STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165290	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTH CREST LIVING CENTER	**34 NORTHCREST DRIVE COUNCIL BLUFFS, IA 51503**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations, staff interview, and facility policy review, the facility failed to label and date food items in order to reduce the risk of contamination and food-borne illness. The facility reported a census of 53 residents. Findings include: Observation of the kitchen refrigerator and freezer during the initial tour on 3/2/20 at 9:50 AM with Staff A revealed the following: a. 9 salads, no date b. Scrambled egg mix without open date c. 32 ounces smoked ham open to air and without an open date d. Diced chicken not labeled; date not legible e. 4 liters shredded cheese lid open to air f. Half 144 oz container of barbeque sauce without an open date g. 5 juices in individual cups not dated h. Shredded cabbage wrapped in saran wrap not labeled; date not legible i. 3 full cabbages in bag, open with no date j. 3 pounds cream cheese, open with no date k. 36 turnover pastry squares, not dated l. 9 individual containers of ice cream, not covered or dated m. Full frozen pie, not dated or labeled On 3/5/20 at 8:54 AM the Dietary Manager provided the Food Storage policy which directed staff to cover, label, and date food as they placed it on the shells. In an interview on 3/2/20 at 10:10 AM, the Dietary Manager verified the facility expected staff to label, cover, and date opened items in the refrigerator and freezer are.

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.