

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  34A001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/15/2024
NAME OF PROVIDER OR SUPPLIER  Black Mountain Neuro-Medical Treatment Center		STREET ADDRESS, CITY, STATE, ZIP CODE 932 Old US Highway 70 Black Mountain, NC 28711	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37538</b></p> <p>Based on record review and interviews with staff and the Nurse Practitioner, the facility failed to protect the resident's right to be free from neglect when Nurse Aide (NA) #1 started providing incontinence care for Resident #2 without assistance and was aware of the plan of care instructions for 2-person assist. NA #1 turned away from the bed to reach supplies and Resident #2 rolled off the raised bed onto the fall mat. The deficient practice occurred for 1 of 3 residents reviewed for abuse (Resident #2).</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on [DATE] with diagnoses including traumatic brain injury and osteoporosis.</p> <p>The activities of daily living (ADL) care plan dated 2/21/24 identified Resident #2 was unable to complete ADL without assistance and for nursing staff to refer to the resident's care tracker profile for current recommendations. The care plan further noted Resident #2 was non-ambulatory but had the ability and did slide down but was unable to reposition herself and at risk for falls related to the use of psychotropic medications, incontinence, a history of falls, and poor safety awareness. Interventions included eliminate potential hazards as needed, provide toileting and change every 2 hours and as needed and place the bed in a low position with fall mats at the bedside.</p> <p>Review of the facility's online resident plan of care called care tracker utilized by Nurse Aide (NA) staff to ensure they provide the level of assistance needed for ADL care, revealed Resident #2 required 2-person extensive assistance for incontinence care and bed mobility.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was severely impaired cognitively, always incontinent of bladder and bowel, and needed substantial to maximal assistance with rolling from the left to the right and toileting hygiene. The MDS indicated one fall with no injury had occurred since Resident #2's last assessment.</p> <p>Review of the fall incident report dated 6/25/24 at 9:15 AM revealed NA #1 had changed Resident #2 in the bed and as she turned away to grab some wipes the resident rolled off the bed and onto the floor. The incident report noted Resident #2 rolled onto her back on the fall mat, denied pain, and the physician was notified. The report was completed by Nurse #1.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Nurse #1's progress notes dated 6/25/24 revealed at 9:15 AM Resident #2 fell from the bed and rolled onto the bedside mat. The fall was witnessed and there were no injuries noted. Resident #2 denied pain and did not demonstrate signs of pain. The Nurse Practitioner (NP) was notified of the fall and ordered an x-ray of lumbar (L) spine (lower part of the back) and to give as needed pain medication as ordered.</p> <p>During an interview on 08/14/24 at 1:14 PM Nurse #1 revealed NA #1 notified him Resident #2 had rolled out of bed and when he asked how it happened NA #1 said, I was changing her. Nurse #1 asked how that happened because the resident was 2-person assist and stated NA #1 told him, she did it by herself and when she reached for the wipes Resident #2 rolled herself off the bed. Nurse #1 did a head-to-toe assessment and stated Resident #2 did not have any signs of injury or complaints of pain after the fall and he notified the Nurse Supervisor. Nurse #1 revealed Resident #2 was known for rolling herself out of bed and would slowly inch herself out of the bed onto the floor. Nurse #1 revealed staff were provided in-service education to always have 2 people for check and change care for all residents requiring 2-person assistance.</p> <p>Review of the facility's self-reported incident dated 6/25/24 at 9:15 AM revealed the facility became aware and submitted an allegation of neglect to the state agency that involved NA #1 and Resident #2. The report revealed NA #1 started to provide 1-person assistance with incontinence care for Resident #2 who required 2-person assist, and as a result the resident fell from the bed. NA#1 was placed on leave on 6/25/24 for the facility to complete an investigation of the incident. The facility's 5-day investigation revealed NA #1 reported she was providing 1-person assist even though she was aware Resident #2 required 2-person assistance and the allegation of neglect was substantiated. Both the initial and 5-day reports were completed by the Nurse Supervisor.</p> <p>Review of NA #1's written statement dated 6/25/24 revealed she was interviewed by the Nurse Supervisor and read in part, I went into Resident #2's room to change her. NA #2 was in the bathroom changing another resident. I pulled the covers back and undid the brief and reached behind me on the dresser for wipes and Resident #2 rolled off the bed onto the mat. Resident #2 said I rolled off. NA #2 turned on the call light and Nurse #1 came in, so I told him what happened. NA #3 walked by, I called her into the room, and she called NA #2 in the room.</p> <p>During an interview on 8/14/24 at 8:28 AM NA #1 stated she had started incontinence care for Resident #2 and described the resident had taken part of the brief off, had a bowel movement, and she was getting Resident #2 prepared for incontinence care. NA #1 explained Resident #2 was laying on her back and it was after she had elevated the bed and turned away towards the dresser, that was close to the bed, when Resident #2 rolled herself off the bed. NA #1 revealed she was aware Resident #2 had a history of rolling herself off the bed. Prior to the fall NA #1 had reviewed the care tracker plan of care and stated she knew Resident #2 was a 2-person assist with incontinence care and NA #2 had said she would be right back to help. After the fall NA #1 turned the call light on and Nurse #1 came into the room and checked Resident #2 for injury. NA #1 revealed the Nurse Supervisor spoke to her about the incident and explained Resident #2 needed 2-person assistance and it was expected a partner was with her. NA #1 stated she wasn't attempting to change Resident #2 by herself she was just getting the resident ready.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of NA #2's written statement dated 6/25/24 revealed she was in the bathroom changing another resident and she did not know anything was happening and never heard NA #1 call for help or anything. Her statement indicated the only reason she found out was when NA #3 came out of the room and asked for help to get Resident #2 off the floor.</p> <p>During an interview on 08/14/24 at 3:53 PM NA #2 stated NA #1 did not ask her for help with incontinence care and she didn't even know NA #1 was in the room with Resident #2 when the fall happened. She described being in the bathroom that adjoined Resident #2's room and she was providing care for another resident. When NA #2 was finished she came out of that room and saw NA #1 and two other staff members (she did not recall) in the room, and Resident #2 was laying on the mat on the floor beside the bed. NA #2 revealed she did receive in-service education after the fall related to Resident #2's care plan for 2-person assistance with incontinence care and where to locate that information in care tracker. NA #2 stated she knew Resident #2 needed 2-person assistance with incontinence care prior to the fall and after it happened, she was monitored by her supervisor who checked if 2-person assistance was being provided during care.</p> <p>Review of NA #3's written statement dated 6/25/24 revealed she had gone on break, and it was approximately 9:00 AM or 9:15 AM when she came back on the floor. She stopped NA #2 in the hall and asked what residents needed to be checked and changed then went right to Resident #2's room. She saw NA #1 standing by the resident who was lying beside the bed on a mat and asked if the nurse was needed. NA #1 said Nurse #1 had already been in the room to check Resident #2. She called NA #2 for help with transferring and they along with other staff put Resident #2 back to bed. She and NA #1 then provided incontinence care for Resident #2.</p> <p>During a phone interview on 08/13/24 at 6:10 PM NA #3 revealed when she entered Resident #2 's room on 6/25/24, she saw the resident laying on her back on the mat on the floor and NA #1 was in the room. She asked NA #1 what happened and was told when she reached for the wipes the resident rolled herself off the bed. NA #3 stated at times Resident #2 would roll herself off the bed and prior to the fall was a 2-person assist with incontinence care. After the fall her and the other nursing staff used the mechanical lift to transfer Resident #2 back to bed. NA #3 revealed 6/25/24 was her last shift and she did not recall receiving training afterward the fall but upon hire her training included where to locate residents' level of assistance needed when providing care on their care tracker profile for activities of daily living and always have a nurse or another NA available to assist with 2-person check and change if required.</p> <p>Review of the x-ray results for Resident #2 completed on 6/25/24 revealed no acute fracture was identified.</p> <p>During an interview on 08/15/24 at 11:35 AM the Nurse Practitioner (NP) revealed she was notified on 6/25/24 and ordered the x-ray due to Resident #2's diagnosis of osteoporosis (deterioration of bone tissue). She revealed the Medical Doctor saw Resident #2 the next day on 6/26/24 and noted there was no complaint of pain and reviewed the x-ray results with no acute fracture identified.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/14/24 at 10:15 AM the Nurse Supervisor confirmed he was informed about the fall on 6/25/24 at 9:15 AM. He spoke with Nurse #1 first and asked who was with NA #1 when the fall occurred and was told no one. He spoke with NA #1 and asked who was with her to help provide care and NA #1 stated nobody came in to help her and at the time of the fall NA #2 was assisting another resident with toileting and NA #3 was on break. The Nurse Supervisor confirmed NA #1 told him she had asked NA #2 to help, and he questioned her about that statement because NA #2 was assisting another resident. He asked NA #1 if she was aware Resident #2 needed 2-person assistance with incontinence care and she stated yes. NA #1 had explained she checked Resident #2 and realized incontinence care was needed and when she turned to get the brief and wipes, that's when she heard Resident #2 rolling out of bed. The Nurse Supervisor confirmed NA #1 had raised the bed and was getting Resident #2 ready for incontinence care. He described Resident #2 did have a history of putting herself on the floor and would put her feet over the side of the bed and slide to the floor and was not able to make good choices for her safety. They considered NA #1's actions neglect as she made a poor decision about her time management, and it was poor conduct on her part, and she was removed from the unit and sent home on 6/25/24. He reported the fall to the Administrator, and their investigation determined it was a policy violation when Resident #2's care plan was in place to provide 2-person assistance with incontinence care and NA #1 started the care without a second person present. NA #2 returned to work third shift on 6/27/24 and was counseled and provided training along with all nursing staff related to 2-person assistance. The Nursing Supervisor revealed observations were made of 2-person care to ensure it was done correctly and it was emphasized not to start care without a second person with you.</p> <p>During an interview on 08/15/24 at 4:55 PM the Administrator was aware of Resident #2's behavior of putting herself on the floor and explained the fall occurred because NA #1 was doing 1-person care for the resident when the care plan was to provide 2-person assist. She stated adaptive equipment was already in place for fall preventions and neglect was clear when 2-person assist was not done based on the care plan. She revealed Quality Assurance and Performance Improvement (QAPI) implemented a plan of correction on 6/25/24 that included training and audits of all staff on each shift to look for areas staff needed more support and if needed ongoing training was provided.</p> <p>The facility provided the following corrective action plan with a completion date of 7/2/24:</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>On 6/25/24 the nurse immediately assessed Resident #2 for injury. The Nurse Supervisor provided training on 2-person care for Nurses and Nurse Aide staff on the unit where the fall occurred. The training elements and objectives included: ensure safety and dignity of residents and provide proper and safe resident care; review of location of ADL assistance information (Care Tracker Profile and Messages, Community Updates, and Care Plan). When providing care, know the level of assistance needs for residents in their Care Tracker profile prior to providing care and asking coworkers for assistance when appropriate. A Physical Therapy (PT) evaluation of Resident #2's mattress type and fall mats was completed on 6/25/24 to ensure safety measures for activities of daily living care were in place.</p> <p>How corrective action will be accomplished for the residents having the potential to be affected by the same deficient practice:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Training was implemented on 6/25/24 for all unit staff Nurses and Nurse Aides including temporary agency staff on 2-person care that included elements and objectives to ensure safety and dignity of residents and provide proper and safe resident care; review of location of ADL assistance information (Care Tracker Profile and Messages, Community Updates, and Care Plan); when providing care, know the level of assistance needs for residents in their Care Tracker prior to providing care and asking coworkers for assistance when appropriate. Nurse Supervisors were educated and provided with audit tasks on 6/25/24. Audits started on 6/25/24 for residents who require 2-person care and were conducted by each Nurse Supervisor three times per shift for 1 week. Audits included review of the following: the individualized Care Plan, utilization of correct transfers, following all safety measures on transferring and repositioning, and maintaining dignity. Issues identified during audits immediate training was completed with that staff. The projected completion date of the audits was 7/2/24 and reported to Quality Assurance (QA).</p> <p>Measures that will be put into place and/or what systematic changes will be made to ensure that the deficient practice does not recur:</p> <p>On 6/26/24 any unit-based Nurses and Nurse Aides including agency staff who were unavailable (vacation, sick, etc.) were trained prior to starting their next scheduled shift. New Hires are trained on 2-person care on the first day of hire by PT and Occupational Therapy. Additional on-unit training occurs for the first 2 weeks of employment which includes return demonstration. Weekly Community Update Meetings for unit staff occur on all 3 units and 3 shifts to train on any Care Plan changes.</p> <p>How will the facility monitor performance to ensure that solutions are sustained.</p> <p>QA was implemented on the date of the incident 6/25/24 when the Plan of Correction was established. Two-person care was added to QA standing agenda and reported by the Assistant Director of Nursing (ADON) for compliance with 2-person care at each QA meeting. Audits were completed from 6/25/24 to 7/2/24 and ongoing for report to QA. QA audits will be required for 12 months.</p> <p>Date of completion: 7/2/24.</p> <p>The facility's corrective action plan with a completion date of 7/2/24 was validated onsite on 8/14/24 and 8/15/24 by record review, observations and staff interviews.</p> <p>Review of the nursing staff in-service training started on 6/25/24 included the objective was to provide proper and safe resident care and the goal was to know the level of assistance needed by residents and where to find that information on the care tracker profile. In-service training included names, signature acknowledgement and dates. The training encompassed all three units and nursing staff on first, second, and third shifts.</p> <p>Review of the check and change audits started on 6/25/24 included all three units and nursing staff on first, second, and third shift. Observations included: did staff follow the individualized care plan, was the correct transfer device used, was safety measures followed while transferring/repositioning the resident, was dignity maintained throughout the interaction, and was staff teaching performed for any discrepancies noted during care.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation was conducted on 08/14/24 at 12:51 PM of two NA staff assist Resident #2 with bed mobility, incontinence care, and mechanical lift transfer to the chair. The two NA staff entered the room together and one stood at each side of the bed at the start of care. Resident #2 was rolled towards the NA to help prevent a fall from the bed. Fall mats were placed on the floor by both sides of the bed prior to care.</p> <p>During interviews nurses and NA staff confirmed they received in-service training to review the resident's care plan information on care tracker that included if 2-person assistance was required and always have a nurse or another NA to assist, and if not available to wait for a second person before starting care. Nurses and NA staff revealed audits were randomly done to ensure they provided 2-person assistance.</p> <p>The completion date of 7/02/24 was validated.</p>		

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<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> 37014</p> <p>Based on observations and staff interviews the facility failed to discard food items past the use by date in 1 of 2 reach-in coolers; discard food with signs of spoilage in 2 of 2 walk-in coolers; and label and date two bags of unidentifiable frozen food items that had been removed from the original container in 1 of 1 reach-in freezer. This failure had the potential to affect food served to residents.</p> <p>Findings included:</p> <p>a. An observation with the Food Service Director of the reach-in cooler on [DATE] at 9:27 AM revealed the following:</p> <p>A package of sliced white cheese with an opened date of [DATE].</p> <p>A package of sliced yellow cheese with an opened date of [DATE].</p> <p>A 4.5 ounce jar of minced garlic with an open date of [DATE].</p> <p>A package of sliced provolone cheese with an opened date of [DATE].</p> <p>A bag of grated parmesan cheese with an opened date of [DATE].</p> <p>A 16-ounce container of chicken base stock with an opened date of [DATE].</p> <p>A one-pound package of sliced ham with an opened date of [DATE].</p> <p>During interviews on [DATE] at 9:30 AM and [DATE] at 10:10 AM, the Food Service Director revealed for prepared food items, the use-by date was 3 days from the date prepared and for other items, the use-by-date was 7 days from the date the food item was opened. The Food Service Director stated dietary staff were responsible for checking their assigned coolers daily and discarding any food items that were past the 7-day use-by-date.</p> <p>During an interview on [DATE] at 4:29 PM, the Administrator revealed she expected dietary staff to discard food items that were expired or with visible signs of spoilage.</p> <p>b. An observation with the Food Service Director of the walk-in coolers on [DATE] at 09:40 AM revealed the following:</p> <p>One half of a 5-pound block of ham covered with plastic wrap and dated [DATE].</p> <p>A box containing several red onions that had visible white spots with fuzzy matter.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interviews on [DATE] at 9:30 AM and [DATE] at 10:10 AM, the Food Service Director revealed for prepared food items, the use-by date was 3 days from the date prepared and for other items, the use-by date was 7 days from the date the food item was opened. The Food Service Director stated dietary staff were responsible for checking their assigned coolers daily and discarding any food items that were past the 7 day use-by-date or had visible signs of spoilage.</p> <p>During an interview on [DATE] at 4:29 PM, the Administrator revealed she expected dietary staff to discard food items that were expired or with visible signs of spoilage.</p> <p>c. An observation with the Food Service Director of the walk-in cooler on [DATE] at 09:45 AM revealed on the shelf were two small, clear bags containing frozen food items that were not labeled with the product name or dated.</p> <p>During interviews on [DATE] at 09:30 AM and [DATE] at 10:10 AM, the Food Service Director revealed for prepared food items, the use-by date was 3 days from the date prepared and for other items, the use-by date was 7 days from the date the food item was opened. The Food Service Director stated dietary staff were responsible for labeling and dating food items when removed from the original container.</p> <p>During an interview on [DATE] at 4:29 PM, the Administrator revealed she expected dietary staff to label and date food items when opened.</p>		