STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345482	A. BUILDING _____ B. WING _____	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CARRIAGE CLUB PROVIDENCE	5804 OLD PROVIDENCE ROAD CHARLOTTE, NC 28226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		10/12/22

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

Electronically Signed | 10/05/2022

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a facility and comprehensive Emergency Preparedness (EP) plan which had been developed, reviewed, and maintained specifically for the health care center. The facility failed to maintain, review, and update the EP plan, conduct a facility and community based risk assessment for the health care center. The EP plan failed to address the health center specific patient/client population, update for current contacts, collaborate with local stakeholders, develop, update, and review EP policies and procedures based on a developed EP plan specifically for the health center. The EP plan failed to address subsistence needs for residents and staff, address evacuation, transportation, needs of evacuees, and staff responsibilities, update or review for arrangements with other facilities, review and update the communication plan, update names and contact information specifically for the health care center. The EP plan failed to put into place EP training, testing, specifically for the healthcare center. Findings included: A review of the facility's supplied Emergency Preparedness plan material on 9/14/22 revealed: A. The supplied EP plan provided by the health center was a corporate EP plan and did not	E 001	The following is the Plan of Correction for Brookdale Carriage Club Providence regarding the Statement of Deficiencies dated 9/14/2022. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. E001 Establishment of the Emergency Program (EP) CFR(s): 483.73 403.784, 416.54, 418.113, 441.184, 460.84, 482.15, 483.73, 483.475, 484.102, 485.68, 485.625, 485.727, 485.920, 486.360. 491.12 1. Corrective action which will be accomplished for those residents found to have been affected by the deficient	

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E 001	Continued From page 2 provide health care specific information, such as information about the health center staff, local surroundings, evacuation site, potential emergency specific situations related to the health center 's location, information regarding local resources such as the fire department, emergency coordinator, information regarding the health center's emergency power, etc ... in the event of an emergency. B. The health center provided EP plan had not been reviewed or updated annually by the Administrator in the health center. The current Administrator, the current Director of Nursing, nor any other facility staff were listed in the EP plan. C. The provided EP plan did not provide information about community-based risk assessment. D. The supplied EP plan did not address the health center's resident population such as persons at risk or the type of services the facility had the ability to provide in an emergency. E. The reviewed EP plan did not address the procedures for EP collaboration with local, tribal, regional, state and federal EP officials. F. The health center provided EP plan did not provide information regarding a system to track the location of on-duty staff and sheltered residents in the health center ' s care during an emergency including the specific name and location of a receiving facility or other location. G. The supplied EP plan did not provide information for arrangements with other facilities, who would provide transportation, primary and	E 001	practice: The Health Care Emergency Preparedness (EP) was updated on 10/3/22 and will include the following components described below: A: Information about the health center staff, local surroundings, evacuation site and emergency specific situations related to the health center□s location, information regarding local resources in the event of an emergency B. Annual Review (2022) of the EP by the Administrator, Director of Clinical Services and Infection Preventionist nurse was completed on 10/3/2022 C. Annual Review of the Community-Based Risk Assessment completed on 09/29/2022 by the Interdisciplinary Team. D. Review completed on 10/03/2022 by the Assistant Director of Clinical Services (ADCS) addressing the Resident population for those at risk or types of services the facility has the ability to provide in an emergency utilizing the Community Resident Evacuation Ability Form. E. A collaborative meeting is scheduled with an outside agency as indicated on 10/12/2022 to review EP procedures and issue a copy of the EP. F. Information about the system to track the location of on-duty staff and sheltered resident in the health center□s care during an emergency. Agreements with information signed on 10/3/2022. G. Information for arrangements with other facilities who will provide transportation during an Emergency	

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E 001	Continued From page 3 alternate means of communication with external sources of assistance. H. The supplied EP plan did not address the development of arrangement with other facilities and other providers to receive residents in the events of limitations or cessation of operations. I. The provided EP plan for communication was not health center specific, nor was it reviewed by the health center administration. J. There were no names nor contact information for health center specific staff, residents' physician, other facilities, and/or volunteers in the supplied EP plan. K. The names and contact information contained in the EP plan for emergency officials contact information was not health center specific, nor was it reviewed and signed off by the health center's administration. L. The facility failed to provide information regarding training and testing for the health center specific EP plan. M. The health center failed to provide information regarding EP training program which would include training of the health center specific EP policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. An interview was conducted with the Administrator on 9/14/22 at 10:00AM which revealed he had recently started at the health center in April of this year and was focused on	E 001	obtained by the Director of Financial Services (DFS) on 10/3/2022. H. Developed and arranged on 10/3/2022 with other facilities and other providers to receive residents in the event of limited or cessation of operation. I. EP is specific to Health Center and Reviewed by the Health Care Administrator on 10/03/2022. J. Names and contact information for Health Center specific staff, residents, physician, other facilities and/or volunteers have been updated in EP plan by the Administrator on 9/30/22. K. Names and contact information contained in the EP plan for emergency officials has been made Health Care specific and has been reviewed and signed off by the Health Center□s administrator on 9/30/22. L. Training and testing of the health center EP plan. The Hazard Vulnerability Assessment Tool Completed and Reviewed as a Health Care Team on 9/30/22 and a collaborative meeting is scheduled with a local agency schedule 10/11/2022. Table Top Discussion regarding the preparation/execution for Hurricane Ian completed by the Continuum Care Retirement Community Team on 10/10/22 and a collaborative meeting is scheduled with the local agency for 10/11/2022. M. Training program on EP Policies & Procedures for new and existing associated, agency personnel, and volunteers. Human Resources/Designee will provide EP re-education for associates, agency personnel and	

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E 001	Continued From page 4 patient care and staffing. He explained he had not reviewed the facility risk assessment or the EP plan. He added that all the staff in the health center were new, and he was sure that none of them including his Director of Nursing (DON) were familiar with the EP plan. He further added he did not think there was a facility risk assessment specific to the health center and that the EP plan was a corporate plan that was for the entire campus not specifically for the health center. He stated the manual for EP was sent out annually to the campus and the Executive Director over the entire campus was the only one who reviewed and signed it. The Administrator revealed the facility risk assessment had not been reviewed or updated annually and the EP plan had not been reviewed or updated for the health center.	E 001	volunteers by 10/12/2022. 2. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: Residents have the potential to be affected by this alleged deficient practice. 3. The measures the facility will put into place or systemic changes made to ensure that the deficient practice will not recur: a) EP re-education to be provided by the Administrator on 10/11/2022 to Department Managers on EP locations, Leadership phone tree, community response teams and their contact information. EP education will be provided upon initial hire, periodically no less than annually, provided as needed for agency and volunteer personnel reviewed by Human Resource Department for compliance. b) The Safety Committee meets monthly and will review any concerns to include any EP concerns. EP concerns will be reported to the Quality Assurance Performance Improvement (QAPI) for the 3 months. . 4. Plans to monitor facility performance to make sure solutions are sustained: a) The Human Resource Director/designee will monitor that EP education has been completed and report any concerns monthly for the next 3 months in the QAPI then re-evaluate. b) The Safety Committee will present EP	

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E 001	Continued From page 5	E 001	concerns monthly for the next 3 months in Quality Assurance Performance Improvement (QAPI) to determine any actions needed c) The Safety Committee will present the EP as a Policy and Procedure Review in the QAPI each year to monitor compliance. . 5. Dates when corrective action will be completed: 10/12/22	
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and	E 015		10/12/22

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E 015	Continued From page 6 safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on observations, policy review and staff interviews, the facility failed to have subsistence food available to meet the needs for residents and staff as identified in the emergency preparedness plan. This had the potential to affect all residents in the facility. The findings included:	E 015	The following is the Plan of Correction for Brookdale Carriage Club Providence regarding the Statement of Deficiencies dated 9/14/2022. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as	

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E 015	Continued From page 7 The facility's emergency preparedness plan revealed a document titled, "Preparing for an Emergency- Dining Services" last approved 01/2022 read in part: * Inventory emergency food supply on a regular basis. * Remove items that may be coming close to their expiration date. * Replace and restock items in emergency supplies as they are used and before they expire. An observation of the emergency preparedness storage area in health center was conducted on 9/14/22 at 2:45PM. The following items were found to be expired: * 2 cases of Pineapple puree (6/68-ounce cans) expiration date 5/3/22 * 1 case of Pineapple puree (6/68-ounce cans) expiration date 9/13/22 * 13 cases of Sloppy Joe (6/52-ounce (oz) cans) expiration date 6/17/22 * 3 cases of three bean salad (6/ 6-pound (lbs.) 15oz cans) expiration date 12/21 * 1 case of Apricot halves (6/10 lbs. cans) expiration date 10/2/20 * 1 box of peanut butter with 200 individual packets -6 oz serving expiration date 5/5/22 * 1 case of salad sliced beets expiration date 9/8/21 An interview was conducted with the Certified Dietary Manger (CDM) on 9/14/22 at 12:15PM revealed the emergency food supply was stored in the health care center. The CDM stated she believed there was 5-7 days' worth of food and that it was checked weekly or monthly by the	E 015	confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. E015 Subsistence Needs for Staff and Patients CFR(s): 483.73 403.748(b)(1), 418.113(B)(6)(iii), 441.184(b)(1), 460.84(b)(1), 482.15(b)(1), 483.73(b)(1), 483.475(b)(1), 485.625(b)(1) 1. Corrective action which will be accomplished for those residents found to have been affected by the deficient practice: a) Expired food was immediately removed and discarded from inventory by Assistant Director of Dining Services (ADDS) on 9/12/2022. New provisions were ordered and received to replenish supply to allow for a 3 day Emergency supply by ADDS on 9/12/2022 received on 9/29/2022. b) Dietary Managers were re-educated on the Emergency Food and Supply Policy & Procedures by the Certified Dietary Manager (CDM) on 10/3/2022. 2. How the facility will identify other residents having the potential to be	

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E 015	Continued From page 8 Dining Service Manager (DSM). An interview was conducted with the DSM on 9/14/22 at 3:00PM revealed the facility was to have 3 days' supply of emergency food for residents and staff. He explained that he only checked the emergency food every time there was a disaster warning. He further explained he focused on removing expired foods and replacing stock when there were hurricane warnings. The DSM stated the facility did not have enough food for an emergency food supply due to the multiple amounts of expired food items. The Administrator was interviewed on 9/14/22 at 4:15PM and he explained the emergency food supply should be incorporated into the campus menus, and a rotation of the food would have occurred to reduce product expiration.	E 015	affected by the same alleged deficient practice: a) Residents have the potential to be affected by this alleged deficient practice. b) Dietary Managers were re-educated on the Emergency Food and Supply Policy & Procedures by the Certified Dietary Manager (CDM) on 10/3/2022. 3. The measures the facility will put into place or systemic changes made to ensure that the deficient practice will not recur: a) The Dietary Services Manager (DCM)/designee completed an Emergency Food & Supply Inventory Audits (including replacement/restocking of items used or before expiration) on 9/27/2022 and will continue to audit monthly for the next 3 months. 4. Plans to monitor facility performance to make sure that solutions are sustained: a) The Dietary Services Manager (DCS)/designee will present any concerns from the Emergency Food & Supply Inventory Audits in the Quality Assurance Performance Improvement (QAPI) each month for the next 3 months then re-evaluate. 5. Dates when corrective action will be completed: 10/12/2022	
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted from 9/11/22 through 9/14/22. Event ID# PYL211.	F 000		

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F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews , the facility failed to store milk products at a temperature of 41 degrees (°) Fahrenheit (F) or below, discard expired foods, discard potentially hazardous thawed food, label and date, failed to ensure frozen items were not open to air and dated, repair a malfunctioning freezer unit and maintain a clean walk-in refrigerator for 1 of 1 reach-in refrigerators in the satellite kitchen, 1 of 1 walk-in refrigerators in the main kitchen, 1 of 1 reach-in freezers in the main kitchen and 1 of 1 walk-in freezer which had the potential to affect food served to residents. The findings included:	F 812	The following is the Plan of Correction for Brookdale Carriage Club Providence regarding the Statement of Deficiencies dated 9/14/2022. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating	10/12/22

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F 812	Continued From page 10 1. An initial tour of the satellite kitchen in the health center was conducted with the Certified Dietary manager (CDM) on 09/12/22 at 10:52 AM, the thermometer in the refrigerator read 48° F. The following concerns were identified with the temperature of the reach in refrigerator: * (2) 32-ounce (oz) containers of thickened milk, one of which was opened and unlabeled or dated. * (2) 1-gallon containers of milk, one of which was opened and dated 9/12/22. An observation was made on 9/12/22 at 12:00PM of the reach in refrigerator in the satellite kitchen in the health care, there were two thermometers in the refrigerator that both read 48°F. The following items were stored in the reach-in refrigerator: * (2) 32-ounce (oz) containers of thickened milk, one of which was opened and unlabeled or dated. * (2) 1-gallon containers of milk, one of which was opened and dated 9/12/22. A follow up observation was conducted with the CDM on 9/12/22 at 12:15PM of the satellite kitchen in the health center. The following concerns were identified. * A plastic container with coffee grounds dated prepped 7/27/22 and use by 8/29/22. There were two scoops lying in the coffee. An interview with Certified Dietary Manager (CDM) on 9/12/22 at 12:15PM revealed she would be contacting a repair person to fix the refrigerator and would be discarding the (2) 1-	F 812	factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. F812 Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) 1. Corrective action which will be accomplished for those residents found to have been affected by the deficient practice: a) Items noted in the 2576 as unlabeled and undated were and food noted from the reach in refrigerator were relocated with the appropriate timeframe to the main kitchen refrigerator until the reach in refrigerator was serviced and the temperature was maintained at or below 40 degrees F discarded by Certified Dietary Manager on 9/12/22. The two scoops were removed from the coffee storage container and the coffee itself was discarded by the CDM on 9/12/22. Food items that were expired, improperly thawed, not prepared and/or served by its use date and/or prepped and not dated were discarded by the Assistant Director of Dining Service (ADDS) on 9/12/22. The floors in the walk in refrigerator and freezer were cleaned by the ADDS on 9/13/22. The reach in refrigerator was serviced by an outside contractor on 09/14/2022 at which time it was determined to be in proper working condition. Temperature logs have been maintained with no temperature readings	

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	345482	A. BUILDING _____ B. WING _____	09/14/2022

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F 812	Continued From page 11 gallon milk containers and moving all the other items to the main kitchen. On 9/12/22 at 12:17PM the CDM was observed to remove the scoops from the coffee container and discarded the coffee. An interview with the CDM on 9/12/22 at 1:53 PM revealed the scoops should not have been left in the coffee container. She explained the staff probably were refilling the coffee but never changed the label on the container and should have changed the label with each new refill. A follow up observation of the reach in refrigerator in satellite kitchen in healthcare was made on 9/13/22 at 11:34AM and the thermometer in the refrigerator read 40°F. Follow-up interview with the CDM on 9/13/22 at 4:18PM revealed the reach in refrigerator was thought to have been cycling down and they did not feel it needed repair. She added the thickened liquid that was open should have been discarded due to the high temperature in the reach in refrigerator. Interview with the Administrator on 9/13/22 at 4:30 PM revealed all the kitchens regardless of their location on campus to have followed all regulations at all times. 2. An initial tour of the main kitchen's walk-in refrigerator was conducted with the DSM on 9/12/22 at 11:25AM. The following concerns were identified: * large plastic container of 24-26 chicken	F 812	resulting in a temperature greater than 40 degrees F. b) Re-Education regarding Satellite Kitchen/Pantry Safety and Sanitation, Labeling Safety and Sanitation, Dining Services Closing Report (Checklist), Food Safety Control and Thawing Food Safety and Sanitation was completed by the Certified Dietary Manager on 10/5/2022 with dietary associates. 2. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: a) Residents have the potential to be affected by this alleged deficient practice. b) Re-Education regarding Satellite Kitchen/Pantry Safety and Sanitation, Labeling Safety and Sanitation, Dining Services Closing Report (Checklist), Food Safety Control and Thawing Food Safety and Sanitation will be completed by the Certified Dietary Manager (CDM) on 10/5/22 with dietary associates. 3. The measures the facility will put into place or systemic changes made to ensure that the deficient practice will not recur: a) The ADDS/designee completed an audit 10/3/2022 regarding the kitchen, satellite kitchen and pantry areas for cleanliness, label and dating of food, proper thawing techniques, food storage, food cross contamination, refrigerator and freezer temperatures. The ADDS/designee will continue to complete	

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F 812	Continued From page 12 quarter legs with a label that read prep date 9/5/22 and used by date of 9/8/22. * a quarter of a cooked ham prep date of 9/5/22 and used by date of 9/8/22. * a plastic container of cucumber dip (Tzatziki) which was watery once opened with an expiration date of 5/2/22. * a 13-quart container with sliced sweet potatoes in a clear liquid with a prep date of 9/7/22 and use by date of 9/10/22. * a 2-quart container of lemon slices with a prepped date of 9/2/22 and no used by date. * The floor of the walk-in refrigerator had debris on it which included empty water bottles, green leafy vegetables, raw pasta, tomatoes and pieces of plastic. An observation was made on 09/12/22 at 11:35AM of the Associate Director of Dining Services (ADDS) removing the labels from the chicken quarter legs and cooked ham and relabeling the items with a prep date of 9/5/22 and use by date of 9/12/22. An interview was conducted with the Chef on 9/12/22 at 11:37AM. The chef revealed the chicken and ham were good for use for 7 days and should have had a used by date of 9/12/22. The Chef added the sweet potatoes should have been used by 9/10/22 and therefore should have been tossed. The Chef also added the sliced lemons should have been discarded within 3 days of prep. He explained the dishwasher should sweep the floors daily and he would have swept it but he was too busy.	F 812	the Dietary Kitchen & Sanitation Audit weekly for the next 3 months. 4. Plans to monitor facility performance to make sure that solutions are sustained: a) The ADDS/designee will present any concerns from the Dietary Kitchen & Sanitation Audit in the Quality Assurance Performance Improvement (QAPI) each month for the next 3 months then re-evaluate. 5. Dates when corrective action will be completed: 10/12/2022	

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An interview was conducted with the DSM on 9/12/22 at 11:38AM revealed the chicken and ham should have been tossed within 3 days and the cucumber dip (Tzatziki) by expiration date.

An interview was conducted with the ADDS on 9/12/22 at 11:40AM stated he relabeled the chicken, ham and sweet potatoes because they were good for 7 days and that the person who labeled them made a mistake by making the used by date 3 days.

A follow up interview was conducted with the ADDS on 9/13/22 at 11:25AM revealed the walk-in floors should be kept clean and free of debris.

Interview with the ADDS on 9/13/22 at 3:07 PM revealed the DSM informed him and the Chef that the ham and marinated chicken should have been discarded after 3-4 days and the ham was discarded by the chef on 9/12/22.

Interview with the Administrator on 9/13/22 at 4:30 PM revealed all the kitchens regardless of their location on campus to have followed all regulations at all times.

3. An initial tour of the main kitchen's reach in freezer was conducted with the DSM on 9/12/22 at 11:44AM. The following concerns were identified:

* 2 (2lb) bags of shrimp that were soft to touch and defrosted.

The DSM was observed to stop the ADDS from discarding the bags of shrimp and instruct him to

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leave them in the freezer.

Interview with the DSM on 9/12/22 at 11:45AM revealed the bags shrimp were taken out of the freezer 9/11/22 for an event and were not used. He added the staff left them in the refrigerator and placed them back in the freezer the morning of 9/12/22.

Interview with the ADDS on 9/13/22 at 3:03PM revealed the shrimp should not have been placed back in the reach in freezer after thawing but should have been discarded. The ADDS added the shrimp were discarded 9/12/22.

Interview with the Administrator on 9/13/22 at 4:30 PM revealed all the kitchens regardless of their location on campus to have followed all regulations at all times.

4. An initial tour of the walk-in freezer was conducted with the DSM on 9/12/22 at 11:45AM. The following concerns were identified:

*1 (2lb) bag of Brussel sprouts open to air undated and unlabeled.
*1 (20lb) box of corn kernels open to air with ice crystal observed on the corn undated and unlabeled.
*right side of the freezer wall, with icicles formed on the pipes approximately 3-9 inches in length and dripping water. The ice was observed on 26 boxes stacked under the pipes.

Interview with the DSM was conducted on 9/12/22 at 11:48AM revealed the freezer unit was repaired 3-4 weeks ago.

An interview with the ADDS on 9/13/22 at 3:23PM

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F 812	Continued From page 15 revealed the items in the freezer should have been bagged once opened, labeled and dated. The ADDS added the freezer unit created ice crystals and it caused the fan to stop or malfunction. He explained the facility had called the repair company and frequently had to call them to repair the freezer unit. Interview with the Administrator on 9/13/22 at 4:30 PM revealed all the kitchens regardless of their location on campus to have followed all regulations at all times.	F 812		