STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525497	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines Post Acute and Memory Care	1625 E Main St Clintonville, WI 54929

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure 1 resident (R) (R21) of 16 sampled residents had a call light within reach and was provided hearing aids. On 7/16/25, R21 was in R21's room without access to a call light or a means to notify staff if assistance was needed. In addition, R21 did not have hearing aids in either ear on 7/15/25. Findings include:From 7/15/25 to 7/17/25, Surveyor reviewed R21's medical record. R21 was admitted to the facility on [DATE] and had diagnoses including hemiplegia (paralysis on one side of body) and hemiparesis (weakness on one side of the body) following a stroke affecting the left non-dominant side, anxiety, chronic pain, asthma, and neuromuscular dysfunction of bladder with urinary incontinence. R21's Minimum Data Set (MDS) assessment, dated 4/29/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R21 had intact cognition. The MDS assessment also indicated R21 had hearing aids. R21 had a Guardian who assisted with healthcare decisions.R21's plan of care indicated R21 was at risk for falls related to left hemiparesis and contained interventions to be sure the call light was within reach and encourage R21 to use the call light to call for assistance. R21's plan of care also indicated R21 was at risk for impaired visual function but did not indicate R21 had impaired hearing. On 7/15/25 at 11:00 AM and 11:18 AM, Surveyor interviewed R21 who stated, Sometimes they (staff) put my call light on my left side where I can't reach it. They do it on purpose. I have a reacher and I have to be creative to reach the things I need. R21 also indicated R21 had two hearing aids that were not very good ones. Surveyor noted R21 did not have hearing aids in either ear. R21 indicated R21 was not wearing hearing aids because staff did not put them in. R21 stated R21 had to ask staff to put them in.On 7/16/25 at 11:49 AM, Surveyor observed Certified Nursing Assistant (CNA)-I provide cares for R21. CNA-I left the room and was halfway down the hallway when Surveyor informed CNA-I that R21's call light was hung on the left bedrail and out of R21's reach.On 7/16/25 at 11:57 AM, Surveyor interviewed CNA-I who verified the call light was not within R21's reach. CNA-I then placed the call light on R21's abdomen.On 7/16/25 at 1:25 PM, Surveyor interviewed Director of Nursing (DON)-B who verified R21's plan of care did not address hearing/hearing aids. DON-B also verified R21's MDS assessment indicated R21 had hearing aids and agreed R21 should have had a care plan for hearing/hearing aids. On 7/17/25 at 10:45 AM, Surveyor interviewed DON-B who verified R21's call light should have been within reach due to R21's limited mobility from a stroke that affected the left upper extremity. DON-B indicated the facility did not have a call light policy and stated it was a standard of care that call lights need to be within residents' reach.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure a written transfer and/or bed hold notice or Ombudsman notification was provided when 2 residents (R) (R45 and R47) of 2 sampled residents transferred to the hospital and/or discharged from the facility.R45 was transferred to the hospital on 4/14/25 and 5/13/25. Neither R45 or R45's Guardian were provided a written transfer notice. R45 was also transferred to the hospital on 4/29/25. Neither R45 or R45's Guardian were provided a written transfer or bed hold notice. In addition, the Ombudsman was not notified of the transfers or R45's discharge from the facility following the 5/13/25 hospital transfer.R47 was discharged to an assisted living facility on 5/12/25. The Ombudsman was not notified of the discharge. Findings include:The facility's Admission/Discharge/Transfer: Subject: Bed Hold - Transfer/Discharge - Ombudsman notification policy, revised 7/17/25, indicates: It is the policy of this facility to inform the resident or the resident's representative in writing of the right to exercise the bed hold provision of 15 days upon admission and before transfer to a general acute care hospital .A written transfer/discharge notice must be completed at the time of transfer or discharge and the Ombudsman is to be notified of all transfers and discharges. A copy of the bed hold notification along with the transfer/discharge notice shall become a part of the resident's health record at the time of transfer .each transfer/discharge notice shall include: The reason for the transfer or discharge, the right to appeal the transfer or discharge, and the contact information of the state Ombudsman and the Disability Rights Commission.1. From 7/15/25 to 7/17/25, Surveyor reviewed R45's medical record. R45 was admitted to the facility on [DATE] and had diagnoses including stroke affecting the left non-dominant side, seizures, and depression. R45's Minimum Data Set (MDS) assessment, dated 4/22/25, had a Brief Interview for Mental Status (BIMS) score of 2 out of 15 which indicated R45 had severely impaired cognition. R45 had a Guardian for healthcare decisions.On 4/14/25, R45 was transferred to the hospital following a fall. R45 was diagnosed with an intraventricular hemorrhage in the posterior right ventricle (brain bleed). R45's medical record did not not indicate a written transfer notice was provided to R45 or R45's Guardian or that the Ombudsman was notified of the transfer.On 4/29/25, R45 was transferred to the hospital and diagnosed with a complicated urinary tract infection (UTI). R45 returned to the facility the same day. R45's medical record did not indicate a written transfer or bed hold notice was provided to R45 or R45's Guardian or that the Ombudsman was notified of the transfer.On 5/13/25, R45 was transferred to the hospital and diagnosed with pneumonia. R45 did not return to the facility. R45's medical record did not indicate a transfer notice was provided to R45 or R45's Guardian or that the Ombudsman was notified of the transfer and discharge.On 7/17/25 at 11:16 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who was not aware that a transfer notice should be completed for residents who are transferred to the hospital. NHA-A verified R45 and R45's Guardian were not provided with a written transfer and/or bed hold notice and the Ombudsman was not notified. On 7/17/25 at 12:36 PM, Surveyor interviewed Director of Nursing (DON)-B who verified neither R45 or R45's Guardian were provided a bed hold notice for R45's 4/29/25 hospital transfer. DON-B indicated the Ombudsman notifications for May were missed.2. From 7/15/25 to 7/17/25, Surveyor reviewed R47's medical record. R47 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, cognitive communication deficit, epilepsy, and history of repeated falls. R47's MDS assessment, dated 3/31/25, had a BIMS score of 4 out of 15 which indicated R47 had severely impaired cognition. R47 had a Guardian for healthcare decisions.On 5/12/25, R47 was discharged to an assisted living facility. R47's medical record did not indicate the Ombudsman was notified of the discharge. On 7/17/25 at 1:20 PM, Surveyor interviewed NHA-A who verified Ombudsman transfer and discharge notifications were missed in May and were sent on 7/17/25.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, staff interview, and record review, the facility did not ensure the resident environment was as free of accident hazards as possible for 1 resident (R) (R10) of 4 sampled residents.R10 had a fall with injury on 6/6/25. Following the fall, the facility did not implement or add physical therapy recommendations to R10's plan of care to prevent future falls or injury.Findings include:The facility's Nursing Clinical Safety Assessment-Falls policy, revised 1/2025, indicates: It is the policy of this facility to evaluate extent of injury after a fall and prevent complications .16. If there is an existing plan of care in the resident's medical record pertaining to falls, it must be updated to reflect newly identified risk factors and approaches . On 7/15/25, Surveyor reviewed R10's medical record. R10 had diagnoses including dementia, diabetes mellitus type 2, unsteadiness on feet, long term use of anticoagulants, and general weakness. R10's Minimum Data Set (MDS) assessment, dated 5/20/25, had a Brief Interview for Mental Status(BIMS) score of 3 out of 15 which indicated R10 had severely impaired cognition. R10 had an activated Power of Attorney for Healthcare (POAHC). A progress note, dated 6/6/25, indicated the writer was outside R10's room and heard R10 say R10 needed to use the restroom badly. The writer saw R10 sit up on R10's bed, lock the walker, and stand. R10 was wearing gripper socks. R10 started to walk toward the bathroom and left the writer's view. R10 yelled that R10 had fallen and hit R10's head. The walker was observed on top of R10's chest. When the writer asked if R10 had moved too fast and lost R10's footing, R10 indicated that must have been what happened. R10 reported pain and the writer observed redness on the left side of R10's forehead. R10's vital signs were within normal limits. Staff assisted R10 up and R10 walked to bed with the walker. R10 then used the restroom with the assistance of staff. An Interdisciplinary Team (IDT) note, dated 6/9/25, indicated the fall occurred on 6/6/25 and R10 was referred for physical therapy (PT) and occupational therapy (OT) with an authorization date of 6/17/25.A care plan, dated 6/11/25, indicated R10 was independent or needed limited assistance with ambulation with a walker in R10's room. R10 was independent with wheelchair mobility and used an assistive device-walker, wheelchair. R10 was independent or needed limited assistance with transfers. The care plan contained interventions to provide supportive care and assistance with mobility as needed and document assistance as needed. A therapy referral was ordered. A Fall Risk Evaluation, dated 6/12/25, indicated R10 was at moderate risk for falls. Surveyor noted R10's transfer and ambulation statuses were not updated following the therapy referral on 6/17/25. On 7/17/2025 at 8:15 AM, Surveyor interviewed Director of Rehabilitation (DOR)-G who indicated R10 currently worked with OT and was discharged from PT on 7/14/25. DOR-G confirmed PT/OT was ordered due to a fall on 6/6/25 and indicated the goal was to get R10 back to independent with transfers and ambulation. DOR-G confirmed R10 required the assistance of one staff with a gait belt for all transfers and ambulation which was recommended by PT/OT on 6/19/25 and discussed with nursing staff in a morning meeting. DOR-G indicated transfer and ambulation status is conveyed to nursing staff during morning meetings and it is the responsibility of nursing staff to update residents' care plans. DOR-G also indicated things get lost in the system at times and care plans do not always get updated. DOR-G indicated DOR-G had documentation of the discussion during the 6/19/25 morning meeting and would provide the documentation to Surveyor. On 7/17/25 at 8:35 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-F who indicated R10 was independent with transfers and ambulation unless R10 requested assistance and used the call light. CNA-F confirmed R10 did not use the call light for transfers or ambulation. On 7/17/25, Surveyor received the 6/19/25 morning meeting documentation from DOR-G. Surveyor noted R10's PT/OT evaluation was completed and indicated R10 transferred with the assistance of 1staff, a four-wheeled walker, and a gait belt. On 7/17/25 at 11:56 AM, Surveyor interviewed Registered Nurse (RN)-H who indicated R10 was referred to PT/OT so R10 could maintain independence. RN-H indicated therapy staff give nursing staff a recommendation sheet with a resident's transfer/ambulation status following an evaluation which is how nursing staff know the resident's care plan should be updated. RN-H indicated therapy staff should provide a recommendation sheet and not just update staff in morning meeting. RN-H indicated a new Director of Rehabilitation had just started and the team should discuss how to ensure care plans get updated. RN-H confirmed R10's care plan did not accurately reflect R10's current transfer and ambulation status.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure appropriate weight monitoring was provided for 1 resident (R) (R14) of 3 sampled residents.The facility did not update the physician regarding R14's weight loss of 6.15% from 6/6/25 to 7/4/25. In addition, the facility did not use the same device to obtain R14's weight on each weigh date. Findings include:The facility's Nursing Administration - Nutrition policy, revised 1/2025, indicates: It is the policy of this facility to ensure all residents maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible .Significant weight loss - 5% in one month, 7.5% in three months, or 10% in six months, as well as unplanned weight loss that occurs over time that does not meet the guidelines for significant weight loss and does not trigger review of the nutritional status .should be addressed in the care plan .Weights should be obtained via the same device on each weigh date .The Interdisciplinary Team (IDT) will further assess nutritional needs and goals of the resident in the context of his/her overall condition. Nutritional assessment may include: Weighing and weight changes .2. Any resident weight that varies from the previous reporting by 5% in 30 days, 7.5% in 90 days, and 10% in 180 days will be evaluated by the IDT to determine the cause of the weight loss/gain and interventions required. Family member/responsible party and attending physician will be notified by the unit manager .4. The nurse will notify the physician, family, and/or resident of the weight loss/gain with interventions. 5. Any resident meeting the criteria for weight loss and any resident at risk will be weighed weekly with the weight entered in the weekly weight progress notes. Weekly weights will be reviewed each week by the dietary manager. Any obscure weights will be re-weighed the next day .From 7/15/25 to 7/17/25, Surveyor reviewed R14's medical record. R14 was admitted to the facility on [DATE] and had diagnoses including nontraumatic intracerebral hemorrhage, vascular dementia with mood disturbance, cognitive communication deficit, and hemiplegia affecting the right dominant side. R14's Minimum Data Set (MDS) assessment, dated 4/15/25, had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated R14 had severely impaired cognition. R14 had an activated Power of Attorney for Healthcare (POAHC). A care plan, revised 1/8/25, indicated R14 was at high nutritional risk secondary to cerebrovascular accident, diabetes, dementia, hypertension, anxiety, and dysphagia, needed a therapeutic diet, and had significant weight loss. The care plan contained the following interventions: Will maintain adequate nutritional status as evidenced by maintaining weight, however, incremental weight loss (1 kilogram/week) beneficial related to high body mass index (BMI) - goal <30; No concentrated sweet, regular texture diet (no corn, no peas), thin liquids; dependent for eating; Sit on R1's right side to help encourage R1 to keep head upright; Usually able to complete liquids independently; Encourage healthy snacks between meals low in refined carbs; Offer cottage cheese; Meals in Blue Spruce dining area; Monitor intake and record every meal; Monitor/assess per primary care physician recommendations with any reported coughing concerns with meals; No preference for mealtimes; Offer and encourage fluids throughout day to help maintain hydration status. Provide 240 milliliters (ml) of fluids between meals. Monitor for signs and symptoms of dehydration. Report significant changes to provider; Weekly weights times four weeks and then monthly if stable.Surveyor reviewed R14's weights and noted the following:~ On 7/4/25 at 11:39 AM, R14 weighed 190.7 pounds (sitting) ~ On 6/27/25 at 11:43 AM, R14 weighed 192.0 pounds (sitting) ~ On 6/20/25 at 12:32 PM, R14 weighed 188.4 pounds (sitting) ~ On 6/14/25 at 11:21 AM, R14 weighed 189.4 pounds (Hoyer scale) ~ On 6/13/25 at 1:02 PM, R14 weighed 199.7 pounds (Hoyer scale) ~ On 6/6/25 at 12:32 PM, R14 weighed 203.2 pounds (sitting) ~ On 5/30/25 at 1:01 PM, R14 weighed 201.4 pounds (Hoyer scale) ~ On 5/23/25 at 11:27 AM, R14 weighed 198.6 pounds (Hoyer scale) ~ On 5/16/25 at 11:05 AM, R14 weighed 200.4 pounds (Hoyer scale) ~ On 5/9/25 at 12:13 PM, R14 weighed 198.3 pounds (sitting) ~ On 5/2/25 at 11:17 AM, R14 weighed 199.2 pounds (sitting) ~ On 4/25/25 at 11:10 AM, R14 weighed 199.4 pounds (sitting)A weight/skin assessment, completed by Registered Dietitian (RD)-K and dated 6/26/25 at 9:21 PM, indicated R10 had a current weight (as of 6/20/25) of 188.4 pounds and a BMI of 29.1 (which was considered overweight). R10 flagged for weight loss. R10's weight loss history included a loss of -5.1% (significant) in 1 month. R10 was prescribed a diuretic medication and mild weight fluctuations were expected. There was no edema noted. The assessment indicated gradual weight loss (1-2 kilograms/week) was beneficial due to R10's high BMI. R10 was prescribed a no concentrated sweets, regular, thin liquids (no corn, no peas) diet and had an order for 240 ml of fluids three times daily between meals. R10's meal intake

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, and record review, the facility did not ensure drugs and biologicals were stored in accordance with the facility's policy. One of three medication carts was observed unlocked and unattended during medication administration. This practice had the potential to affect more than 4 of the 44 residents residing in the facility.The Memory Lane medication cart was unlocked and unattended during medication administration on 7/17/25. Findings include:The facility's Medication Storage policy indicates: .b. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. On 7/17/25 at 9:35 AM, Surveyor noted the medication cart on Memory Lane was unlocked and unattended. During the observation, Registered Nurse (RN)-C returned to the medication cart. The medication cart was left unlocked and unattended for 10 minutes. On 7/17/25 at 9:45 AM, Surveyor interviewed RN-C who verified RN-C left the medication cart unlocked and unattended. RN-C indicated it was an accident and RN-C's practice was to lock the medication cart.On 7/17/25 at 9:59 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated medication carts should be locked when unattended.

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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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a sanitary manner. This practice had the potential to affect all 44 residents residing in the facility.Staff did not test the parts per million (PPM) of the Quaternary sanitizing solution per the manufacturer's instructions.The reach-in cooler did not maintain a consistent and safe temperature for items that required storage at 41 degrees Fahrenheit (F) or below.The reach-in cooler contained unlabeled, undated, and/or expired items. Findings include:On 7/15/25, Lead [NAME] (LC)-D indicated the facility follows the Wisconsin Food Code. Sanitizing Solution Testing:The Hydrion Quaternary test strip package insert indicates the test solution should be between 65 and 75 degrees F at the time of testing.During an initial kitchen tour on 7/15/25 at 8:21 AM, Surveyor observed the three-compartment sink which contained a bucket of sanitizing solution. Surveyor also observed a sanitizer bucket log which contained PPM documentation. Surveyor noted the log did not indicate the temperature of the sanitizing solution. Surveyor also noted a poster above the three-compartment sink that indicated the recommended water temperature for the Oasis 146 QUAT sanitizer was 65 to 73 degrees F.During a continuous kitchen observation that began at 10:25 AM on 7/16/25, Surveyor interviewed LC-D and Director of Food and Nutrition (DFN)-E. DFN-E indicated kitchen staff use the three-compartment sink to prepare sanitizer buckets used to clean dining and food prep areas. DFN-E confirmed staff do not test or document the temperature of the water added to the the sanitizer buckets. LC-D then temped the water from the faucet that is used to prepare sanitizer buckets and showed Surveyor the thermometer which read 98.4 degrees F. LC-D indicated the temperature was above the recommended range. DFN-E filled another container with water from the faucet and indicated the temperature was 79.5 degrees F. DFN-E again indicated the water temperature was above the manufacture's recommended temperature range of 65 to 75 degrees F. Reach-In Cooler:The 2022 Wisconsin Food Code documents at 3-202.11 Temperature: .Perishable food items must be stored at appropriate temperatures to prevent spoilage and reduce the risk of foodborne illnesses. Refrigerators should be set below 41 F (5 Celsius (C)) and freezers at or below 0 F (-18 C) .The 2022 Wisconsin Food Code documents at 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking: . Refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature and time combination of 5 degrees C (41 degrees F) (A) A food specified under 3-501.17 (A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17 (A), except time that the product is frozen; (2) Is in a container or package that does not bear a date or day.During an initial kitchen tour that began at 8:21 AM on 7/15/25, Surveyor noted the reach-in cooler thermometer read 49 degrees F and observed the following items in the reach-in cooler:~ Two unopened gallons of milk~ One open and half-full gallon of milk~ One case of string cheese~ One three-quarters full case of yogurt ~ Three containers of Magic Cups~ One half-full case of whipped margarine spread~ One unlabeled container (dated 7/14) of thickened pre-mixed honey consistency red juice~ One container of honey consistency thickened water (dated 7/11)~ One container of nectar consistency apple juice (dated 7/8)~ Two open containers of Med Pass 2.0 (one dated 4/20 and the other dated 6/2)~ Three containers of Prairie brand lactose-free milk During a continuous kitchen observation that began at 10:25 AM on 7/16/25, Surveyor noted the reach-in cooler thermometer read 51 degrees F. Surveyor interviewed DFN-E who indicated a 50 degree temperature in the reach-in cooler was concerning and the food in the cooler needed to be brought to the correct temperature or it would not be served. Surveyor noted the following items in the reach-in cooler:~ One unopened gallon of milk~ One open gallon of milk~ One case of string cheese~ One three-quarters full case of yogurt~ Three containers of Magic Cups~ One half-full case of whipped margarine spread~ One container of thickened juice (dated 7/14)~ One unlabeled container of thickened pre-mixed honey consistency red juice (dated 7/14)~ One container of honey consistency thickened water (dated 7/11)~ One container of nectar consistency apple juice (dated 7/8)~ Two open containers of Med Pass 2.0 (one dated 4/20 and the other dated 6/2)~ One covered tray of individual bowls of fruit cocktail Surveyor observed LC-D remove the fruit cocktail during lunch service and obtain a temperature of 49.6 degrees F. The fruit cocktail was served to residents during lunch. Surveyor noted thickened liquids and juice from the reach-in cooler were also served