STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH REIDSVILLE	543 MAPLE AVENUE REIDSVILLE, NC 27320

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E 000	Initial Comments An unannounced recertification and compliant investigation survey was conducted on 11/29/21 through 12/2/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # DZFH11	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and compliant investigation survey was conducted on 11/29/21 through 12/2/21. Event ID # DZFH11 22 of the 23 complaint allegation's were not substantiated. 1 of the 23 complaint allegation's was substantiated and resulted in deficient practice.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life	F 565		12/30/21

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

Electronically Signed | 12/20/2021

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F 565	Continued From page 1 in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and review of resident council minutes, the facility failed to address and resolve ongoing grievances about food that were reported at resident council meetings by 4 of 4 residents who regularly attended the resident council meetings for two consecutive months (Resident #1, #39 #46, and #53). The findings included: Observations on 11/29/21-12/1/21 coffee carts were on halls for extended periods of time without being changed. Staff were not offering to reheat the coffee. Meals were observed with the coffee left on the halls and residents reported it was cold. Staff were not offering to reheat coffee. Observation of the coffee delivery 11/29/21 at 11:15AM, the coffee was not offered to residents unless a resident requested a cup. The coffee sat on hall through lunch meal which ended at 1:30	F 565	F-565 The group concern including residents numbered 1, 39, 46 & 53 regarding food and coffee were readdressed, and each resident that was known to have expressed the concerns were followed up with regarding the changes to the coffee and food delivery processes. Each known resident was provided a letter restating the changes. To ensure that all affect residents were communicated with regarding food and coffee temperatures all residents will be interviewed regarding food and coffee temperatures. As the facility realizes the potential for this alleged deficient practice to impact other facility residents the activities director, social services director, and entire Interdisciplinary Team were re-educated on the group grievance process. Additionally, the social services director or	

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F 565	Continued From page 2	F 565		

PM. On 11/30/21 the coffee was delivered to the unit at 11:25 AM, sat on hall through the end of meal staff were not offering the coffee during the meal process.

The resident council minutes dated 9/29/21, documented the concern was the coffee sat on the units for long periods of time. When it was delivered to residents in the room it was served cold. The dietary action documented the coffee carts would go out right before the tray line starts instead of earlier.

Review of the resident council concern form dated 10/27/21, documented the portion sizes were too small, running out of food, coffee cold, milk warm, ticket not matching what ' s on tray, dinner carts come between 6-6:30 PM. The dietary response was the portion sizes for specific resident was increased in the system. Dietary would be working to ensure portions are available for all residents and discussed with the team and review the concern with the new manager. Additional, concerns with meal card missing food items would also be discussed with dietary team. The residents reported food availability was biggest concern at this time as well as food preparation and presentation. The dietary response was new staff was hired and dietary would continue to focus on this until all residents are happy.

A meeting with the members of the Resident Council was conducted on 12/1/21 10:30 AM. A total of 4 residents who regularly attended the facility ' s monthly resident council meeting were present at the meeting. The meeting revealed 4 of 4 residents had ongoing concerns with the meal of the day not being served and food items

designee will audit group concern responses to ensure that they are resolved timely, and that a written response is provided to the known parties. The audits will be conducted monthly for 3 months.
The social services director or designee will provide a written copy of findings to the QAPI committee monthly for their review and recommendations.
12/30/2021
The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been.

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F 565	Continued From page 3	F 565		

on the meal cards not available or served. The residents ' reported staff do not check the meal card for accuracy, they would have to ask staff to get the missing items from the kitchen. In addition, the residents also reported the food preferences, likes/dislikes were not listed on the meal card and staff had no clue of what they like or not and what needs to be the substitute. The residents r further stated the coffee and food was being served cold. In addition, the four members of the resident council reported administration and the previous dietary manager stated they would resolve their food concerns, but they were unaware of what action was taken to resolve the issues. The residents stated the food continued to be served cold and there were no changes in the quality of the food or the selection of food choices. The residents added there had been no individual discussions held with them by dietary or administration about the changes or resolution to their food concerns. Residents stated that despite all the conversations held in resident council meetings discussion regarding food concerns, things have not improved. The registered dietician (RD) never came to talk to them, they were told one exist and we have never seen them or talk to them. They have no idea who the person was, and the dietary manager staff change so much, we have no idea what was happening with the food. The resident's stated they did not feel as though management was addressing their concerns with the food concerns discussed monthly.

Review of meal cards, there were no identified resident food preferences, likes/dislikes listed. Observations during meals revealed food/beverage items were not missing from trays at the time of meal delivery.

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F 565	Continued From page 4	F 565		

An interview was conduction on 12/2/21 at 7:45 AM, the Activities Director (AD) stated when she completed the grievance form, she gave it to the department heads for their response. She added the dietary staff had been made aware of the individual and group concerns via the form. She stated dietary staff have not come directly to the resident council meetings to resolve the group concerns, possibly addressed concerns individually. The AD further stated the coffee and cold food, food missing on trays, milk and other concerns had been a concern since Sept-Oct. The residents continue to have on-going food concerns that were brought up in the meetings when they feel things were not resolved.

An interview was conducted on 12/2/21 at 9:07AM, the Director of Nursing (DON) stated that staff should be looking at the meal tickets to make sure they were accurate. The dietary manager (DM) resigned a month ago and several conversations had been held with the interim DM to get residents coffee, variety of foods and extra fluids. She further stated concerns of the resident group regarding food should have been resolved by the dietary team. She added she had to go out and buy products for residents when the kitchen runs short of supplies. She stated she was unaware if the DM/RD attended the resident council meeting to resolve issues.

An interview was conducted on 12/2/21 at 9:36 AM, the temporary Dietary Manager (DM) stated the concerns for the group were not resolved due to lack of dietary staff.

A telephone interview was conducted on 12/2/21 at 9:38 AM, the Registered Dietician (RD) stated she was unaware of the group concerns in

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F 565	Continued From page 5 October because the former dietary Manager (DM) should have addressed the concerns at the time it was received. She added the DM should been attending resident council meetings when invited. She added that there was a vendor issue regarding coffee. She further stated that the computer system has all the food preference, likes/dislikes and the kitchen would substitute the required food from the computer-generated list to ensure the resident does not get food items they did not like or want. An interview was conducted on 12/2/21 at 10:39 AM, the Administrator stated the expectation would be for the department heads to meet/discuss with resident/individuals to discuss the concern and resolve the concern to the resident satisfaction. The resident/ group grievances should be addressed within a month of receipt of the concern. The department head were responsible for ensuring follow-up with group to ensure the concerns were addressed. He added there had been some kitchen concerns that were being addressed with new management changes.	F 565		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the	F 644		12/30/21

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F 644	Continued From page 6 PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to refer a resident with serious mental illness for Pre-Admission Screening and Resident Review (PASARR) Level II screening for 1 of 1 residents reviewed for PASARR (Resident #2). Findings included: Resident # 2 was admitted on 07/11/14 with diagnoses that included heart failure and hypertension. In 12/07/16 diagnoses were added for major depressive disorder, bipolar disorder, and anxiety disorder. The annual Minimum Data Set (MDS) dated 04/01/21 revealed Resident #2 was cognitively intact. The MDS indicated she was currently not considered by the state Level II PASARR process to have serious mental illness. A care plan dated 09/30/21 revealed Resident #2 had a diagnosis of depression and bipolar. She preferred to remain in her bed and was able to make her needs known. Interventions included follow up with psychological and psychiatric services and monitored for changes in mood or behavior.	F 644	F-644 A Level 2 PASSAR review was requested for the affected resident (#2). The facility will audit all resident diagnosis to ensure all PASSAR level accuracy. The facility realizes the potential for this alleged deficient practice to affect other residents; therefore, the facility re-educated the responsible staff and the entire Interdisciplinary Team on the need to review PASSAR's for accuracy, and to update them at regular intervals. Therefore, the facility audited all facility residents for correct PASSAR types then requested PASSAR reviews if indicated. In addition, the Social Services Director or designee will audit resident diagnosis and PASSAR levels weekly for 4 weeks, then monthly for two additional months. The Social Services Director or designee will provide a summary of finding monthly to the QAPI Committee for their review and recommendations. 12/30/2021 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is	

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F 644	Continued From page 7 A psychotherapy progress note dated 10/25/21 revealed Resident #2 received supportive therapy and was assessed to need continued treatment. The quarterly MDS dated 11/25/21 revealed Resident #2 had received antianxiety and antidepressant medication for 7 out of the previous 7 days. She had not received an antipsychotic medication. Review of Resident #2's medical record on 12/01/21 (the resident's profile) revealed a PASARR Level I was completed and a PASARR number was assigned to the resident. The record stated a PASARR Level II was not indicated. Observations of Resident #2 on 11/29/21 at 1:30 PM revealed she was in bed and watched television. In an interview with Resident #2 on 11/29/21 at 1:30 PM, she revealed she felt her care needs were met. In an interview with the social worker on 12/01/21 at 11:27 AM, she revealed she was not responsible for PASARR processes. An interview with the admissions coordinator was conducted on 12/01/21 at 11:38 AM. She explained the facility's PASARR process and stated when there was a referral to the facility, she let the hospital know to start the PASSAR process. If the hospital doesn't start the PASSAR process, she submitted it when the resident was admitted more than 30 days. The admissions coordinator further explained completing a PASSAR Level II depended on a resident's diagnoses. She would initiate a Level II if a resident was in the facility and it was determined	F 644	completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been.	

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F 644	Continued From page 8	F 644		

a Level II was required. When a resident's diagnoses changed to include mental illness or intellectual disability, a PASSAR Level II would be warranted. She stated a diagnosis of major depression would warrant a PASSAR review. When the admission's coordinator reviewed Resident #2's medical record, she revealed diagnoses were added for bipolar disorder and major depression in 2016. She explained Resident #2 should have had a PASSAR Level II review when the resident's diagnoses changed. The admissions coordinator stated she would need to be notified of diagnosis changes that warrant a PASSAR review. She was not responsible for PASARRs in 2016. It was the responsibility of the former social worker at that time. The admissions coordinator revealed she was not notified when residents' diagnoses changed.

In an interview with the Director of Nursing (DON) on 12/01/21 at 02:17 PM she stated when longer term residents' diagnoses changed, she notified the MDS nurse and the admissions coordinator. The DON explained the admissions coordinator was part of the department head meetings where diagnosis changes were discussed.

An interview was conducted with the MDS nurse on 12/02/21 at 1:09 PM. The MDS nurse stated she called the admissions coordinator if there was a concern with a resident's PASARR code to find out what services a resident was getting and if any changes would be made. The MDS nurse reviewed Resident #2's chart and stated the resident's profile said no Level II PASARR was required, and it must have been determined upon her admission in 2014. She revealed a significant change MDS was not completed for Resident #2

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F 644	Continued From page 9 in 2016. Resident #2's annual MDS in 2016 did not list a significant change or need for PASARR Level II. She reviewed Resident #2's diagnoses and indicated a PASARR Level II review was required.	F 644		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to schedule a registered nurse (RN) for at least 8 consecutive hours a day for 2 of the past 35 days reviewed (11/6/21 and 11/7/21). Findings included: Review of staffing sheets from 10/28/21 through 11/30/21 revealed the following: On 11/6/21 the staffing sheets indicated the facility census was 92 and "0" (zero) RN on duty. On 11/7/21 the staffing sheets indicated the facility census was 92 and indicated the Director of Nursing (DON) a RN was scheduled from 7	F 727	F-727 The nursing schedules were revised to ensure that eight hours of consecutive RN coverage is provided seven days per week. Additionally, the nurse manager audited the nurse schedule for the past 30 days to ensure proper RN coverage. As the facility realizes the potential for this alleged deficient practice to negatively impact resident care the Director of Nursing/designee were re-educated on providing eight hours of consecutive RN coverage seven days per week.	12/30/21

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F 727	Continued From page 10 AM- 7 PM. During an interview on 12/2/21 at 2 PM, the scheduler stated she did the daily staffing schedule for the facility. The scheduler further stated the DON was a registered nurse and was assigned to work as the floor nurse on those day. She indicated the Unit manager was also a registered nurse and was on call. Scheduler indicated the DON, and the Unit manager were the RN for 8 consecutive hours for those days. During an interview on 12/2/21 at 9 AM, the DON stated was scheduled to work on assigned medication cart on some weekends. She confirmed she was the only RN working on those days in the facility. DON indicated the unit manager was a registered nurse and had been on call. The Director of nursing stated she was under the impression that she could serve as the facility's 8 consecutive hour RN coverage on the days in question. During an interview on 12/02/21 03:12 PM, the Administrator stated he was unaware that the DON could not be counted as the facility's 8 consecutive hour RN coverage when scheduled to work on assigned medication cart on the weekends.	F 727	Additionally, the DON/designee will audit the RN schedule daily, Weekly X4 weeks and monthly X 2 months to ensure proper RN coverage. The DON/designee will provide a summary of findings to the QAPI Committee monthly for their review and recommendations. 12/30/2021 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been.	
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date.	F 732		12/30/21

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F 732	Continued From page 11 (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to post accurate daily nurse staffing information for 33 out of 35 days reviewed for staffing. Findings included:	F 732	F-732 The daily staffing posting was corrected. An audit was conducted on the staff postings for the past 30 days to ensure accurate reporting. The facility realizes the potential for this alleged deficient practice to negatively	

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(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 732	Continued From page 12 A review of the nursing staff posting (report of nursing staff directly responsible for resident care) from 10/27/21 through 11/30/21 was conducted. The staff posting included the day shift 7:00 AM - 3:00 PM, the evening shift 3:00 PM - 11:00PM and the night shift 11:00 PM - 7:00 AM. Each shift listed the category for Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nurses (CNAs), the census (# of residents in the facility), a column for actual hours worked and a column for total hours. A review of the actual working assignment sheets compared to the daily staff posting sheets from 10/27/21 through 11/30/21 revealed the staff posting sheets were noted to have discrepancies of actual working hours and actual nursing staff that was physically in the facility working including the RNs, LPNs, and CNAs. A total of 33 days of the 35 days reviewed. During an interview on 12/1/21 at 2 PM, the scheduler stated she did the nursing/staffing schedule for the facility. A copy of staff schedule was provided to the receptionist for completing the daily staff posting. The scheduler confirmed that when any nurse or nurse aide call out for the day this was not communicated to the receptionist. The daily staff posting did not match with the actual working assignment sheets. During an interview on 12/2/21 at 8:10 AM, the receptionist stated was responsible for completing the daily staff posting sheet based on the actual working assignment sheet for the day. The receptionist further stated she was not communicated when an assigned staff had called out for that day, hence the posting was not accurate. The receptionist indicated the nurses	F 732	impact the residents; therefore, the Director of Nursing, and Interdisciplinary Team were educated regarding maintaining an accurate daily nursing staffing posting. Additionally, the Director of Nursing/designee will check the posting for accuracy X2 weeks then monthly for X2 months. The DON/designee will provide a written copy of findings monthly to the QAPI committee for their review and recommendations. 12/30/2021 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 12/02/2021

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F 732	Continued From page 13 (both LPN and RN) worked 12-hour shift per day, and the staff posting indicated nurses worked 16 hours day. The daily staff posting was not reflecting the actual worked hours and actual number of staff working for the day. During an interview on 12/2/21 at 9:00 AM, the Director of Nursing (DON) confirmed the daily staff schedule was inaccurate. The daily staff schedule included the Minimum Data Set (MDS) nurse and DON who were both registered nurse (RN) but not on assignment as RN working for the day. The DON further stated the daily staff posting did not also reflect the actual working hours of the nurses and had not included staff that had called out for the day. An interview was conducted with Administrator on 12/2/21 at 3:23 PM. The discrepancies were reviewed with the Administrator and he reported that further education was needed to make sure the daily staff postings were filled out currently. The daily staff postings should be an accurate picture of how many nursing staff were in the building each day.	F 732		
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	F 812		12/30/21

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F 812	Continued From page 14 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 maintain dinnerware in clean and good condition. Findings included: Observations conducted on 12/01/21 at 11:47am revealed 56 white porcelain bowls, 5 had black spots with discoloration and 1 was chipped. Multiple serving utensils were observed to have dried food on them with clean serving utensils on the drying rack. Staff removed the broken and discolored bowls and rewashed the serving utensils. An interview conducted on 12/1/21 at 1:00pm with the Dietary Aide (DA). She stated she was responsible for placing clean dishes in the appropriate place. The DA said she should have removed and re-washed serving utensils and removed and reported the discolored and broken bowls. An interview conducted on 12/1/21 at 12:00pm with the Cook. The Cook stated staff should remove broken and discolored dinnerware and inform the Dietary Manager so that the dinnerware can be replaced. The cook stated that	F 812	F-812 The affected plates were disposed of, and new dinnerware including bowls, plates, and silverware have been purchased for the facility. The facility realizes the potential for this alleged deficient practice to impact other facility residents. The dietary manager/designee audited all dinnerware to include bowls, plates, and silverware to ensure they were clean and in good condition. All affected plates were disposed of. All dietary staff including the manager will be re-educated on the proper procedures for cleaning, sanitizing, storing, and reporting soiled or discarding broken dinnerware. Additionally, the dietary manager/designee will audit maintenance of all dinnerware regarding cleanliness and condition. The audits will be conducted weekly for four consecutive weeks, and monthly for two additional months. The dietary manager will provide a written copy of findings to the QAPI committee monthly for their follow up.	

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F 812	Continued From page 15 the previous Dietary Manger (DM) resigned, and the interim has been responsible for ordering dinner and service ware. An interview conducted on 11/29/21 at 10:30am with the interim Dietary Manager (DM) stated when dietary staff found broken and discolored dinnerware it should immediately be removed from service and reported to the DM. The DM was responsible for ordering replacement dinnerware. The DM further stated that the second dishwasher was responsible to ensure the dishes/serving utensils were clean and unbroken prior to placing on the drying rack. The DM stated he was not aware of broken and discolored bowls.	F 812	12/30/2021	