified Nurse Practitioner #1 (not the MD, as indicated in the above note) about the INR results and Nurse #2 said that NP #1 said that the coumadin should be on hold. Nurse #2 said he did not receive orders to recheck Resident #43's INR. Review of Resident #43's Medication Administration Record (MAR), dated August 2024, indicated on 8/23/24, 8/24/24, 8/26/24, 8/27/24, and on 8/28/24, Nurse #3 implemented the physician's order to coumadin - monitoring dosing, give one unspecified by mouth every evening for coumadin monitoring per INR. Further review indicated there were no coumadin orders in place. Review of Resident #43's nursing progress note written by Nurse #3, dated 8/24/24 at 6:40 A.M., indicated: - Coumadin on hold until further notice no INR lab scheduled at this time per nurse report. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/29/24 at 8:31 A.M., Nurse #3, said she thought it was strange that there were no further orders to check an INR for Resident #43. Nurse #3 said she received this information during report. Nurse #3 said that she called NP #1 on 8/24/24 for coumadin dosing and INR monitoring but she did not hear back from NP #1. Nurse #3 said she did not reach out to the physician but should have. During an interview on 8/28/24 at 12:55 P.M., Nurse Practitioner #1 said he was not aware that Resident #43 has not had an INR level completed since 8/23/24. NP #1 said that he spoke with nursing on 8/23/24 when the specimen had clotted, and he said he told nursing to hold the coumadin for the night and recheck the INR in the morning on 8/24/24. NP #1 said he needed to order an INR for Resident #43 on 8/29/24. Review of the physician's order dated, 8/28/24, indicated: - INR on 8/29/24. Review of Resident #43's laboratory results tab, indicated the following: 8/29/25 INR was 1.3 Low. During an interview on 8/29/24 at 12:20 P.M., Resident #43 said he/she likes his/her family member involved in care and he/she is taking the blood thinner. During an interview on 8/29/24 at 11:20 A.M., NP #1 said that Resident #43's INR was now low because he/she has not received coumadin and he/she should not have gone this long without a repeat INR or any type of anticoagulation. NP #1 said that he would reach out to Resident #43's family member and review alternative anticoagulation options. During an interview on 8/29/24 at 12:06 P.M., Unit Manager #1 said she wasn't aware that Resident #43 did not have his/her INR checked for almost a week and Resident #43 did not receive any coumadin. Unit Manager #1 said that Resident #43 is his/her responsible person. Unit Manager #1 said that in the past the facility had used a coumadin tracking log but no longer used any tracking devices. During an interview on 8/30/24 at 8:14 A.M., the Director of Nursing (DON) said coumadin dosing requires INR monitoring and the facility does not use the coumadin book anymore. The DON said that Nurse #2 and Nurse #3 should have followed up with the provider for INR monitoring and coumadin dosing. The DON said she was not aware that Resident #43 did not have his/her INR monitored for almost 7 days. The DON reviewed the nursing notes with the surveyor, and she said there was no plan documented for further monitoring the INR or blood draws, and there was no documentation for future anticoagulation plans. The DON said that if Nursing had not heard back from the providers, she would have gotten involved and obtained orders for INR monitoring.

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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. 45763 Based on observation, policy review, and interview, the facility failed to store and prepare food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure food was labeled, that food was not stored directly on the floor, and that dented cans were not accepted into storage/circulation. Findings include: Review of the current FDA (Food and Drug Administration) food code indicated the following: - food shall be protected from contamination by storing the food: 1) In a clean, dry location; 2) Where it is not exposed to splash, dust, or other contamination; and 3) At least 15 cm (6 inches) above the floor. Review of the facility's undated policy titled Food Handling, indicated, but was not limited to, the following: - Prepared foods should be checked before serving to residents and non-labeled and foods older than 72 hours should be discarded. - Food should be stored appropriately in the refrigerator or at room temperature. - Foods should be labeled when opened and foods prepared in the facility should also be labeled. - Foods prepared in the facility should be discarded within 72 hours. Prepared foods should be inspected daily before noon time. On 8/27/24 at 7:30 A.M., the surveyor made the following observations during the initial walkthrough of the 1st floor kitchen: - Bananas and a container of unlabeled and undated brown food stored directly on the floor in the roll-in refrigerator. - A container of cottage cheese, half-empty, opened but undated in the roll-in refrigerator. - Three sandwiches, undated and unlabeled in the roll-in refrigerator. - A box containing 11 jelly donuts, undated in the roll-in refrigerator. - A plastic container of canned fruit, unlabeled and undated in the roll-in refrigerator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225540	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
German Center for Extended Care	2222 Centre Street Boston, MA 02132

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	- Tomato juice opened but undated in the roll-in refrigerator. - Two cups of red liquid with lids, undated and unlabeled in the roll-in refrigerator. - 14 cups of fruit and cottage cheese individually portioned, wrapped but undated in the roll-in refrigerator. During an interview on 8/27/24 at 7:40 A.M., the Food Service Director (FSD) said he would expect all prepared foods and all foods that were opened to be labeled, dated, and discarded after three days. The FSD said the cottage cheese and fruit should have been labeled and dated, and that food should not be stored directly on the floor. During an interview on 8/27/24 at 7:43 A.M., the food service employee said she didn't work the weekend but thinks the canned fruit was opened at some point during the weekend. The food service employee said the donuts were from last Friday, and that the cups of red liquid were cranberry juice but that she does not know when they were poured. During an interview on 8/27/24 at 8:34 A.M., the surveyor and FSD observed a can of blueberry filling on the can rack in the upstairs kitchen. The can had a significant dent on the rim. The FSD said that all cans are inspected when received and cans with dents should be set aside in a room downstairs to be returned, not stored on the can rack. The FSD said he had not seen the dented can, and that he would have pulled that can especially because the dent is on the rim; the FSD said that cans on that rack are used to serve residents in the facility. During an interview on 8/28/24 at 8:20 A.M., the food service supervisor said that all food in the 1st floor kitchen is served to residents in the facility.