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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>345163 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing  | (X3) DATE SURVEY COMPLETED<br><br>04/16/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Glenbridge Health and Rehabilitation |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>211 Milton Brown Heirs Road<br>Boone, NC 28607 |  |

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

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51142</p> <p>Based on record review, Nurse Practitioner and staff interviews, the facility failed to notify the provider when five daily doses of Metoprolol Succinate ER (medication to treat heart failure) and Quetiapine Fumarate (an antipsychotic medication that helps regulate mood behaviors and thoughts) was not administered for 1 of 1 resident reviewed for notification (Resident #36).</p> <p>The findings included:</p> <p>Review of the hospital discharge summary dated 3/20/2025 revealed orders for Metoprolol Succinate 25 milligrams 24 hr tablet. Take 0.5 tablets (12.5 milligram total) by mouth nightly, and Quetiapine 25 milligram tablet. Take 1 tablet (25mg total) by mouth nightly.</p> <p>Resident #36 was admitted to the facility on [DATE] with diagnoses that included chronic systolic (congestive) heart failure, type 2 diabetes mellitus with diabetic peripheral angiopathy (the presence of diabetes which involves damage to the blood vessels particularly to the extremities), hypertensive heart disease with heart failure, unspecified dementia with agitation.</p> <p>A physician order dated 3/25/2025 read Metoprolol Succinate ER tablet Extended Release 24 hour 25 milligrams. Give 0.5 (half) tablet by mouth at bedtime HOLD if heart rate less than 60 beats per minute.</p> <p>Review of Resident #36's medication administration record (MAR) dated March 2025 revealed the following:</p> <p>a. Documented by Nurse #1 that on 3/21/2025 Resident #36 did not receive the metoprolol due to the medication not being available.</p> <p>b. Documented by Nurse #2 that on 3/22/2025, 3/23/2025, 3/24/2025, Resident #36 did not receive the dose of Metoprolol Succinate ER or Quetiapine Fumarate due to the medication not being available. Nurse #2 documented on 3/27/2025 Resident #36 did not receive Quetiapine Fumarate due to medication not being available.</p> <p>c. Documented by Nurse #3 that on 3/25/2025 Resident #36 did not receive the dose of Metoprolol Succinate ER or Quetiapine Fumarate due to the medication not being available.</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>There were no nursing progress notes that indicated the provider had been notified that Resident #36 had not received the doses of Metoprolol SuccinateER on [DATE], 3/22/2025, 3/23/2025, 3/24/2025 and 3/25/2025, or the doses of Quetiapine Fumarate on 3/22,2025, 3/23/2025, 3/24/2025, 3/25/2025 and 3/27/2025.</p> <p>Nurse #1 was interviewed by phone on 4/2/2025 at 4:27pm. Nurse #1 stated when he worked on 3/21/2025 it was his first and only shift that he worked at the facility. Nurse #1 stated Resident #36 was admitted late in the evening of 3/21/2025 and some of the medications had not arrived from pharmacy in time for the 9:00pm med pass, but arrived in the midnight delivery. Nurse #1 stated he reported to the oncoming shift that not all of Resident #36's medications had arrived from pharmacy. Nurse #1 stated he did not notify a provider regarding the missing medication because the resident had just been admitted .</p> <p>Nurse #3 was interviewed on 4/2/2025 at 6:00pm. Nurse # 3, an agency nurse, stated she was not normally assigned to Resident #36's hall. Nurse #3 stated if a resident did not have a medication that was ordered she would verify the medication had been reordered, indicate on the MAR the medication was not available, add a note in the MAR, and notify the unit manager. Nurse #3 stated that was the only night she had worked with Resident #36 and was unaware the night she worked was the fifth night Resident #36 had not received metoprolol succinate and fourth night Resident #36 did not receive quetiapine fumarate. Nurse #3 stated she normally notified the provider after the first missed dose of medication. Nurse #3 stated if she did not document she had notified the provider, she probably did not notify the provider. Nurse #3 stated she should have notified the provider about the missed medications.</p> <p>Nurse #2 was interviewed by phone on 4/2/2025 at 7:53pm. Nurse #2 verified she had worked with Resident #36 on 3/22/2025, 3/23/2025, and 3/24/2025, and 3/27/2025. Nurse #2 stated she did not notify the provider of the missed doses of metoprolol succinate and quetiapine fumarate because it was the weekend and the on-call providers would say it was a pharmacy issue regarding delivery, not an issue that required a new order or monitoring.</p> <p>During a telephone interview on 4/3/2025 at 10:06am, the Nurse Practitioner (NP) stated he had been notified on the morning of 3/24/2025 through a text chain application on his phone, that Resident #36 had missed doses of two medications over the weekend. The NP stated he was not notified of further missed doses of metoprolol succinate on 3/24/2025 and 3/25/2025, and quetiapine fumarate on 3/24/2025, 3/25/2025, and 3/27/2025. The NP stated the on-call providers on the weekend could have been notified that Resident #36 missed doses of scheduled medications.</p> <p>During an interview on 4/2/2025 at 5:30pm the Director of Nursing (DON) stated she would expect nurses to notify the provider of missed doses of metoprolol succinate and quetiapine fumarate.</p> <p>During an interview on 4/4/2025 at 12:40pm the Administrator stated she would expect the provider to be notified when a nurse became aware a dose of medication was missed.</p> |   |  |

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| <p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>51142</p> <p>Based on record review and staff interviews, the facility failed to provide Registered Nurse (RN) coverage for at least 8 consecutive hours for 6 of 53 days reviewed for staffing (2/15/2025, 3/2/2025, 3/15/2025, 3/16/2025, 3/29/2025, 3/30/2025).</p> <p>Findings included:</p> <p>On 4/1/2025 the Daily Posted Staffing sheet was observed in the front lobby of the facility, it was dated 3/30/2025 and indicated no Registered Nurse (RN) hours for 7am -7pm and 7pm-7a shift.</p> <p>Review of the daily schedule book revealed a calendar from March 2025 labeled RN coverage, which indicated on 2/15/2025, 3/1/2025, 3/2/2025, 3/15/2025, 3/16/2025, 3/29/2025, 3/30/2025 there was RN coverage.</p> <p>Review of daily staffing sheets and posted daily staffing records indicated on 2/15/2025, 3/1/2025,3/2/2025, 3/15/2025, 3/16/2025, 3/29/2025, 3/30/2025 there were no RNs listed on the daily staffing sheets, and no RN hours listed on the posted daily staffing sheets.</p> <p>On 4/2/25 at 3:30pm an interview with the Director of Nursing (DON) stated she was aware there should be 8 consecutive hours of RN coverage daily. The DON stated they had RN coverage and would provide a timecard for the days with missing coverage.</p> <p>The DON provided a timecard that supported on 3/1/2025 there was RN coverage for at least 8 consecutive hours in the facility. There were no additional timecards provided for 2/15/2025, 3/2/2025, 3/15/2025, 3/16/2025, 3/29/2025, 3/30/2025</p> <p>On 4/3/2025 at 12:55pm during a phone interview the current scheduler stated she was aware of the need to have RN coverage on the schedule but was unaware until 4/3/2025 that the coverage had to be for at least 8 consecutive hours. The current scheduler stated she had told the DON previously, when there was no RN coverage, that the DON needed to make rounds. The current scheduler stated that having an RN scheduled for 8 consecutive hours on every other weekend had been difficult since they had only one RN on staff that worked every other weekend, but recently hired a new RN who would be scheduled on the weekend that did not have RN coverage. The current scheduler stated the DON helped her with the schedule and was aware of the days without RN coverage.</p> <p>On 4/3/2025 at 1:05pm during a telephone interview the previous scheduler stated was not aware that there had to be RN coverage for 8 consecutive hours a day. The previous scheduler stated prior to a RN being hired recently it was not uncommon for there to be no RN working on the weekends. The previous scheduler stated the DON helped with the schedule and was aware there were no RNs scheduled on the weekends.</p> <p>(continued on next page)</p> |

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| <p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>During a telephone interview on 4/4/2025 at 12:40pm the Administrator stated she was aware and expected the facility to have RN coverage for at least 8 consecutive hours each day. The Administrator stated she was now aware the facility had days without RN coverage between the dates of 2/7/2025 and 4/4/2025.</p> |   |  |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51142</b></p> <p>Based on record review, Pharmacist, Nurse Practitioner, and staff interviews, the facility failed to prevent a significant medication error when they failed to administer five daily doses of Metoprolol Succinate (medication to treat heart failure) and Quetiapine Fumarate (an antipsychotic medication that helps regulate mood behaviors and thoughts) for 1 of 3 residents reviewed for medications (Resident #36).</p> <p>The findings included:</p> <p>Review of the hospital discharge summary dated 3/20/2025 revealed orders for Metoprolol Succinate 25 milligrams 24 hr tablet. Take 0.5 tablets (12.5 milligram total) by mouth nightly, and Quetiapine 25 milligram tablet. Take 1 tablet (25mg total) by mouth nightly.</p> <p>Resident #36 was admitted to the facility on [DATE] with diagnoses that included chronic systolic (congestive) heart failure, type 2 diabetes mellitus with diabetic peripheral angiopathy (the presence of diabetes which involves damage to the blood vessels particularly to the extremities), hypertensive heart disease with heart failure, unspecified dementia with agitation.</p> <p>Review of Resident #36's medical record revealed on 3/21/2025 the Assistant Director of Nursing (ADON) entered admission orders for Resident #36 into the electronic medical record, which included Metoprolol Succinate, and Quetiapine Fumarate.</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 had moderate impairment in cognition.</p> <p>The MDS indicated Resident #36 received an antipsychotic medication during the assessment reference period.</p> <p>A physician order dated 3/25/2025 read Metoprolol Succinate ER tablet Extended Release 24 hour 25 milligrams. Give 0.5 (half) tablet by mouth at bedtime HOLD if heart rate less than 60 beats per minute.</p> <p>Review of Resident #36's medication administration record (MAR) dated March 2025 revealed the following:</p> <p>a. Documented by Nurse #1 that on 3/21/2025 Resident #36 did not receive the metoprolol due to the medication not being available.</p> <p>b. Documented by Nurse #2 that on 3/22/2025, 3/23/2025, 3/24/2025, Resident #36 did not receive the dose of Metoprolol Succinate ER or Quetiapine Fumarate due to the medication not being available. Nurse #2 documented on 3/27/2025 Resident #36 did not receive Quetiapine Fumarate due to medication not being available.</p> <p>c. Documented by Nurse #3 that on 3/25/2025 Resident #36 did not receive the dose of Metoprolol Succinate ER or Quetiapine Fumarate due to the medication not being available.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Review of Resident #36's medical record revealed multiple electronic Medication Administration Record (eMAR) progress note regarding Metoprolol Succinate and Quetiapine Fumarate which included:</p> <p>An eMAR progress note dated 3/21/2025 at 10:28 pm written by Nurse #1 read Metoprolol Succinate ER Tablet by mouth at bedtime for heart. Awaiting pharmacy.</p> <p>An eMAR progress note dated 3/22/2025 at 10:13 pm written by Nurse #2 read Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 milligram. Give 0.5 (half) tablet by mouth at bedtime for heart on order.</p> <p>An eMAR progress note dated 3/22/2025 at 10:13 pm written by Nurse #2 read Quetiapine Fumarate Tablet 25 milligram. Give one tablet by mouth at bedtime for confusion on order.</p> <p>An eMAR progress note dated 3/23/2025 at 10:30 pm written by Nurse #2 read Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 milligrams. Give 0.5 (half) tablet by mouth at bedtime for heart on order.</p> <p>An eMAR progress note dated 3/23/2025 at 10:30 pm written by Nurse #2 read Quetiapine Fumarate Tablet 25 milligram. Give one tablet by mouth at bedtime for confusion on order.</p> <p>An eMAR progress note dated 3/24/2025 at 10:47 pm written by Nurse #2 read Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 milligrams. Give 0.5 (half) tablet by mouth at bedtime for heart on order.</p> <p>An eMAR progress note dated 3/24/2025 at 10:47 pm written by Nurse #2 read Quetiapine Fumarate Tablet 25 milligram. Give one tablet by mouth at bedtime for confusion on order.</p> <p>An eMAR progress note dated 3/25/2025 at 10:19 pm written by Nurse #3 read Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 milligrams. Give 0.5 (half) tablet by mouth at bedtime for heart HOLD IF Heart Rate &lt;60 beats per minute waiting for delivery from pharmacy.</p> <p>An eMAR progress note dated 3/25/2025 at 10:20 pm written by Nurse #3 read Quetiapine Fumarate Tablet 25 milligram. Give one tablet by mouth at bedtime for confusion Waiting for delivery from pharmacy.</p> <p>An eMAR progress note dated 3/27/2025 at 10:11 pm written by Nurse #2 read Quetiapine Fumarate Tablet 25 milligram. Give one tablet by mouth at bedtime for confusion on order.</p> <p>Review of Resident #36's vital signs contained in the electronic medical record from 3/21/2025 through 3/31/2025 revealed Resident #36's heart rate and blood pressure were within normal limits.</p> <p>Review of Resident #36's medical record revealed visit notes from the Nurse Practitioner dated on 3/24/2025 and 3/25/2025 which read in part Heart is regular in both rate and rhythm and on 3/25/2025 which read in part resident is calm, smiling and in good spirits.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During a telephone interview on 4/2/2025 at 10:59 am Pharmacist #1 stated, it was significant if a resident missed Metoprolol Succinate for five days because it could cause elevated blood pressure and had the potential to worsen heart failure. Pharmacist #1 stated missing quetiapine fumarate for five of seven days was not as significant. Pharmacist #1 stated if a new order was not entered when a resident was admitted the pharmacy would not be aware to send the medication to the facility.</p> <p>During a telephone interview on 4/3/2025 at 12:05 pm the Assistant Director of Nursing (ADON) stated she started at the facility in January of 2025 and was new to long term care. The ADON stated she was still learning but she did try to help the unit managers and enter orders for new admissions. The ADON stated she reviewed Resident #36's hospital records on 3/21/2025 and she entered some new orders and reactivated Resident #36's orders in the electronic health record for Metoprolol Succinate and Quetiapine Fumarate from a previous admission in January 2025. The ADON stated she thought if a resident had an old order in the pharmacy system that was the same, the old order could be reactivated, and a new date added. The ADON stated on 3/21/2025 she had entered new orders and reactivated several old orders in the electronic medical record for Resident #36, which included Metoprolol Succinate and Quetiapine The ADON stated the Director of Nursing had told the ADON on the morning of 4/3/2025 that old orders could no longer be updated, that new orders had to be entered.</p> <p>During a telephone interview on 4/2/2025 at 4:27 pm, Nurse #1 stated he was an agency nurse and 3/21/2025 was the only day he worked at the facility. Nurse #1 stated Resident #36 was admitted to the facility on the evening of 3/21/2025 and at the 9:00 pm medication pass, not all of Resident #36's medications had been received from the pharmacy. Nurse #1 stated after the midnight pharmacy delivery, not all of Resident #36's medications had arrived. Nurse #1 stated he reported that to the oncoming nurse for first shift regarding the medication that had not been delivered. Nurse #1 thought Resident #36's medication had not been delivered since she had just been admitted . Nurse #1 stated since he was an agency nurse, and it was his first shift he was unaware of the process for using the pyxis (back up supply of medication).</p> <p>Nurse #3 was interviewed on 4/2/2025 at 6:00 pm. Nurse #3 stated she was an agency nurse and was not normally assigned to the hall Resident #36 was on. Nurse #3 stated if a resident did not have a medication that was ordered, she would verify the medication had been reordered and indicate on the eMAR the medication was not available, indicated by the number 9, then make a note in the MAR, and notify the unit manager. Nurse #3 stated 3/25/2025 was the only night she was assigned to work with Resident #36. Nurse #3 stated she did not notify the provider. Nurse #3 stated she did not recall if she had notified the unit manager, since a new order had been written on 3/25/2025 and was supposed to be delivered. Nurse #3 stated she was not aware the medication had been missed on previous shifts. Nurse #3 was aware that some staff nurses had access to the pyxis, she did not know which ones. Nurse #3 was not aware she could call the on-call nurse to pull medication from the pyxis.</p> <p>Nurse #2 was interviewed on 4/2/2025 at 7:53 pm and verified she had worked with Resident #36 on 3/22/2025, 3/23/2025, 3/24/2025 and 3/27/2025. Nurse #2 stated if she had entered a number 9, in the eMAR, that the medication was not given and there would be a note to correspond with the reason the medication was not administered. Nurse #2 stated she did not have access to the pyxis since she was an agency nurse. Nurse #2 stated she knew some non-agency nurses had access that worked on other halls, but she did not ask them to pull medication from the pyxis. Nurse #2 stated Resident #36's medication would not be in pyxis because the medications in the pyxis were specific to each resident, not general medications.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0801</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>                                   | <p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>45380</p> <p>Based on staff interviews, the facility failed to employ a director of food and nutrition services that met the minimum qualifications, and it affected 108 of 111 residents.</p> <p>Findings included:</p> <p>On 04/01/2025 at 11:00 AM, the Assistant Dietary Supervisor was interviewed and revealed that he did not have any of the following: certification as a dietary manager or food manager, national certification for food service management and safety, an associate's or higher degree in food service management or in hospitality, 2 or more years of experience in the position of Director of Food and Nutrition Services in a nursing facility setting. The Assistant Dietary Supervisor stated that he did have a dietician that he could consult and call if needed. He revealed that he had been at this facility in this kitchen for a little over six months and that he left for a while and then came back.</p> <p>On 04/01/2025 at 11:56 AM, an interim Dietary Manager at a sister facility was interviewed and stated that she was a Certified Dietary Manager and a Certified Food Protection Professional. She stated that she was at the facility once weekly to help the Assistant Dietary Supervisor. She denied having any regular scheduled meetings with the facility Assistant Dietary Supervisor, but he could call her if needed. She added that she had recently resigned her position and her last day with the company would be 4/16/25.</p> <p>An Administrator interview on 04/04/2025 at 12:40 PM revealed that she was aware of the facility's need to have a certified Dietary Manager. She stated they had hired a certified Dietary Manager that was supposed to have started on 3/25/25 but was unable to start her position on that date due to a family emergency and was scheduled to start her position the week of 4/07/2025. She revealed in the meantime, an interim Dietary Manager from their sister facility had been coming to their facility at least once a week to oversee the kitchen and assist their Assistant Dietary Supervisor. The Administrator stated they also had a Registered Dietician they consulted with and could call if needed.</p> <p>A telephone interview with the Administrator on 04/16/25 at 2:12 PM revealed the certified Dietary Manager they had hired and was scheduled to begin her position the week of 04/07/2025 did not show and they rescinded the job offer. She stated they had made a job offer to another certified Dietary Manager this past week and were in the process of completing a criminal background and dietary certification check. She revealed as long as the criminal background and dietary certification checks cleared, they were hoping the new certified Dietary Manager would be able to start her position next week or the following week. The Administrator stated in the meantime, an interim Dietary Manager from their sister facility would continue coming to their facility at least once a week to oversee the kitchen and assist their Assistant Dietary Supervisor and their Registered Dietician would also be available for consultation if needed.</p> |   |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>345163   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing  | (X3) DATE SURVEY COMPLETED<br><br>04/16/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Glenbridge Health and Rehabilitation   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>211 Milton Brown Heirs Road<br>Boone, NC 28607 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |   |  |
| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45380</p> <p>Based on observations and staff interviews, the facility failed to remove expired food and failed to date perishable food stored for use in 1-of-1 walk-in cooler. This practice had the potential to affect food served to residents.</p> <p>The findings included:</p> <p>During the initial tour of the kitchen on [DATE] from 10:45 AM to 11:00 am an observation with the Assistant Dietary Supervisor of the walk-in cooler revealed the following:</p> <ul style="list-style-type: none"> <li>- a plastic container sealed with plastic wrap dated [DATE] that was one quarter full of chicken breasts with seasoning dated [DATE]</li> <li>- a plastic container sealed with plastic wrap dated [DATE] that was half full of chicken noodle soup that had started to separate</li> <li>- a plastic container sealed with plastic wrap dated [DATE] that was half full of creamed corn</li> <li>- a metal tray of seven tuna salad sandwiches sealed with aluminum wrap with no date</li> <li>- a metal tray of 10 bologna sandwiches sealed with plastic wrap dated [DATE]</li> </ul> <p>The Assistant Dietary Supervisor observed on [DATE] at 11:15 AM the food stored inside of the walk-in cooler that were expired and perishable food items not dated. He revealed the process for food storage was making sure all foods were sealed, labeled, and dated with an opened date and discard date. He verbalized all food dates should be checked by all dietary staff on a regular basis and any expired foods should be properly discarded. He indicated she would have the food items discarded.</p> <p>An interview with the interim Dietary Manager on [DATE] at 12:00 PM revealed all food items should be sealed, labeled, and dated when being stored. She stated dietary staff should be checking food items on a regular basis and discard any items that are not sealed, labeled, dated, or have expired immediately.</p> <p>An interview with the Administrator on [DATE] at 12:40 PM revealed all dietary staff had been educated on food storage. She stated all food should be labeled, sealed, dated, and expired foods should be discarded immediately.</p> |   |  |