STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225366	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hathaway Manor Extended Care	863 Hathaway Road New Bedford, MA 02740

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. 49424 Based on records reviewed and interviews for one Resident (#122) out of 26 sampled residents, who had a court appointed legal guardian due to incapacitation (the inability to make his/her own health care decisions), the facility failed to ensure that his/her Legal Guardian was fully informed in advance and given information including the risk and benefits of psychotropic medications (medications that can affect mood and behavior) prior to their use. Findings include: Review of the facility's policy titled Psychotropic Medications, dated 5/3/2005, indicated but was not limited to the following: -Each of the following elements: purpose of administering the psychotropic medication, prescribed dosage, route of administration, known benefits and side effects of medication of the informed consents documents must be discussed with the prescriber, and the resident or the resident's legal representative. -In a case where a legal guardian is assigned, the guardian has the authority to consent to the use of psychotropic medications except antipsychotic medications. Resident #122 was admitted to the facility in October 2023 with diagnoses which included Alzheimer's disease with late onset, major depressive disorder, and dementia. Review of Resident #122's record indicated that an appointment for guardianship was filed on 10/11/23. Review of Resident #122's current Physician's Orders indicated but were not limited to: -Sertraline (antidepressant) 25 milligrams (mg) daily, 9/2/24 Review of the Psychotropic Consent form, dated 9/2/24, indicated that Resident #122 signed the form acknowledging he/she understood the listed risks and benefits for Sertraline 25 mg daily. Review of Resident #122's October 2024 through January 2025 Medication Administration Records (MAR) indicated he/she received Sertraline as ordered. (continued on next page)

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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/14/25 at 3:10 P.M., Unit Manager #2 said the only situation when a person would not sign their own consents is if the health care proxy is activated. She said she believes the resident can sign their own paperwork because the Resident appears to be oriented. She said she would have to talk to social services because they inform the nurses if anyone cannot sign for themselves. She said she can see that the Resident signed their own consent for Sertraline on 9/2/24. During an interview on 1/14/25 at 3:16 P.M., Social Worker #2 said it was a tricky situation because the Resident seemed alert and oriented but has a court appointed legal guardian. She said she didn't know who should sign the psychotropic consent in this case and would need to find out the answer. During an interview on 1/14/25 at 3:29 P.M., Social Worker #1 said the Resident received an emergency guardian in 2023 and has had a court appointed legal guardian to make healthcare decisions for them since 2023. She said the Resident is not capable of signing consents and the legal guardian is the only person who can consent for healthcare related needs. During an interview on 1/14/25 at 3:50 P.M., the Administrator said the consent form should have been reviewed and signed by the legal guardian prior to administering the medication.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 50740 Based on record review and staff interview, for one Resident (#138), of two closed records reviewed, the facility failed to document the recapitulation of the Resident's stay that included his/her course of illness/treatment. Findings include: Review of the facility's policy titled Care Planning, revised 10/28/22, indicated but was not limited to the following: 2. Once discharge is planned, process will be as follows utilizing Discharge Checklist: -Day/night prior to discharge a. initiate post-acute Discharge Transition Summary Form b. Complete Discharge Medication List form and place in packet c. Copy MOLST and place original in packet/copy in chart d. Copy most recent lab/diagnostic testing and place in packet e. Complete medication reconciliation -Day of Discharge a. Review discharge packet and medication list b. Gather medications/treatments c. Review packet/medications/treatments with resident and/or responsible party d. Obtain resident and/or responsible party sign [sic] packet and medication list/s e. Nurse signs packet and medication list(s) f. Fax discharge documents to PCP office (include physician discharge summary) g. Fax discharge documents to home care agency (include physician discharge summary) Resident #138 was admitted to the facility in October 2024 for a brief stay for respite care. Review of the medical record indicated Resident #138 was discharged home on 10/20/24. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 9:14 A.M., Resident Representative #1 said Resident #138 was admitted to the facility for a respite stay in October 2024 while his/her home caregivers were on vacation. Resident Representative #1 said the Resident's home care services and equipment were in place already and his/her discharge home was uneventful with no concerns identified. Review of the closed medical record failed to indicate a recapitulation of the Resident's stay was completed by the Attending Physician. During an interview on 1/15/25 at 1:47 P.M., the Director of Nursing (DON) said that all discharged residents, even those at the facility for respite, should have a discharge summary with a recapitulation of the Resident's stay completed when discharged . During an interview on 1/15/25 at 1:57 P.M., the DON said she reviewed the Resident's closed medical record and could not find that a discharge summary or recapitulation of the Resident's stay had been 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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 36542 Based on observation, record review, and interviews, the facility failed to ensure staff provided appropriate care and services for one Resident (#38) with a Gastrostomy tube (G-tube: a tube that is placed directly into the stomach through an abdominal incision for administration of nutrition, fluids, and medication), out of 26 sampled residents. Specifically, Resident #38 did not receive the physician ordered amount of tube feeding, staff administering tube feedings were not signing off administration, and there were no physician's orders on how much water to administer with and between medications. Findings include: Review of the facility's policy titled Clinical Enteral Feeding- Documentation, revised in September 2010, indicated the following: -Physician's order: record the physician's order for the enteral feeding on the MAR (medication administration record); document the order is being carried out; document the amount of formula and water on the Input/Output Record (I&O) -Water flush: record the amount of hydration flush on the I&O record; record the amount of the pre- and post-medication flush, maintain and record the total water intake every 8 hours and calculate the 24-hour total -Changing the spike set: change the syringe and feeding set according to the manufacturer's recommendations. Do not change the spike delivery set with a closed system until the bottle is empty. Resident #38 was admitted to the facility in April 2024 with a diagnoses of status post cerebral infarction (stroke) and dysphagia, with a new G-tube. Review of the Minimum Data Set (MDS) assessment, dated 11/8/24, indicated Resident #38 had a feeding tube and the portion of the total calories the Resident received through a feeding tube was 51% or more. Review of the care plans indicated Resident #38 was dependent on the G-tube with the following interventions: -hold feeding if greater than 30 cc (cubic centimeters; equal to 30 milliliters (ml)) aspirate [sic] -administer tube feed: Jevity 1.5, 1380 ml, frequency 60 {ml/hour} -free water as ordered, assure total intake is 900 cc's every 24 hours -document tube feed and water intake every shift (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-administer medications per physician order Review of the Physician's Orders indicated Resident #38 had the following orders related to the feeding tube: -Jevity 1.5 1000 ml; rate of 60 ml/hour; total formula volume (rate x 23 hours)= 1380 ml (11/21/24) -free water 150 ml every 4 hours (11/21/24) -routine site care, day shift and as needed; cleanse with normal saline or soap and water, apply drainage sponge (6/2/24) -replace feeding syringe every 24 hours (5/4/24) -Diet: NPO (nothing by mouth) (11/11/24) Review of the physician's orders failed to indicate if/when residuals (fluid/contents that remain in the stomach) should be checked, at what amount of residual the feeding should be held, how much water would be used prior, during, and after the administration of medications. On 1/13/25 at 8:38 A.M., the surveyor observed Resident #38 in bed with the head of bed elevated. The feeding tube pump was observed set at 60 ml/hour and flush 150 ml/4 hours. The 1 liter (1000 ml) bottle of Jevity 1.5 was dated 1/13/25 at midnight (8 hours and 38 minutes prior) with 800 ml left in the bottle (indicating the Resident had received 200 ml since midnight. According to the physician's orders, Resident #38 should have received 510 ml by 8:30 A.M. (60 ml x 8.5 hours= 510 ml total), a difference of 310 ml. Review of the nursing progress note, dated 1/13/25 at 2:10 A.M., indicated Resident #38 was currently on an antibiotic for pneumonia. The nursing progress note indicated Nurse #3 held the tube feeding at midnight due to Resident #38 having 60 ml of residual. The nurse indicated the following re-checks: 12:25 A.M. 30 ml, 1:05 A.M. less than 5 ml. The nurse indicated the tube feeding was restarted at 1:05 A.M. at 60 ml per hour with 150 ml flush every 4 hours. The nursing progress note indicated the tube feeding was held for a little over an hour, which would equate to a loss of 65 ml (not 310 ml as observed). On 1/14/25 at 8:47 A.M., the surveyor observed Resident #38 in bed with the head of the bed elevated. The feeding tube pump was observed set at 60 ml/hour and flush 150 ml/4 hours. The 1-liter bottle of Jevity 1.5 was dated 1/14/25 at midnight (8 hours and 47 minutes prior) with 700 ml left in the bottle (indicating the Resident had received 300 ml since midnight.) According to the physician's orders, Resident #38 should have received 510 ml by 8:30 A.M. (60 ml x 8.5 hours= 510 ml total), a difference of 210 ml. Review of the nursing progress notes failed to indicate the tube feeding which was started on 1/14/25 at midnight was held for any reason. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 8:55 A.M., the surveyor observed Resident #38 in bed with the head of the bed elevated. The feeding tube pump was observed set at 60 ml/hour and flush 150 ml/4 hours. The 1-liter bottle of Jevity 1.5 was dated 1/15/25 at midnight (8 hours and 55 minutes prior) with 650 ml left in the bottle (indicating the Resident had received 350 ml since midnight. According to the physician's orders, Resident #38 should have received 540 ml by 8:30 A.M. (60 ml x 9 hours= 540 ml total), a difference of 190 ml. Review of the nursing progress notes failed to indicate the tube feeding which was started on 1/15/25 at midnight was held for any reason. During an interview on 1/15/25 at 7:15 P.M., Nurse #3 said the bottles for the feeding tube get changed whenever they were almost empty, below 100 ml left and that it happened to be changed at midnight for a couple of nights. Nurse #3 said he checked the residual anytime he provided care related to the G-tube (giving medications, checking placement, changing the bottle). He said he was not sure if it was written down, but he holds the tube feed if the residual was over 45 ml because he was familiar with the Resident who normally had a residual of less than 10 and he had been worried about aspiration related to the most recent diagnosis of pneumonia. He said he normally only administers one medication to the Resident, and he will flush with 5 ml of water before administering the medication, put 5 ml of water in with the medication and flush with 5 ml of water after giving the medication. Review of the January 2025 MAR indicated the order for the tube feeding was only signed off by the day shift every day. The orders were not signed off by the nurse who started a new bottle. Review of the MAR and TAR failed to indicate the amount of intake for Resident #38. During an interview on 1/15/25 at 9:20 A.M., Nurse #2 said Resident #38 was on a continuous feeding so the bottle would get changed whenever it was empty and not on a set schedule. She said I&O's were kept in a separate binder. Nurse #2 reviewed the I&O binder and said there were no recordings of intake for Resident #38. On 1/15/25 at 11:57 A.M., the surveyor observed Resident #38 connected to the feeding tube which was running at 60 ml/hour. At 2:44 P.M. the surveyor observed the tube feed pump beeping with a message that read hold error? The tube feed pump was not administering the Jevity 1.5 at this time and there was 400 ml left in the bottle, 100 ml less than the previous observation almost three hours prior. The surveyor did not observe any staff entering the Resident's room between 2:44 P.M. and 3:09 P.M. During an observation with interview on 1/15/25 at 3:09 P.M., the surveyor observed Nurse #4 enter the room of Resident #38 and hit the continue button on the tube feed pump. Nurse #4 said the machine was beeping when she came into the room and she pressed the button to start the machine again. She said she did not know why it was on hold or how long it had been on hold. She said she didn't normally calculate how much a resident on a feeding tube was getting. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 3:24 P.M., Nurse #4 said she had done the calculations and Resident #38 should have had 900 ml by this point (60 ml x 15 hours) but that she would factor in holding the tube feed for care, holding for medications and possibly holding for activities would all contribute the remaining 400 ml in the bottle. Nurse #4 said when administering medications to Resident #38 she puts each medication in with 5 ml of water and flushes with 5 ml of water between the medications. During an interview on 1/15/25 at 3:40 P.M., Nurse #2 said she had been the assigned nurse for Resident #38 on the 7:00 A.M. to 3:00 P.M. shift. She said the Resident had not gotten out of bed today and the tube feed was only held for care for about 10 minutes. During an interview on 1/15/25 at 3:52 P.M., the Registered Dietitian said there was a 72-hour report that was available on the tube feed pump. She said she had just run the report which indicated Resident #38 had received 3707 ml of nutritional feed (433 less than the ordered amount of 1380 per day for three days for a total of 4140) and 2100 of water (600 less than the ordered amount of 900 per day for three days for a total of 2700). She said the calculated nutritional feed for Resident #38 was for 60 ml per hour for 23 hours per day and the additional hour of the feed being held was for care, for a total of 1380 ml every 24 hours. She said according to the physician's orders Resident #38 should complete a 1000 ml bottle of Jevity in 17 hours and the bottles should not last 24 hours. During an interview on 1/15/25 at 4:05 P.M., the Assistant Director of Nurses said she reviewed the medical record and there was not an order for checking the residual or what amount to hold the tube feed related to the residual. She said there should be an order in place, so the nurses know how much water to use with the medications and to flush with before and after medications. She said unless the physician gives orders to monitor the intake or there was a change in weight, it would not be the process to record intake. She said the tube feed for Resident #38 was being held for care and for administration of medications and it was not possible for the tube feed to have only been held for 10 minutes on the day shift on this day. During an interview on 1/16/25 at 10:20 A.M., the Director of Nurses said the order for the administration of the feeding tube should allow each nurse to sign off, not just the day shift. She said the orders needed to be clarified to include flushes and holding time as the hold time was probably longer in a 24-hour period related to care and medication administration and this should be included in the calculations. She said there should be orders for how much water to mix with medications and how much to flush with between medications.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 36542 Based on record review and interviews, the facility failed to ensure the total program of care was reviewed by a physician for one Resident (#42), out of a total sample of 26 residents. Specifically, the facility failed to ensure the Resident's former primary physician and new primary physician evaluated the significant weight loss of Resident #42. Findings include: Resident #42 was admitted to the facility in August 2020 with a diagnosis of dementia. Review of the Minimum Data Set (MDS) assessment, dated 11/15/24, indicated Resident #42 had a weight loss of 5% or more in one month or 10% or more in six months. Review of the care plans indicated Resident #42 was at a nutritional risk related to dementia, anxiety, depression, hypertension and a history of variable intake with unintentional weight loss. Review of the interventions included but were not limited to: weekly weights, notify physician and dietitian of persistent weight loss, provide fortified foods (cereal at breakfast, potatoes at lunch/dinner), provide nutritional supplements (Magic Cup ice cream and Boost Breeze daily). Review of the weights for Resident #42 included but were not limited to the following: 7/2/24: 128.2 pounds (lbs.) 7/18/24: 128.2 lbs. 8/8/24: 121.2 lbs.; loss of 5.46% in 3 weeks 8/19/24: 122.6 lbs.; loss of 6.69% in one month 9/4/24: 117.80 lbs. 9/16/24: 114.4 lbs. 9/23/24: 109.8 lbs.; loss of 10.6% in one month 10/23/24: 110.60 lbs. 11/12/24: 111.2 lbs. 11/25/24: 111.60 lbs. 12/2/24: 107.0 lbs. 12/6/24: 104.6 lbs. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/9/24: 105.4 lbs.; loss of 5.22 % in one month 12/17/24: 108.6 lbs. 12/23/24: 111.4 lbs. 12/30/24: 113.8 lbs.; loss of 11.23% in six months Review of the Physician's Progress Notes indicated Resident #42 was seen by the MD (Doctor of Medicine) on 6/7/24. The next visit conducted by a physician was 11/1/24. During an interview on 1/14/25 at 3:30 P.M., the Assistant Director of Nurses said Resident #42 had a primary physician who was no longer coming to the facility and switched primary physicians in October 2024, with the first visit with the new physician being 11/1/24. Review of the Physician's Progress Notes from 11/1/24, 12/2/24, and 1/3/25 failed to indicate the Resident's significant weight loss had been addressed by the physician. During an interview on 1/15/25 at 12:53 P.M., the Director of Nurses (DON) said the facility started having issues with the previous physician conducting visits timely. She said the facility had terminated the contract with the previous physician and the Resident was assigned to the Medical Director as the new primary physician. She said the previous physician did not have a Nurse Practitioner and there were no other physicians or physician extenders who would have seen the Resident for the physician between June 2024 and November 2024. She said she had reached out to the office of the previous physician and no physician visits after 6/7/24 had been received. She said the process was for the Unit Manager or the Registered Dietitian to notify the physician to evaluate a resident with significant weight loss. She said the Unit Manager for Resident #42 was not available for interview. During an interview on 1/15/25 at 1:10 P.M., the Registered Dietitian said she did not have any conversations with the previous or current physician regarding the significant weight loss for Resident #42 and the Unit Manager was responsible for speaking with the physicians. During an interview on 1/16/25 at 9:00 A.M., the Medical Director said the previous physician was terminated and the initial visit with Resident #42 was on 11/1/24. He said he was not aware of the significant weight loss for the Resident and it was probably overlooked. He said neither he nor the Nurse Practitioner had evaluated the weight loss. He said in reviewing his progress notes the weight loss may be related to the diagnosis of dementia, but it would have to be reviewed and he would need to run some baseline labs (blood work).

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 36542 Based on interview and record review, the facility failed to ensure one Resident (#42), in a sample of 26 residents, had been seen by a physician every 60 days. Findings include: Resident #42 was admitted to the facility in August 2020. Review of the Physician's Progress Notes indicated Resident #42 was seen by the MD (Doctor of Medicine) on 6/7/24. The next visit conducted by a physician was 11/1/24, 147 days later. During an interview on 1/15/25 at 11:44 A.M., the Director of Nurses (DON) said there were no additional physician visits for Resident #42 between June 2024 and November 2024. She said the Resident's primary physician had not been coming in to see residents timely and a termination notice was issued and the Resident was provided a new physician at the end of October 2024. She said it was not acceptable for a Resident to go from June to November without seeing a physician.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. 49424 Based on interviews and record reviewed, for one Resident (#50) of 26 sampled residents, the facility failed to provide timely dental services. Specifically, for Resident #50, the facility failed to initiate replacement of lost/missing dentures timely. Findings include: Review of the facility's policy titled Dental Services, dated 10/19/2017, indicated but was not limited to the following: -Within 3 days following confirmation of lost or damaged dentures social services or their designee must make a referral for appropriate dental services for repair and/or replacement. -Social Services or their designee will maintain contact with dental services, the resident and/or representative if applicable until the problem is resolved and the dentures are replaced and repaired. Review of the Minimum Data Set (MDS) assessment, dated 11/22/24, indicated that Resident #50 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. Review of the progress note, dated 5/22/24, completed by the Registered Dietitian, indicated Resident #50 needed a dental referral for new dentures and nursing was aware. Review of Resident #50's medical record indicated his/her Health Care Proxy signed a consent for dental services on 9/4/24 and a referral was initiated on 9/11/24 (112 days after the Registered Dietitian acknowledged the need for new dentures). Review of a 2023 Grievance form (month/day not indicated on form) indicated the dentist was contacted for consult for denture replacement due to Health Care Proxy request for replacement. Further review of the Grievance form indicated the outcome included a scheduled (date not specified) dental consult for denture replacement. Review of the dental consult, dated 11/5/24, indicated it was completed in response to the 9/11/24 request. During an interview on 1/13/25 at 2:17 PM., Resident #50's Health Care Proxy said the Resident's upper and lower dentures were reported missing over nine months ago and there was still no resolution. She said she has asked at every care conference she has attended and knows a grievance form was initiated, and she isn't sure when, if at all, the Resident will receive replacement dentures. She said when she brought it up at the September care conference the facility staff had her sign a consent form for dental services that should have been completed when the dentures first went missing. She said the process has been delayed because of changes in staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225366	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hathaway Manor Extended Care	863 Hathaway Road New Bedford, MA 02740

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/14/25 at 4:02 P.M., Social Worker #1 said she was aware of this longstanding issue. She said she started working for the facility in April 2024 and can recall the missing dentures being brought up by family at this time. She said it was brought up again in June and isn't sure what happened. She said she had the Health Care Proxy sign a consent for dental services in September. She said the grievance form is from 2023 and was completed prior to her working at the building. She said she isn't sure why there has been a delay in having the resident referred to and seen by the dentist. During an interview on 1/15/25 at 11:10 A.M., Unit Manager #2 said she had no additional information to explain why the consult didn't happen earlier than September. She said there was supposed to be a consult in July but was unclear why it didn't occur; she said she did not follow up. During an interview on 1/15/25 at 2:15 P.M., the Administrator said she cannot speak to what was done prior to her employment (began in November 2024) but she was aware that Resident #50 had a consult in November 2024. She said she didn't realize this had been a longstanding issue but knows there have been changes in facility staff which could explain the delay. She said there should have been follow up through the entire process to ensure the Resident received replacement dentures.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49428 Based on observation and interview, the facility failed to follow professional standards of practice for food safety to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to ensure food items were properly dated and stored in three of three kitchenettes. Findings include: Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: 3-305.11 (A) Except as specified in paragraphs (B) and (C) of this section, food shall be protected from contamination by storing the food (1) in a clean, dry location. 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request. Review of the facility's policy titled Dietary: Sanitary Conditions, revised 9/21/22, indicated but was not limited to: Policy: [the facility] will procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, prepare, distribute and serve food under sanitary conditions. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Intent: Follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Safe food handling for the prevention of foodborne illnesses begins when food is received from the vendor and continues throughout the facility's food handling processes. Prevention of Foodborne Illness: -Proper food preparation, storage, and handling practices are essential in preventing foodborne illness; -Refrigeration prevents food from becoming a hazard by significantly slowing the growth of most microorganisms; -Practices to maintain safe refrigerated storage include: Labeling, use by dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by-date, or frozen (when applicable) or discarded; -Temperature control and freedom from contamination are also important when ready-to-eat or prepared food items for snack are sent to the unit and are held for deliver; or stored at the nursing station, in a unit refrigerator or in unit cupboards; -Food handling risks associated with food stored on the units may include but are not limited to: Food left in refrigerators beyond safe use by dates (including, but not limited to foods that have been opened but were not labeled, etc.). Review of the facility's policy titled Dietary Department Guidelines, revised May 2018, indicated but was not limited to: -All items stored in the refrigerator will be covered and use by date labeled; -Stock items will be monitored for expiration dates and used or discarded as needed. On 1/14/25 at 10:49 A.M., the surveyor observed three opened containers of thickened liquids in the Unit 1 kitchenette refrigerator. Two of the containers were not labeled with the date they were opened. One container was dated 1/5/25. Manufacturer's instructions on the containers stated: After opening, may be kept up to 7 days under refrigeration. On 1/14/25 at 10:58 A.M., the surveyor observed four opened containers of thickened liquids in the Unit 3 kitchenette refrigerator. The surveyor observed all four containers were not labeled with the date they were opened. On 1/15/25 at 4:15 P.M., the surveyor observed four opened containers of thickened liquids in the Unit 1 kitchenette refrigerator. The surveyor observed three containers were not labeled with the date they were opened, and one container was dated 1/5/25. On 1/15/25 at 4:30 P.M., the surveyor observed two opened containers of thickened liquids in the Unit 2 kitchenette refrigerator. Both containers were not labeled with the date they were opened. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 4:30 P.M., Certified Nursing Assistant (CNA) #2 said the kitchen labels the thickened liquid containers with the expiration date. CNA #2 said they only use containers the kitchen has dated; if a container has no date, CNA #2 said they will open a new container of thickened liquid. CNA #2 and the surveyor observed an unopened bottle of thickened juice that was dated 1/25. CNA #2 said 1/25 was the expiration date written by the kitchen and the thickened juice could be used until 1/25. During an interview on 1/15/25 at 4:40 P.M., the Food Service Director (FSD) said the kitchen handwrites dates on each thickened liquid container with the date it was received to help with product rotation in the main kitchen's dry storage room. The FSD said the containers labeled 1/25 were labeled by the kitchen staff to indicate the facility received the thickened liquid containers in January 2025. The FSD said 1/25 did not indicate an expiration or use by date for opened containers. The FSD said when a new container of thickened liquids is opened, the container is to be dated with the opened date. The FSD said the thickened liquids were good for seven days after opening, per the manufacturer's instructions. During an interview on 1/16/25 at 10:45 A.M., the Administrator said staff was to label all open food and beverages with the date opened. The Administrator said staff should be labeling and dating food and beverages, per the facility's food storage policies, to ensure food and beverages served to residents comply with safe food practices.