STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 00 B. WING	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE MARION LLC	614 WEST 14TH STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00401454. Complaint IN00401454 - Substantiated. Federal/state deficiencies related to the allegations are cited at F600, F609, F755, F761 and F812. Survey dates: March 30, 2023. Facility number: 012809 Provider number: 155799 AIM number: 201136580 Census Bed Type: SNF/NF: 37 SNF: 5 Total: 42 Census Payor Type: Medicare: 5 Medicaid: 29 Other: 8 Total: 42 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 4, 2023.	F 0000		
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tamera Shirels	ED	04/10/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on record review and interview, the facility failed to protect a resident's right to be free from abuse for 1 of 5 residents reviewed for abuse (Resident B). Findings include: Resident B's clinical record was reviewed on 3/30/23 at 3:31 p.m. Diagnoses included, but were not limited to, senile degeneration of the brain and depressive disorder. A quarterly Minimum Data Set, dated 1/16/23, indicated he had severe cognitive impairment. A progress note, dated 2/26/23 at 5:15 p.m., indicated there had been accusations of a verbal altercation. Review of an Incident Report sent to the Indiana Department of Health's reporting system, provided by the ADON on 3/30/23 at 3:10 p.m. indicated CNA 8 had become upset when she had been asked to lay Resident B down and had raised her voice at him. The facility did not complete a follow-up action report. Review of an Investigation Summary, dated 2/26/23, indicated CNA 8 had been asked to assist	F 0600	Tag number: 600 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **CNA was suspended and sent home, she then text and quit her position.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents and staff will be interviewed to identify any potential abuse. Any alleged abuse will be reported to IDOH and investigated III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **All staff will be educated on abuse and abuse reporting. The ED will be educated by RVPO on**	04/11/2023

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	the resident with incontinent care related to loose stools. The CNA could be heard cursing loudly at the resident because he had loose stools and needed to be changed. During an interview on 3/20/23 at 3:25 p.m., the DON indicated the CNA had sent a text message to the nursing scheduler to inform the facility she had quit. Since the CNA had quit, she didn't think a follow-up report was necessary and didn't send one. Review of a current facility policy, titled "Abuse Prevention and Reporting - Indiana," with a latest revised date of 10/28/22 and provided by the AIT (Administrator In Training) on 3/30/23 at 4:19 p.m., indicated the following: "...Guidelines: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment ...Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation...." This Federal tag relates to complaint IN00401454. 3.1-27(b)		**reporting/follow-up to IDOH** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The administrator in training will interview 5 residents and 5 staff members weekly to ensure abuse is not occurring. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and			

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	misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure a report of an allegation of abuse included a follow-up was sent to the State Agency in a timely manner for 1 of 5 residents reviewed for abuse (Resident B). Findings include: Resident B's clinical record was reviewed on 3/30/23 at 3:31 p.m. Diagnoses included, but were not limited to, senile degeneration of the brain and depressive disorder. A quarterly Minimum Data Set, dated 1/16/23, indicated he had severe cognitive impairment. A progress note, dated 2/26/23 at 5:15 p.m.,	F 0609	Tag number: 609 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The alleged incidents will be thoroughly investigated and will be reported to the IDOH within the 2 hour time frame.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents and staff**	04/11/2023

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	indicated there had been accusations of verbal altercation. Review of an Incident Report sent to Indiana Department of Health, provided by the ADON on 3/30/23 at 3:10 p.m. indicated C.N.A. 5 had become upset when she had been asked to lay Resident B down and raised her voice at him. The report did not include a follow-up report. Review of an Investigation Summary, dated 2/26/23, indicated C.N.A. 8 had been asked to assist the resident with incontinent care related to loose stools. The C.N.A. could be heard cursing loudly at the resident because he had loose stools and needed to be changed. During an interview on 3/20/23 at 3:25 p.m., the DON indicated the C.N.A. had sent a text message to the Nursing Scheduler that she had quit, since the C.N.A. had quit she didn't think a follow-up report was necessary and didn't send one. Review of a current facility policy, titled "Abuse Prevention and Reporting - Indiana," with a latest revised date of 10/28/22 and provided by the AIT (Administrator In Training) on 3/30/23 at 4:19 p.m., indicated the following: "...Guidelines: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment ...Five-day Final Investigation Report: Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health ...." Cross Reference F600		**will be interviewed to identify any potential abuse. Any alleged abuse will be reported to IDOH and investigated** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **The ED will be reeducated on abuse and abuse reporting by RVPO.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **The administrator in training will review all grievances and reported alleged abuse incidents weekly as well as interview 5 residents and 5 staff members weekly to ensure all alleged abuse is being reported timely. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	This Federal tag relates to complaint IN00401454. 3.1-28(e)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and			

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	periodically reconciled. Based on record review and interview, the facility failed to ensure physician prescribed insulin doses were administered within the scheduled time frame for 2 of 3 residents reviewed for insulin administration (Residents D and C). Findings include: 1. Resident D's clinical record was reviewed on 3/30/23 at 12:04 p.m. Diagnoses included, but were not limited to, diabetes mellitus type 2. Current physician orders included: a. Basaglar (long-acting insulin) KwikPen (pen for injecting insulin), inject 60 units subcutaneously two times a day, scheduled at 7:00 a.m. and 7:00 p.m. b. Humalog (short-acting insulin) KwikPen, inject 25 units subcutaneously with meals, scheduled 7:00 a.m., 12:00 p.m. and 5:00 p.m. An annual MDS (Minimum Data Set) assessment, dated 2/20/23, indicated he had received insulin injections everyday during the assessment period. A current care plan, dated 2/21/22, indicated he was at risk for complications related to diabetes mellitus. Interventions included, diabetes medication as ordered by doctor. A review of the March 2023 MAR (Medication Administration Record) indicated the following: The 7:00 a.m. doses of Basaglar had been administered two or more hours later than scheduled 18 times.	F 0755	Tag number: 755 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident C and D were assessed, and MD notified of insulin not being administered within the scheduled time frame. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All resident charts will be audited for the last 30 day for appropriate administration times. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; the Nurses and QMA's were in-serviced on medication administration policy and procedure. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e what quality assurance program will be put into place; The DON or designee will review the 24 hour report Tuesday-Friday and the 72 hour	04/11/2023

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	The 7:00 p.m. doses of Basaglar had been administered two or more hours later than scheduled eight times. The 7:00 a.m. doses of Humalog had been administered two or more hours later than scheduled 11 times. 2. Resident C's clinical record was reviewed on 3/30/23 at 2:35 p.m. Diagnoses included, but were not limited to, diabetes mellitus type 2. Current physician orders included, Lantus (long-acting insulin) SoloStar (pen for injecting insulin), inject 45 units subcutaneouly two times a day, scheduled at 8:00 a.m. and 8:00 p.m. A current care plan, dated 1/6/23, indicated he was at risk for complications related to diabetes mellitus. Interventions included, diabetes medication as ordered by doctor. A review of the March 2023 MAR (Medication Administration Record) indicated the following: The 8:00 a.m. doses of Lantus had been administered two or more hours later than scheduled twice. The 8:00 p.m. doses of Lantus had been administered two or more hours later than scheduled once. During an interview, on 3/30/23 at 9:45 a.m., LPN 6 indicated they sometimes had trouble getting insulin from the pharmacy and she thought she was able to pass medications timely. Review of a current facility policy, titled "MEDICATION ADMINISTRATION POLICY,"		report on Monday during the clinical meeting for any insulin doses administered outside the scheduled time frame. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	revised on 11/1/2015 and provided by the Administer-In-Training indicated "...Medications must be administered in accordance with a physician's order, e.g., the right resident, right medication, right dosage, right route, and right time...." This Federal tag relates to complaint IN00401454. 3.1-25			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			

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	Based on observation, interview and record review, the facility failed to ensure insulin pens and eye drops were labeled with the dates opened, and the dates of expiration, for 2 of 3 medication carts reviewed for medication storage and labeling (E Hall cart 2 and D Hall cart 1). Findings include: 1. During a review of the E Hall medication cart 2, accompanied by LPN 6, on 3/30/23 at 9:42 a.m. the following was observed: a. Four insulin pens labeled as Lantus SoloStar had been opened. There was no label to indicate when the insulin pens had been opened or when they expired. The resident had discharged from the facility on 2/28/23. b. An insulin pen labeled as Lantus SoloStar had been opened. There was no label to indicate when the insulin pen had been opened or when it expired. This resident had discharged from the facility on 4/21/22. c. An insulin pen labeled as insulin glargine had been opened. There was no label to indicate when the insulin pen had been opened or when it expired. d. A bottle of polyvinyl alcohol solution 1.4% had been opened. There was no label to indicate when the bottle had been opened or when it expired. e. Another bottle of polyvinyl alcohol solution 1.4% had been opened. There was no label to indicate when the bottle had been opened or when it expired.	F 0761	Tag number:F761 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All medication carts have been checked for proper medication labeling and storage. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All medication carts will be audited weekly to assure proper labeling, dating and storage of medications. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Nurses and QMAs were in-serviced on labeling, dates, and storage of medications. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The DON or designee will report, during Monday-Friday clinical meeting, the outcome of each audit. The results of these audits will be reviewed in Quality Assurance	04/11/2023

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	f. A bottle of cromolyn sodium 4% ophthalmic solution had been opened. There was no label to indicate when the bottle had been opened or when it expired. 2. During a review of the D Hall medication cart 1, accompanied by QMA 4, on 330/23 at 9:42 a.m. the following was observed: a. An insulin pen labeled as insulin lispro was unopened. QMA 4 indicated insulin pens should be kept in the refrigerator until they were opened. Review of a current facility policy, titled "Medication Storage," with a last revised date of 7/2/29 and provided by the Administrator in Training on 3/30/23 at 4:19 p.m., indicated "...5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration once opened...." This Federal tag relates to complaint IN00401454. 3.1-25(j)		Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §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			

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	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. Based on observation, interview, and record review, the facility failed to ensure foods were stored in a safe and sanitary condition in 2 of 2 kitchens and 2 of 2 food storage areas observed. Findings include: During an observation of the main kitchen, on 3/30/23 at 9:42 a.m., the top shelf of a food preparation table, directly in front of the stove and oven, had a gooey substance and crumbs all over the surface between the spice containers. A dental floss pick was on the edge of the top shelf near the spice containers. A container of pancake syrup was setting on the shelf in dry storage. The container indicated it had been opened on 2/16/23 and was to be used by 3/18/23. During an interview, on 3/30/23 at 10:03 a.m., Dietary Cook 2 indicated she was unaware of any use of dental floss picks for food preparation. There was a bag of dental floss picks the staff used for their teeth after eating. She did not know who would have left the dental floss pick on the food preparation table shelf. She was uncertain when the shelf had been last cleaned. The shelf	F 0812	Tag number: F812 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Both kitchens have been deep cleaned to meet standards. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Both refrigerators in the upstairs are no longer available for use. Cabinets and work stations are clean and on the cleaning schedule. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All dietary staff was in serviced on proper food storage	04/11/2023

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	155799	A. BUILDING 00 B. WING	03/30/2023

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APERION CARE MARION LLC	614 WEST 14TH STREET MARION, IN 46953

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	was supposed to be cleaned at least one time weekly. They had been short staffed lately, and good help was hard to find. The pancake syrup should have been thrown away and she did not know why it was there, as they typically used individually packed syrups. During an observation, on 3/30/23 at 10:16 a.m., in the second-floor kitchen/serving area, a cabinet above the single cup coffee maker contained an open bag of tortilla chips folded over to close it, with no open date. A cabinet with cups stored in it had food debris and stains on the shelf. The second drawer, under a coffeemaker, contained two opened bags of vanilla wafers folded over to close them with no open date. Food debris and stains were on the cabinets and drawer fronts. During an observation, on 3/30/23 at 10:29 a.m., in the second-floor kitchen/serving area, a mini refrigerator contained the following: a covered plastic coffee cup of white liquid with no label or date, a covered plastic cup with white viscous liquid and green flecks with no label or date, a plastic covered cut tomato labeled with a date of 3/23/23, four hard - boiled eggs in a plastic bag with a date of 3/10/23, and food debris on the bottom shelf. There was no thermometer in the refrigerator. During an observation, on 3/30/23 at 10:43 a.m., of the D-Hall nursing station, in the cabinet above the coffee maker, were two bags of opened tortilla chips, folded over to close them, had no name or open date. An uncovered plastic cup with a white powdery substance and a spoon in it was in the cabinet above the sink. During an interview, on 3/30/23 at 10:51 a.m., QMA 4 indicated the white powdery substance		sanitary conditions of a kitchen. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The dietary manager or designee will audit the daily cleaning schedule for each kitchen Tuesday-Friday and on Monday will check the schedule for Saturday-Monday. The same will be done for dating open food items that the food will have an open date and expiration date. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	was food thickener and should have been thrown away. During an observation, on 3/30/23 at 10:54 a.m., of the E-Hall nursing station, disinfectant wipes, alcohol wipes, an open package of flying insect traps, and an air freshener can were stored in a bottom cabinet on the same shelf as an open canister of thickener, electrolyte replacement drinks, and plastic drinking cups. During an interview, on 3/30/23 at 11:03 a.m., CNA 5 indicated she did not know who was responsible for keeping the cabinets/shelves clean and organized or who had placed items in the cabinets. During an interview, on 3/30/23 at 11:05 a.m., LPN 6 indicated the food items should not be stored with the cleaning products or the flying insect traps. During an interview, on 3/30/23 at 11:46 a.m., LPN 3 indicated the open bags of tortilla chips should not have been left in the cabinet (on the D-Hall). During an interview at time of an additional observation of the second-floor kitchen, on 3/30/23 at 2:02 p.m., Dietary Cook 2 indicated the cabinets in the second-floor kitchen were slated to be removed. The cups in the cabinet were not supposed to be placed there, as they were to be brought up and down from the kitchen with each meal. The cabinets and refrigerators should be cleaned at least once weekly. The tortilla chips in the cabinet were probably from the previous evening and should not have been stored in the cabinet. The vanilla wafers should not have been stored in the drawer. She looked in the mini refrigerator and indicated the eggs and tomato should have been thrown away three days after			

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	their marked dates (3/23/23 and 3/10/23). The white liquid substance in the coffee cup was a lactose free milk for one of the residents, and should have been labeled and dated. The viscous white liquid in the plastic cup was probably ranch dressing, but she was not certain. She was unable to locate a thermometer in the refrigerator, but it should have had one. During an interview, on 3/30/23 at 3:53 p.m., the DON indicated the cleaning supplies and insect traps should not be stored with food supplies. The tortilla chips should have been labeled, dated, and closed. During an interview, on 3/30/23 at 4:09 p.m., the Administer in Training (AIT) indicated the corporate consultants had inspected the kitchens the week prior. The facility had been working on the corporate recommendations from the inspection, but it did not excuse the out-of-date food items. A current policy, dated 2020 and provided by the AIT on 3/30/23 at 4:19 p.m., titled "Sanitation of Dining and Food Service Areas" indicated the following: "...Guideline: The Dining Services staff will uphold sanitation of the dining area according to a thorough, written schedule ...Staff will be held responsible for all cleaning tasks. ..." A current policy, dated 2020 and provided by the AIT on 3/30/23 at 4:19 p.m., titled "Refrigerator and Freezer Temperatures," indicated the following: "...Guideline: To ensure all perishable foods stay fresh and palatable, temperatures will be recorded on all refrigerators and freezers in use ...." A current policy, dated 6/3/19 and provided by			

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	the AIT on 3/30/23 at 4:19 p.m., titled "Food - Resident Pantry - Safe Storage," indicated the following: " ...All resident foods and beverages, including alcoholic beverages shall be labeled with the resident's name and dated ...Foods which are outdated or are not labeled and dated shall be discarded daily when cleaning ...." This Federal tag relates to complaint IN00401454. 3.1-21(i)(3)			