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WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint investigation KS00163705. The 2567 was electronically sent on 12/20/21.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This Requirement is not met as evidenced by: The facility reported a census of 49 residents with 16 sampled including one for hospitalization.	F 625		

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

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 625	Continued From page 1 Based interview and record review the facility failed to provide a copy of the facility bed hold policy to Resident (R) 45 or her representative for her facility-initiated hospitalization. Findings Include: - R45's "Electronic Health Record" lacked evidence of written notification of the facility-initiated hospitalization transfers and bed holds to R45 or R45's representative. The 09/11/21 "Nursing Progress Note" documented R45's son requested R45 be sent to the hospital when it was determined R45 had difficulty breathing. The facility obtained an order from Provider K to send R45 to the hospital. Interview on 12/06/11 at 01:52 PM with Social Services Director (SSD) J revealed she spoke with R45's son on the telephone during the weekend of 09/11/21. SSD J stated R45's son requested R45 be sent to the hospital. SSD J verified that no bed hold was placed for R45 in the chart. The "Discharge Process" policy revised on 11/12/19 stated the facility was to complete the bed hold arrangement for all emergency discharge or transfers of residents. The facility did not provide a policy regarding "Bed Hold" as requested by surveyors on 12/06/21. The facility failed to provide a copy of the bed hold policy for R45 or her representative for her 09/11/21 hospitalization.	F 625		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

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F 657	Continued From page 2 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This Requirement is not met as evidenced by: The facility reported a census of 49 residents, with 16 sampled, and one reviewed for elopement. Based on observation, interview, and record review the facility failed to update Resident (R) 22's care plan in a timely manner to include interventions related to the use of a wander guard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort). Findings Include:	F 657		

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- The 10/28/21 "Electronic Medical Record (EMR)" documented the following diagnoses for R22: dementia (progressive mental disorder characterized by failing memory, confusion), Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness).

The 10/28/21 "Admission Minimum Data Set" (MDS) revealed a "Staff Assessment for Mental Status" indicating R22 had short- and long-term memory problems, moderately impaired decision-making skills with fluctuating inattention and continuous disorganized thinking. The "MDS" documented R22 with wandering behaviors occurred four to six days of the seven-day look back period.

The 10/28/21 "Behavioral Care Area Assessment" (CAA) documented R22's memory deficit put him at risk for exit seeking behaviors.

The 10/22/21 "Baseline Care Plan" lacked documentation related to the use of a wander guard for R22.

The 10/22/21 "Elopement Risk Screen" revealed score of 12, indicating at risk for elopement.

Observation and interview on 12/02/21 at 03:17 PM revealed R22 in his roommates' room when the surveyor knocked on the door, and R22 conversed with the roommate. When asked if R22 knew what the bracelet on his right wrist was, he stated his daughter got it for him. He then told the surveyor he had to get ready for work and asked if there were any more questions and upon

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F 657	Continued From page 4 hearing there were no more questions he proceeded to sit on his bed and read the newspaper. He wore lace up boots, jeans, short sleeved shirt, and suspenders. His gait (manner or style of walk) was strong and steady, when he walked. On 12/02/21 at 04:59 PM Licensed Nurse (LN) I revealed the facility placed a wander guard on R22 on 10/25/21. On 12/06/21 at 09:43 AM Licensed Nurse (LN) F revealed R22 was an elopement risk, with a wander guard checked every shift, he has been at risk since he admitted. On 12/02/21 at 02:59 PM Administrative Nurse B revealed she expected all staff to recognize a wander guard and redirect a resident who attempted to go through the locked doors. Administrative Nurse B also confirmed she expected the care plan to be updated promptly and contain information regarding R22's wander guard. The facility "Care Plan" policy revised 07/26/19 documented the person-centered plan of care would be based on sound, clinical judgement that reflects current standards of practice and include treatment objectives that were reasonably obtainable and measurable. The facility failed to update R22's care plan in a timely manner, to include interventions related to the use of a wander guard.	F 657		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		

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F 689	Continued From page 5 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility reported a census 49 residents, with 16 included in the sample, and one reviewed for elopements. Based on observation, interview, and record review, the facility failed to provide sufficient supervision to cognitively impaired Resident (R) 22 who eloped from the facility for approximately eight minutes without staff knowledge within a mile of a busy four-lane highway and within a quarter mile of a busy four-lane intersection next to live railroad tracks. These failures placed R22 in immediate jeopardy. Findings included: - R22's pertinent diagnoses from the 10/28/21 "Physician's Orders" in the "Electronic Medical Record (EMR)" revealed dementia (a progressive mental disorder characterized by failing memory, confusion) and Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure). The 10/28/21 "Admission Minimum Data Set" (MDS) revealed a "Staff Assessment for Mental Status" indicating short and long-term memory problems, moderately impaired decision-making skills with fluctuating inattention, and continuous disorganized thinking. R22 exhibited wandering for four to six days of the seven-day review period, but less than daily that did not place the resident at significant risk of getting to a potentially dangerous place. The resident required limited one staff assistance for transfers	F 689	Past noncompliance: no plan of correction required.	

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and staff supervision with set-up for walking in his room and corridor on the unit. His balance with walking was not steady, but he could stabilize without human assistance and used a walker. R22 also required a wander/elopement alarm during the review period but used less than daily.

The 10/28/21 "Cognitive Care Area Assessment" (CAA) revealed a diagnosis of dementia, which explained his inability to stay on task. He exhibited unorganized thinking and could not always verbalize his wants/needs. He required staff to cue him to stay on task and was not familiar with his surroundings. R22 was only oriented to himself and his memory deficit put him at risk for exit seeking behaviors.

The 10/28/21 "Activities of Daily Living (ADL) CAA" revealed R22 required assistance with mobility, balance, and ADLs.

The 10/28/21 "Behavioral CAA" revealed staff reported R22 wandered all day every day. He wandered into other resident rooms, tried to exit entry doors. and wore a Wanderguard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort).

The 10/22/21 "Baseline Care Plan" revealed R22 had severely impaired cognition with disorganized thinking, inattention, and was a wandering/elopement risk. He could walk, but his gait was unsteady. He was frail, with generalized weakness, and he wandered and a Wanderguard might be needed to ensure the resident's safety.

The 10/25/21 "Comprehensive Care Plan" revealed a 11/10/21 revision, which noted R22 had impaired physical function related to impaired balance, Alzheimer's, and dementia. He loved

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being outside most of all and when he was in his late 80's, he walked a mile a day and ran marathons. He loved "going to the office and still, to this day, loved to work in an office." An 11/12/21 revision noted he needed supervision to limited staff assistance with ADLs/cueing. He "exit seeked" while in the facility. An 11/16/21 revision revealed staff easily re-directed him when he "searched for his car to make an appointment." The care plan lacked information/interventions related to the Wanderguard used for R22.

The 10/22/21 "Elopement Risk Screen" assessment revealed a score of 12, indicating the resident was at risk for elopement.

The 11/23/21 "Physician Orders" revealed staff checked his Wanderguard every shift for placement/function.

The 10/22/21 to 11/23/21 "Interdisciplinary (ID) Notes" revealed the resident wandered most shifts. He would state in multiple instances he was at an airport and needed to find his terminal or searched for his keys, car, and wanted to go to work. He attempted to exit all exit doors and set off door alarms multiple times throughout the day. Staff redirected him as necessary and was effective, but "short lived."

The 10/22/21 to 12/06/21 "Point of Care Charting for Wandering every shift and as needed" revealed the following:
For the question, "Does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g. stairs, outside facility)?" revealed "yes" marked for 23 out of 42 potential instances.
For the question, "Has the resident wandered?" revealed "yes" marked for 41 out of 42 potential

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instances.

The 11/23/21 "Facility Investigation" revealed on 11/20/21 at approximately 03:16 PM, Cook C (who thought the resident was a visitor) assisted R22 out of an alarmed door to the Independent Living area (connected to the LTC facility). The Wanderguard alarm sounded after the door closed, but Cook C thought it was because he put in a wrong code, so he ignored it. CMA D (another staff member on the unit at the time) did not have a pager in her possession (which would have alerted her to the Wanderguard alarm) and when the south doors closed, the alarm could not be heard well. R22 proceeded towards the main entrance and exited the facility with some visitors who were leaving the building. Per interviews, he stayed underneath the outside awning, and then re-entered the facility at approximately 03:22 PM (approximately six minutes later) and asked Concierge staff E if she could help him find his wallet and he was not sure where he needed to go. It was then that, CMA D reacted to the sounding Wanderguard alarm and directed the resident back to the Long-Term Care (LTC) unit.

Observation of the resident on 12/06/21 at 09:45 AM revealed R22 in the common area completing group exercise, fully dressed with a Wanderguard on his right wrist. At 09:58 AM, Licensed Nurse (LN) F assisted R22 to the same door he exited on 11/20/21 to see the Christmas tree in the entrance area. He exited the door with LN F to test the Wanderguard alarms, staff pagers, and response time. At approximately 10:01 AM Certified Nurse Aide (CNA) G came through the alarmed door and found the resident safe with LN F. CNA G showed her pager which did indicated appropriate functioning and the Wanderguard alarm was clearly heard throughout LTC.

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F 689	Continued From page 9 Observation of the area outside the facility on 12/06/21 at 07:00 AM revealed a sidewalk leading to a major road, which led to a major interstate highway if one walked west and if one walked east led to a four-lane major intersection (with speed limits of 40 miles per hour, mph) located about 500 feet east of the facility. About 20 feet further east of the intersection were active railroad tracks running northwest to southeast (parallel to one of the major 4 lane roads). A 10-minute walk to the northwest, revealed an interstate freeway overpass (speed limit of 65 mph), with a six-lane road (speed limit of 40 mph) and intersection with two on and two off ramps to/from the interstate. This was a heavily trafficked area with minimal gaps of vehicles. Interview with R22 on 12/02/21 at 03:17 PM revealed when asked about the Wanderguard on his right wrist and what it was for, he stated his "daughter got it for him. I have to get ready for work, are there any more questions?" He then proceeded to sit on his bed and picked up the paper to read. He was appropriately dressed and wore laced up boots, and his gait (manner of walking) was steady. Interview with Cook C on 12/02/21 at 05:11 PM revealed on 11/20/21 he was in the south hallway at the kiosk completing employee training when R22 walked over to him with a briefcase and asked for help through the alarmed door. Cook C did not recall a Wanderguard and R22 wore a long-sleeved cardigan. Cook C stated R22 "seemed like a visitor with his briefcase, he walked fine. I was unaware of protocols to identify residents as opposed to visitors and did not know to look for the Wanderguard, so I pushed in the code let him through to exit. When the door	F 689		

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closed, the Wanderguard alarm went off, but I did not know what that sound was and did not think to get anyone." Cook C said he then sat back down to complete his employee training. LN H then came to him and asked if he had seen anyone leave through the alarmed door, and that was when Cook C told her he had helped a man through the alarmed door. CMA D then went through the alarmed door and located R22. Cook C then stated, "I have only worked here a couple months, and during orientation was trained on 'at risk' residents for elopement, but it was short, and I did not remember it." He completed re-education after the elopement incident including retraining on the alarm sound when a resident with a Wanderguard was close to the exit doors and what a Wanderguard looked like.

Interview with LN F on 12/06/21 at 09:43 AM revealed R22 was at risk for elopement and had a Wanderguard the nurses checked every shift. The staff pagers and Wanderguard alarms sound when a resident with a Wanderguard went out of the alarmed doors.

Interview with LN H on 12/06/21 at 09:16 AM revealed the resident wandered often throughout the facility, but staff ensured he could be seen at all times. On 11/20/21, the Wanderguard alarms went off and she walked down to the south alarmed exit door and spoke to Cook C, who told her that he put in the code for the alarmed door to let R22 out and he did not know what the alarm was that sounded. The staff found R22 at the concierge desk, and Concierge staff E stated the resident walked out the front doors, came back in asking about his wallet and some books. R22's Wanderguard was in place on his right wrist that the nurses checked for function each shift. She stated there was adequate staff at the time of the

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elopement. R22 eloped because Cook C let him out due to not knowing he was a resident. R22 walked constantly throughout the facility as was pretty steady, but very confused and would carry a briefcase/satchel.

Interview with Concierge Staff E on 12/06/21 at 09:36 AM revealed R22 walked through the main entrance lobby and went out the exit doors. She stated she thoughtR22 was with the visitors leaving. When R22 came back into the facility, approximately 10 minutes later, with his briefcase, he was confused on where he needed to go and said something about a book. Then, CMA D and LN H came to retrieve the resident.

Interview with Administrative Staff A on 12/02/21 at 02:34 PM revealed she stated R22 resided on the east side of the facility. He walked southwest down the hall and then headed south down the hallway to the closed double unalarmed doors. CMA D was seen re-directing R22 once in that hallway, but he then walked through the unalarmed double doors while carrying briefcases, one in each hand. He wore jeans, a white button-down shirt with suspenders and a cardigan with leather laced up shoes. R22 approached the alarmed exit doors to the main exit in independent living on the south side of facility near the employee training kiosk. Cook C sat and worked on employee education when R22 asked him for assistance to get through the alarmed doors. Cook C, thinking R22 was a visitor, entered the code and allowed the resident to pass through. As the alarmed door closed the Wanderguard alarm sounded, but Cook C thought he pressed the code in wrong. From there, the resident made his way past the main exit and followed others leaving the facility. R22 walked out under the covered awning from

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F 689	Continued From page 12	F 689		

approximately 03:19 PM. He could not be seen on the facility cameras until he returned inside to speak with Concierge E at 03:22 PM and asked her if she could assist him with finding his wallet and locating his car. He told her he was not sure what he needed to do and mentioned something about a book and as she picked up the phone to call the LTC, CMA D walked around the corner and escorted him back to LTC at 03:24 PM.

Interview with Administrative Nurse B on 12/02/21 at 02:59 PM revealed she expected Cook C and all staff to know the information about elopement risk residents and said that staff completed training during orientation about Wanderguards. Cook C should have looked for his Wanderguard, acknowledged the alarm, and realized the resident did not have a visitor sticker, and/or checked with nursing staff regarding R22's identity. Cook C had only worked at the facility since this summer. R22's steady gait and prior walking/running abilities made him very able bodied and strong. He thinks that he still works. Since the day he admitted, he would have those briefcases, "ready to go," exit seeking, and staff re-directed him as needed. Staff placed R22's Wanderguard on 10/25/21, and staff added the order to check the Wanderguard every shift on the administration record on 11/23/21.

Interview with LN I on 12/02/21 at 04:59 PM revealed staff placed R22's wander guard on 10/25/21, but staff added the order on the administration record on 11/23/21.

The 02/02/19 "Hazardous Wandering and Elopement Policy" revealed the community will define what constitutes risk for injury of a resident based on the physical location and attributes of the manor and identification of residents at risk.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

(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
F 689	Continued From page 13 The community will exercise reasonable care to ensure a secure environment for residents. The unwitnessed exit policy/procedure will be reviewed with each staff member during orientation and reviewed thereafter, at least annually. Staff failing to follow the unwitnessed exit policy will be counseled, re-educated, and disciplined accordingly. Alert band batteries will be checked daily by the nursing staff to ensure they are functioning properly. Checks will be documented on the TAR. If a door alarm sounds: Staff will visually check inside and outside the area and/or exit triggering the alarm to determine the reason for the alarm. If the reason for the alarm cannot be immediately identified, residents in the affected area will be accounted for, beginning with residents assessed at risk for an unwitnessed exit. The facility failed to provide sufficient supervision to cognitively impaired R22 who eloped from the facility for approximately eight minutes without staff knowledge within a mile of a busy four-lane highway and within a quarter mile of a busy four-lane intersection next to live railroad tracks. These failures placed R22 in immediate jeopardy. The facility identified and corrected the deficient practice by 11/24/21 when the facility implemented the following: 1. The facility provided immediate re-education to on-duty staff, 11/20/2021 and continued with re-education to 100% of community staff through 11/24/21. The topics of the education were Policy/Procedure of hazardous wandering/elopement, elements of inquiry to identify residents at risk of unsafe wandering and the required response to the wander-guard alarm/unauthorized exit. 2. The facility reviewed all residents identified as	F 689		

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F 689	Continued From page 14 at risk for hazardous wandering and elopement and identified a total of 6 residents at risk with wander guards at the time of the elopement. 3. Facility staff have acknowledged understanding and have demonstrated competency. Teachable moment documents with participation, staff observations of residents and interactions with wandering residents will be reviewed at least weekly by the Risk Committee. 4. The Director of Nursing or designee will be responsible to monitor resident and staff behavior to assure residents status is known to staff and residents are provided supervision to prevent unauthorized exit. Due to the facilities actions to identify and correct the deficient practice on 11/24/21, it was deemed past non-compliance and remained at a scope and severity of "J".	F 689		
F 812 SS=F	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	F 812		

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	175301	A. BUILDING _____ B. WING _____	12/06/2021

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F 812	Continued From page 15 standards for food service safety. This Requirement is not met as evidenced by: The facility reported a census of 49 residents with one main kitchen and two satellite kitchens, which served all residents in the facility. Based on observation, interview, and record review the facility failed to store food in accordance with professional standards for food service safety, ensuring the residents remain free from the potential of a foodborne illness, when staff failed to date or discard expired food items. Findings included: - On 12/01/21 at 11:22 AM, during the initial tour of the main kitchen, the following items were noted to be expired: five 32-ounce plain frozen yogurt dated 08/01/21 (two months prior), three 32-ounce plastic containers of garlic sauce dated 11/29/21, one 48-ounce plastic Boursin cream cheese spread dated 11/12/21, and one 16-ounce plastic container of sautéed vegetable base dated 10/07/21. There were also 154 thawed nutritional shakes in the refrigerator that were not dated for when they were placed in the refrigerator for thawing, found during the initial tour of the main kitchen. Interview on 12/01/21 at 11:37 AM with Certified Dietary Manager (CDM) L revealed that the nutritional shakes expired 14 days from the thaw date and expected the staff to have a sticker with a thaw date on the tray of nutritional shakes. The "Food Storage (Dry, Refrigerated, and Frozen)" policy dated 2020 documented "All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded . . . Discard food that has passed the expiration date."	F 812		

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F 812	Continued From page 16 The facility failed to store food in accordance with professional standards for food service safety to prevent the outbreak of foodborne illness when observations revealed expired food in the kitchen.	F 812		