

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER HALE OLA KINO BY ARCADIA		STREET ADDRESS, CITY, STATE, ZIP CODE 1314 KALAKAUA AVE SECOND FLOOR HON, HI 96826		
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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 02/18/25 - 02/21/25. The facility was found not to be in substantial compliance with 42 CFR §483, Subpart B. Survey Dates: 02/18/25 - 02/21/25 Survey Census: 32 Sample Size: 14	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

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

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F 550	<p>Continued From page 1</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity by protecting and promoting the rights of one of one resident (Resident (R) 4) reviewed for resident rights. R4's personal property was taken from his room without his knowledge or proper communication. This deficient practice has the potential to affect R4's dignified existence.</p> <p>Findings include:</p> <p>On 02/19/25 at 12:55 PM, an interview and observation of R4 was done. R4 was lying down in his room on his bed and complained that a friend brought him a bottle of TUMS yesterday morning and he does not know what happened to them. R4 reported he wanted TUMS and even asked the facility to get him a bottle, but no one helped him get it, so he asked his friend who was able to get him some and had put it in his drawer.</p>	F 550			

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F 550	<p>Continued From page 2</p> <p>R4 raised his voice and loudly stated " ...they took it from me. I don't know what happened ...it's my personal property! I got it, someone brought it for me, and it disappeared. Nobody can find it! Should I call the police? It disappeared; they use it for themselves. I'm afraid, people I should be trusting ...this is not doing me any good." R4 continued to threaten to call the police because his personal property was stolen and expressed, he did not understand why someone would take it from him. With R4's permission to search his room, TUMS was not found in his room.</p> <p>On 02/20/25 at 02:59 PM, concurrent record review and interview with Registered Nurse (RN) 5 and Licensed Practical Nurse (LPN) 2 was done. Inquired with RN5 if she was aware a visitor brought TUMS for R4, RN5 reported she did not hear anything but can check the medication cart because she would be able to identify if the medication was from the pharmacy or bought over-the-counter. RN5 and LPN2 was observed to find a bottle of opened TUMS in the medication cart with R4's room and bed number written on top of the lid. Concurrent review of R4's physician orders, RN5 confirmed R4 did not have an order for TUMS and the bottle was R4's personal property. RN5 reported if a resident brings an over-the-counter medication, nursing staff should be notified and check if there is an active order for the medication. Inquired if the resident should be notified, explained, and educated about why he cannot keep the medication in his room prior to removing it and documented in the Electronic Health Record (EHR), RN5 stated yes because it is considered his personal item and confirmed the communication between the resident and the facility was not documented in R4's EHR.</p>	F 550		

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F 656 SS=D	<p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care</p>	F 656		

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F 656	<p>Continued From page 4</p> <p>plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interviews and record reviews, the facility failed to develop and implement the comprehensive person-centered care plan for two of 15 residents (Resident (R) 4 and R21) care plan reviewed. The facility did not develop a dietary care plan for R4 and did not implement R21's care plan for edema. This deficient practice has the potential to negatively affect R4 and R21's health and well-being.</p> <p>Findings include:</p> <p>R4 was admitted to the facility on 01/13/25 with diagnosis of, but not limited to, unspecified severe protein-calorie malnutrition.</p> <p>Review of R4's weight since admission found on 01/14/25, the resident weighed 175.6 pounds (lbs.) and on 02/11/25, a month later, he weighed 166.2lbs. which is a 5.35% weight loss.</p> <p>Review of the initial interdisciplinary team (IDT) care plan meeting notes, dietary services documented "PO [by mouth] intake has been poor, eating 25% or less at meals. No c/o [complaints of] food or menu. Likes ice cream and crispy bacon, however, currently on a minced diet. Wt [weight] 165.1# [pounds] is within IBW [ideal body weight] (144-199#). Significant 10.5# wt loss (6.0%) noted since adm [admission],</p>	F 656			

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F 656	<p>Continued From page 5</p> <p>however, his usually wt from ALF [assisted living facility] was 160-170# without edema. Ensure Plus was increased...[to]...120mL [milliliters] TID [three times a day] on 1/28/25 ...meets criteria for severe protein calorie malnutrition. He doesn't not like chocolate flavor, only vanilla or strawberry flavored ensure. Will continue to honor [to honor] food preferences and monitor weekly wts."</p> <p>On 02/21/25 at 08:44 AM, an interview and concurrent record review with Dietician was done. Dietician stated she creates a care plan for residents within the week of admission. Dietician stated she is familiar with R4 from the assistive living he resided in and reported he had a hard time adjusting to the facility. His weights are within range but based on his usual weight was losing and so his plan of care was to honor food preferences, include a protein shake but not chocolate flavor, offer alternative items, constantly encourage him, and for nursing to ensure his pain was managed. Concurrent review of R4's care plan, found R4 did not have a dietary section. Dietician confirmed there should have been a care plan for his nutritional needs.</p> <p>2) R21 is an 82-year-old male admitted to the facility on 12/20/24. A review of R21's Electronic Health Record (EHR) noted that R21 had an order for an diuretic medication since 12/31/24 for congestive heart failure and edema (swelling caused by too much fluid trapped in the body's tissue).</p> <p>Concurrent interview and record review were conducted with the Director of Nursing (DON) on 02/21/25 at 07:29 AM in his office. State Agency</p>	F 656		

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F 656	Continued From page 6 (SA) reviewed with the DON R21's current care plan which noted a focus that R21 has the potential for fluid imbalance and activity intolerance related to congestive heart failure. One of the interventions listed on the care plan noted, "Medication as ordered-Lasix ...Monitor/document/report PRN any s/sx of hypokalemia in residents receiving diuretic therapy: Fatigue, muscle, weakness, diminished appetite, nausea and vomiting and dysrhythmias, Monitor potassium levels..." DON then searched in R21's EHR and confirmed that R21 did not have any laboratory testing done for potassium level. DON also confirmed that monitoring R21's potassium level should have been implemented, since it is listed in R21's plan of care. A review of the facility policy titled, "Comprehensive Assessment and Care Delivery Process," with a reviewed date of 01/21/25 was conducted. The policy noted, "Comprehensive assessments, care planning, and the care delivery process involve collecting and analyzing information, choosing, and initiating interventions, and then monitoring results and adjusting interventions."	F 656			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of	F 688			

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F 688	<p>Continued From page 7</p> <p>motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record reviews, and interviews the facility failed to ensure one of two residents (Resident (R) 3) sampled for limited range of motion received appropriate treatment for left foot contracture. This deficient practice put R3 at risk of further decrease in range of motion.</p> <p>Findings include:</p> <p>R3 was admitted to the facility on 02/07/19 with diagnoses of dementia, hemarthrosis to right knee, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, cognitive communication deficit, vitamin D deficiency, and osteoarthritis.</p> <p>Review of R3's care plan documented R3 has limited physical mobility related to contractures to left foot. Interventions included "Splint as ordered."</p> <p>Review of R3's physician orders for splint "one time a day for left foot contracture Apply left foot splint on 4 hours/day; ON at 1200 and OFF at 1600 as tolerated and remove per schedule."</p> <p>On 02/18/25 at 12:37 PM, observed splint for left foot on the chair in R3's room, not being used. At</p>	F 688		

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F 688	Continued From page 8 02:26 PM, R3 was observed sleeping in bed, splint for left foot was on the chair next to her. On 02/19/25 at 12:46 PM, observed splint for left foot in R3's room, on the floor next to her wardrobe. R3 was observed in the activity room with no splint on left foot. On 02/19/25 at 02:07 PM, observation and interview with Certified Nurse Aide (CNA) 5 was done. CNA5 was observed to be in R3's room and R3 was observed sleeping in bed. CNA5 reported R3 has only one splint for left foot and the medication nurse puts it on and takes it off the resident, which was observed to be on R3's wheelchair. CNA5 explained R3 had just taken a shower and had taken the splint off. Inquired what time the resident is supposed to wear the splint, CNA5 stated she did not know and then was observed to put the splint on R3. On 02/20/25 at 12:36 PM, observed splint for left foot in R3's room. R3 was observed in the dining room eating lunch with no splint on left foot. On 02/21/25 at 09:18 AM, an interview with Licensed Practical Nurse (LPN) 1 was done. LPN1 confirmed R3 has a splint for her left foot due to her foot dropping and the assigned medication nurse puts it on at 12:00 PM and takes it off at 04:00 PM. Usually, the CNAs will call the medication nurse to put the splint back on if they need to take it off to provide care. Inquired if R3 ever refuses to put the splint on, LPN1 stated R3 never refuses.	F 688			
F 697 SS=D	Pain Management CFR(s): 483.25(k)	F 697			

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F 697	<p>Continued From page 9</p> <p>§483.25(k) Pain Management.</p> <p>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews, and record review, the facility failed to ensure one of three residents (Resident (R) 84) sampled for pain management was consistent with professional standards of practice. R84's pain management was ineffective and not followed up on which has the potential result of discomfort and continued pain.</p> <p>Findings include:</p> <p>R84 was admitted to the facility on 02/04/25 with diagnoses of, but not limited to, insomnia, encounter for surgical aftercare following surgery on the nervous system, and chronic pain syndrome.</p> <p>On 02/19/24 at 08:59 AM interviewed R84 in his room. R84 reported he has constant pain and discomfort on his left shoulder. He requests for oxycodone about every four hours, and it helps the pain go from a 9 to a 7 in the pain index scale (a 0-10 scale where 0 represents no pain and 10 represents the worst possible pain). Nursing staff check on him and ask if the medication is effective and he informs them he is at a pain level of 7. Inquired if nursing staff follow up with other interventions or medications to help relieve his pain further, R84 stated no but he had recently asked the physician to increase his oxycodone dosage from 5 milligrams (mg.) to 7.5 mg., the</p>	F 697		

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F 697	<p>Continued From page 10</p> <p>increase helped a little, resulting in the 7-pain level after taking the medication.</p> <p>Review of R84's physician orders for pain include acetaminophen tablet 325 mg. give two tablets by mouth every four hours as needed for mild pain (1-3), oxycodone hcl oral tablet 5 mg. give 5 mg. by mouth every 4 hours as needed for moderate pain 4-6/10), and oxycodone hcl oral tablet 5 mg. give 7.5 mg. by mouth every four hours as needed for severe pain (7-10/10).</p> <p>On 02/19/25, review of R84's Medication Administration Record (MAR) found on 02/14/25 at 03:20 PM and 02/17/25 at 10:52 AM oxycodone 7.5 mg. was administered and documented as ineffective, and on 02/17/25 at 05:43 AM oxycodone 5 mg. was administered and documented as ineffective.</p> <p>R84's most recent pain management medication (oxycodone 7.5 mg.) was administered on 02/19/25 at 11:23 AM with reported initial pain level of 9 and documented after medication was administered, effective. Follow-up codes in the MAR include ineffective (I), effective (E), unknown (U), and on hold by physician (H).</p> <p>On 02/19/25 at 02:10 PM, a second interview with R84 was done. Inquired if he was administered oxycodone 7.5 mg. at approximately 11:30 AM, he stated he was, and his pain level went down to a 7. R84 reported the medication nurse came in and followed up and told them it went down to a 7. R84 further reported the medication nurse did not offer anything else after reporting his current pain level, post-medication.</p> <p>On 02/20/25 at 12:29 PM, an interview with</p>	F 697		

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F 697	<p>Continued From page 11</p> <p>Licensed Practical Nurse (LPN) 2, medication nurse, was done. LPN2 reported when a resident is in pain she will assess where the location is, provide non-pharmacological interventions, such as repositioning, ask for the pain level, and offer pain medication. After the medication is given, she will follow-up by asking what the pain level is and if it is ineffective offer a stronger medication than the first one given if available. Inquired if the pain level started at a 9 and after the medication was given the pain reduced to a 7 would that be considered effective, LPN2 reported no, a 7 is still considered severe pain, the MAR should be charted as ineffective, and the charge nurse should be notified to inform the doctor.</p> <p>On 02/20/25 at 02:32 PM, a concurrent record review and interview with Registered Nurse (RN) 5, a charge nurse, was done. RN5 reported if pain medication is given the medication nurse needs to follow up within an hour of administration, if the medication is ineffective, the provider should be notified. Inquired if the pain level started at a 9 and after the medication was given the pain reduced to a 7 would that be considered effective, RN5 stated "that would be ineffective." Concurrent record review of R84's MAR for oxycodone 7.5 mg. on 02/14/25 at 03:20 PM and 02/17/25 at 10:52 AM, RN5 confirmed it was documented as ineffective. RN5 further reviewed R84's record for a nursing note and was not able to find any documentation on what happened or what was done further for R84's pain on 02/14/25 and 02/17/25. RN5 reviewed R84's care plan and found no other documentation on R84's pain management that would explain not getting any further treatment if the oxycodone 7.5 mg is ineffective.</p>	F 697		

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F 803 F 803 SS=D	Continued From page 12 Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure resident menus were followed for one of one resident (Resident (R)10) sampled for food and two of 10 residents (R135 and R28) food trays and menus sampled in the kitchenette during food tray line. This deficient practice has the potential to put R10 and R135 at risk of not maintaining their	F 803 F 803			

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F 803	<p>Continued From page 13</p> <p>weight and R28 at risk of low sodium with history of hospitalization.</p> <p>Findings include:</p> <p>On 02/18/25 at 12:31 PM, an observation of R10 and interview with resident representative (RR) 1 was done. R10 was observed to eat lunch (fresh cantaloup, fish, steamed cauliflower, and mashed potatoes with gravy) with assistance from RR1. RR1 reported R10 is supposed to get half the amount of starch on her plate but depending on who plates the food R10 will get the full amount. RR1 stated "today the mashed potato was not half the amount but the full amount." RR1 pointed to the mashed potatoes on her plate and the menu which indicated the mashed potatoes were supposed to be half the amount.</p> <p>On 02/20/25 at 08:09 AM, observed R10 eating breakfast with staff members assistance. The staff member reported R10 was eating mashed potatoes, breakfast sausage and papaya. R10's breakfast menu indicated half the amount for the mashed potatoes written on it. Observed a full scoop of mashed potatoes on her plate.</p> <p>On 02/20/25 at 11:05 AM, during observation of the food tray line for lunch in the kitchenette, observed Dining Room Server (DRS) 3 scoop a full amount of mashed potatoes on R135's plate. R135's menu had half the amount handwritten on the menu. DRS3 finished putting all items from the menu on R135's tray and gave it to another staff member to distribute to the resident. Inquired about the menu and what was written, DRS3 confirmed she was supposed to give R135 half a scoop of mashed potatoes and what she put on the plate was the full scoop. DRS3 was</p>	F 803			

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F 803	Continued From page 14 observed to take the tray back and correct the scoop amount to half. Further observed during observations of the food tray line, R28's menu which indicated she was on fluid restrictions of 1500 milliliters (mL.). The menu specified soup to be 60mL.. Observed DRS3 scoop a full scoop into a bowl and plate it on R28's tray. DRS3 stated the bowl is 120mL. and after reviewing the menu took the bowl back and scooped out half the amount of soup. On 02/21/25 at 08:56 AM, an interview with Dietician was done. Dietician reported that residents with half the amount of starch is usually due to preference or weight control and for R10 and R135 it is for weight control, they are on a controlled carbohydrate diet. Dietician further reported R28 is on fluid restriction of 1500 because of her sodium levels. R28 was hospitalized due to hyponatremia (a condition where the sodium level in the blood is lower than normal) and it is important to keep her on fluid restriction or her sodium level may drop even more. Dietician confirmed the resident menus should be followed.	F 803			
F 812 SS=D	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.	F 812			

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F 812	<p>Continued From page 15</p> <p>(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.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§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:</p> <p>Based on observations, interviews, and record review, the facility failed to ensure opened food was discarded by the use by date for one of five food items sampled in the walk-in refrigerator. Failure to appropriately label stored food has the potential to affect residents that receive food from the kitchen, and visitors and staff who have meals served by the facility, placing them at risk for serious complications from foodborne illness.</p> <p>Findings include:</p> <p>During the initial tour of the main kitchen at 02/18/25 at 08:03 AM observed contracted facility Cook (C) 1 in the walk-in refrigerator gathering food items. C1 stated she is the designated cook for the facility and was gathering food items to make a salad from the top two shelves on the back left of the refrigerator with a little sign "HCC." C1 confirmed those two shelves are food items for the facility, as well as a rolling food tray rack to the right. As C1 exited the walk-in refrigerator, this surveyor (Surveyor (S) 1) and S2 found a small metal container of food, covered with saran wrap, labeled "Olive HCC" S1 and S2 observed the dates on the label to read "TODAY'S DATE 2/8" and was not able to</p>	F 812			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 812	<p>Continued From page 16</p> <p>distinguish the "USE BY" date but concurred it read either "2/15" or "2/16." When Dietary Manager (DM) arrived in the walk-in refrigerator inquired what the observed dates for the olives were, DM stated the "TODAY'S DATE" was "2 ...18" and the use by date was "3 ...16." DM stated the cook forgot to put a slash between the numbers. DM confirmed the dates should be written clearly and the dates on the label for the olives were not written clearly. Compared other labels with dates and all of them included a dash or slash between the month and day. Inquired if the use by date read "2/15" or "2/16" should it had been discarded, DM stated it should have been discarded.</p> <p>At 08:18 AM observed C1 come out of the walk-in refrigerator with a tray of food items for salad and found the same container of olives on the tray. Inquired what the dates on the label read, C1 confirmed "TODAY'S DATE 2/8" and was observed counting forward and stated the use by date was "2/15" (seven days after the opened date) and stated she was going to dump the olives.</p> <p>On 02/20/25 at 09:55 AM, an interview with Dietary Supervisor (DS) was done. DS stated the facility has one cook and she prepares and cooks the food in the main kitchen then brings it up to the facility kitchenette. DS reported opened food items are discarded seven days after opening.</p>	F 812			