STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345228	A. BUILDING _____ B. WING _____	C 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments An unannounced recertification survey was conducted on 01/24/22 through 01/27/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #2XFX11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/24/22 through 01/27/22. Event ID# 2XFX11. One of the 9 complaint allegations was substantiated resulting in a deficiency.	F 000		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the	F 576		2/24/22

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

Electronically Signed | 02/10/2022

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F 576	Continued From page 1 resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews the facility failed to provide residents the right to receive mail when delivered on Saturday. This had the potential to affect all 98 of 98 residents residing in the facility. Findings included: An interview with members of the Resident Council on 01/26/2022 at 1:34 PM indicated at times they did not receive their mail on Saturday. Residents states they could not recall exactly how often or on what date they had not received Saturday mail. Residents indicated they knew their mail arrived at the facility on Saturday because they could see the delivery tracking of the packages on their phone. Residents went on to say this mail would be delivered to them on Monday.	F 576	Resident mail was delivered by Activity Assistant/ Unit Coordinator on the Saturdays following survey 1-29-22 and 2-5-22 and will continue to be delivered on Saturday by _Activity Assistant and or Unit Coordinator/ Certified Nursing Assistant (CNA). All residents residing in the facility have the potential to be affected by this deficient practice. All staff will be in-serviced on resident access to mail. In-services will be presented by the Administrator, Director of Nursing (DON), Assistant DON, Unit coordinator, Staff Development Coordinator (SDC). In servicing began on 2-7-22 and will be completed on or before 2-24-22 Activity assistant, Unit Coordinator, assigned C.N.A. will log the time the mail	

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F 576	Continued From page 2 On 01/26/2022 at 2:39 PM an interview with the Activities Director indicated at times resident's Saturday mail would not be delivered to them on Saturday and she would deliver the Saturday mail to residents on Monday. She stated on Monday 01/17/2022 she delivered resident's Saturday mail. She went on to say the activities assistant scheduled to work Saturday would have delivered the mail but she had not worked. The Activities Director stated on Monday 1/24/2022 she delivered resident's Saturday due to the activities assistant calling out on Saturday. On 01/27/2022 at 2:38 PM an interview with the Administrator indicated she expected resident's Saturday mail to be delivered to resident's on Saturday.	F 576	is received and when it is delivered each weekend. Activity director will audit log each Monday to ensure mail was delivered. Mail delivery will be discussed in resident council monthly to ensure residents are receiving their mail on Saturdays in general as receipt of mail from the USPS varies among residents. Results of audits will be reviewed by the activity director or administrator monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Activity director or Administrator will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Date of completion 2-24-22	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the	F 585		2/24/22

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F 585	Continued From page 3	F 585		

facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for

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example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.

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F 585	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, and record review the facility failed to record a grievance and failed to provide a written grievance summary for 1 of 4 residents (Resident #66) reviewed for grievances. Findings included: A review of the facility's Grievances, Complaint, and Filing policy revealed in part: #5 grievances and complaints may be filed orally or in writing and may be filed anonymously, #7 the Administrator has delegated the responsibility of grievances and or complaint investigation to the grievance officer (Social Worker), and #12 the resident, or persons filing the grievance and or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems. (a)The Administrator or designee will make such reports orally within 5 working days of the filing of the grievance or compliant with the facility. (b) A written summary of the investigation will also be provided to the resident, and a copy will be filed in the business office. Resident #66 was most recently admitted to the facility on 12/15/2021 and originally admitted on 7/25/2021. A review of Resident #66's most recent Minimum Data Set (MDS) dated 12/22/2021 revealed she was coded as cognitively intact with no delusions or hallucinations. During an interview with Resident #66 on	F 585	A grievance was written on 1-24-22 for resident #66 by the Social worker. After investigation, it was determined that the dress was bought approximately 18 months ago, and had been washed multiple times, which fading could be expected, as the facility washers and dryers are used on high temperatures. The facility did choose to replace the dress for the resident on 2-1-22. Order placed on 2-1-22 All residents have the potential to be affected by the deficient practice. All current facility inter viewable residents were interviewed by licensed nurses to see if they had voiced a grievance/concern in the last 30 days and have not received written notice from the facility acknowledging acceptance and resolution. These interviews were completed on 2-9-22. No unknown grievances were identified. In- service for all staff on the Grievance policy was initiated on 2-7-22 by the administrator. In-servicing will be continued by DON / Department managers/ Administrator. In servicing, will be completed on or before 2-24-22. When a grievance/concern is voiced to a staff member, the staff member is responsible to write the grievance on the grievance form and give the form to the supervisor or grievance officer. The grievance will be assigned to the appropriate staff member to complete an investigation and provide a resolution in writing within 5 days, to the person that	

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F 585	Continued From page 6 1/24/2022 at 11:00 am she stated she had a black dress that went to the facility's laundry room for washing. She stated the dress was returned to her in November 2021 a faded brown color. She then stated she told the Assistant Director of Nursing (ADON) in November 2021 and the Administrator in January 2022 about the dress fading during washing. She further stated the Administrator was supposed to get back with her about the dress. She stated she has not heard anything else about the dress from the ADON or Administrator. She further stated she was upset because the dress was not cheap. A review of grievances from January 2021 through January 2022 revealed no grievances concerning Resident #66's black dress. During an interview with the Social Worker on 1/26/2022 at 9:30 am, she stated she did a grievance on 1/24/2022. She stated that was when she first heard about Resident #66's concerns about the dress. The ADON stated during an interview on 1/26/2022 at 11:00 am she was in Resident #66's room around two months ago (November 2021) and heard the resident and the nurse aide talking about the faded dress. She then stated she did not write a grievance because Resident #66 did not seem upset about the faded dress. During an interview with the Administrator on 1/26/2022 at 1:50 pm she stated she remembered Resident #66 telling her about the dress on 1/7/2022. She stated she did not write a grievance and has not given her a grievance summary concerning the investigation. She then stated she believed since the resident had told	F 585	voiced the grievance. The grievance officer will log the grievance and will be reviewed daily in morning meeting to ensure grievances are investigated and responded to within 5 days. Audits to identify unresolved grievances will be conducted by Administrator /Social worker / DON/ ADON/ Admissions/ Unit coordinators. Audits will consist of interviews with 10 residents/ resident representatives a week x 4 weeks, then 5 residents/representatives a week x 8 weeks. Administrator /SW will monitor/review audits monthly to identify patterns and trends, adjust the plan as needed to maintain compliance. The Administrator and/or Social Worker will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Date of completion 2-24-22	

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F 585	Continued From page 7 other staff members a grievance would have already been written. She then stated she did not find a grievance for the dress. She further stated she would have expected the ADON and anyone else that was aware of the issue to write a grievance.	F 585		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's	F 690		2/24/22

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F 690	Continued From page 8 comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review the facility failed to provide sanitary catheter care to prevent contamination when cleaning a urinary catheter by wiping the catheter tubing towards the resident instead of away from the resident for 1 of 2 residents reviewed for catheter care. (Resident #1) Findings included: Resident #1 was admitted to the facility on 2/12/15. His active diagnoses included cerebrovascular disease, acute kidney failure, artificial openings of urinary tract status, and history of urinary tract infections. Resident #1's quarterly minimum data set assessment dated 10/4/21 revealed he was assessed as moderately cognitively impaired. He required extensive assistance with toilet use and personal hygiene. He was assessed to have an indwelling catheter. Resident #1's care plan dated 1/19/22 revealed Resident #1 was care planned to have an increased risk for the development of urinary tract infections (UTIs) related to the use of a suprapubic catheter and history of UTIs. The interventions included to use good handwashing techniques before and after care, administer medications as ordered, monitoring for side	F 690	On 1/26/2022, Resident #1 was provided suprapubic catheter care with Certified Nursing Assistant #1 cleaning towards the resident□s catheter insertion site. Certified Nursing Assistant #1 was re-educated on proper Incontinence Care for Catheters to include Suprapubic Catheters with emphasis on cleaning away from the catheter site by Director of Nursing. On 1/26/2022, 100% audit of all residents with catheters was completed by the Director of Nursing to assure proper catheter care was provided. The Director of Nursing identified any area of concern during the audit to include but not limited to emphasis on cleaning away from the catheter site. On 2/7/2022, In-service was initiated by the RN-Staff Development Coordinator with all Licensed Nurses and Certified Nursing Assistants regarding to Incontinence Care for Catheters to include Suprapubic Catheters with emphasis on cleaning away from catheter site. In-service will be completed by 2/24/2022. All newly hired Licensed Nurses and Certified Nursing Assistants will be in-serviced by the Staff Development Coordinator during orientation in regards to Bowel/Bladder Incontinence, Catheter Care with emphasis on cleaning away	

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F 690	Continued From page 9 effects and effectiveness, and wear gloves with care. During an interview on 1/24/22 at 11:30 AM Resident #1 stated during baths the staff did not wash his catheter well which resulted in him having multiple urinary tract infections. During observation of Resident #1's morning activities of daily living care on 1/26/22 at 9:54 AM Nurse Aide #1 was observed cleaning Resident #1's suprapubic catheter. The nurse aide cleansed the resident's stomach and pelvic area with soap and water on a washcloth. Using the same washcloth, she then took the catheter tubing and wiped the catheter tubing starting away from the catheter insertion site and wiping towards the resident ending at the catheter insertion cite. She wiped the catheter in this way three times still utilizing the same washcloth. She then continued providing his bath and did not return to the catheter for any further cleansing. During an interview on 1/26/22 at 10:11 AM Nurse Aide #1 stated she did not realize she had wiped towards the resident during catheter care. She further stated she was trained to always wipe away from the resident when providing catheter care to avoid introducing bacteria to the catheter entrance cite. During an interview on 1/26/22 at 10:20 AM the Director of Nursing stated when providing care to a resident with a catheter, suprapubic or otherwise, nurse aides were trained to cleanse the catheter by wiping the catheter in the direction away from the resident's body to avoid infections. She concluded Nurse Aide #1 should not have wiped Resident #1's catheter towards the	F 690	from catheter site. The Assistant Director of Nursing and/or Staff Development Coordinator will monitor Catheter Care 3 times a week x 4 weeks, then 2 times a week x 4 weeks, then monthly x 1 month utilizing the Catheter Care Audit Tool. This audit tool is to ensure appropriate catheter care performed. Any Licensed Nurses and Certified Nursing Assistants will be immediately re-educated by the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator for any identified concerns. The Director of Nursing will review and initial the Catheter Care Audit Tool for completion and to ensure all areas of concerns were addressed 3 times a week x 4 weeks, then 2 times a week x 4 weeks, then monthly x 1 month. The Administrator will forward the results of the Catheter Care Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months. The Executive QAPI Committee will meet monthly x 3 months and review the Catheter Care Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 690	Continued From page 10 resident's body during care.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to keep unattended medications stored in a locked medication cart for 1 of 5 medication carts observed (200-hall medication cart). Findings included:	F 761	The Director of Nursing and Administrator initiated education for licensed nurses on 1/25/22, regarding use of key pad lock vs using key on medication and treatment carts in order to assure auto locking of carts for securement of medications and nurse should always assure medication	2/24/22

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F 761	Continued From page 11 During observation on 1/24/22 at 12:09 PM the 200-hall medication cart was observed unlocked and unattended on the 200 hall. At 12:09 PM a nurse aide walked past the unlocked medication cart. At 12:11 PM Nurse #1 returned to the medication cart and noted it was unlocked. During an interview on 1/24/22 at 12:11 PM Nurse #1 stated she left the 200-hall medication cart unlocked and it should have been locked prior to her leaving it unattended. During an interview on 1/26/22 at 8:50 AM the Administrator stated medication carts were to be locked when left unattended and Nurse #1 should have locked the 200-hall medication cart prior to leaving it.	F 761	and treatment carts are locked when they leave the cart unattended. All medication and treatment carts were checked by the Administrator and DON on 1/24/22, to validate that carts were locked and that the auto lock feature was activated to assure that carts would auto lock. Auto lock feature was working properly on all carts. The Director of Nursing and Administrator initiated education for licensed nurses on 1/25/22, regarding use of key pad lock vs using key on medication and treatment carts in order to assure auto locking of carts for securement of medications and nurse should always assure medication and treatment carts are locked when they leave the cart unattended. The nurse should only use the key to unlock the medication and treatment cart in an emergency situation where the keypad lock is not functioning. Use of the key disables the auto lock feature. The Administrator, DON, ADON and Unit Manager will observe medication and treatment carts 5 x week for 4 weeks, then 3 x week for 2 months to assure carts are locked when unattended. Observation will include all shifts and weekends. The Administrator, DON, ADON and Unit Manager will observe medication and treatment carts 5 x week for 4 weeks, then 3 x week for 2 months to assure carts are locked when unattended. Observation will include all shifts and weekends. The DON or ADON will review the audits monthly to identify patterns/trends and will	

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	345228	A. BUILDING _____ B. WING _____	C 01/27/2022

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F 761	Continued From page 12	F 761	adjust the plan as necessary to maintain compliance.	
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 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 label and date opened food and drink containers stored ready for use in for 3 of 4 refrigerators (kitchen, 100 hall pantry, 300 hall pantry) reviewed for food storage. This practice had the potential to affect food served to residents. Findings included: 1. An observation on 1/24/2022 at 11:20 am of the kitchen refrigerator revealed two bottles (water and soda) with less than half the contents	F 812	All items that were not labeled and dated were removed from the refrigerators in the kitchen, 100 hall pantry and 300 hall pantries on 1-24-22 and 1-27-22. The food was discarded by the dietary staff. Pantry room refrigerators on 100 hall and 300 hall and kitchen refrigerator have the potential to be affected. These refrigerators were audited on __2-9-22____, and all items were dated / labeled or discarded. The audit was done by Dietary Aid.	2/24/22

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F 812	Continued From page 13 in the bottles. There were no names or dates on the bottles. The bottles was stored with supplements designated for resident use. During an interview with the Assistant Dietary Manager (ADM) on 1/24/2022 at 11:22 am she stated the refrigerator was used to store the milk and supplements. She stated the soda and water bottles should have been put in the employee's refrigerator. She then confirmed the bottles did not have a name or date on it. The ADM stated she normally checked the refrigerators daily to make sure anything that was opened was labeled and dated. She then stated she did not checked the refrigerators the morning of 1/24/2022. 2. An observation on 1/27/2022 at 12:21 pm of the 100 hall pantry refrigerator revealed a clear bowl with a red top that had soup in it. The bowl did not have a name or a date on it. During an interview with Nurse #2 on 1/27/2022 at 12:21 pm she stated the refrigerator was used to keep the employee's and resident's food in it. She then confirmed the bowl did not have a name or date on it. She further stated that there was a sign on the wall beside the refrigerator instructing the staff to label and date food items. She stated she believed the pantry refrigerators was checked by the dietary department. 3. An observation of the 300 hall pantry room refrigerator was conducted on 1/27/2022 at 12:40 pm with the Administrator. The refrigerator had a white Styrofoam plate with food in it without a date, had food in an aluminum foil package that was open without a name or date, and a container of chicken without a name or date.	F 812	In service on food storage policy was initiated by the administrator for all staff on 2-7-22. In-servicing will continue by administrator/ Director of Nursing (DON) . Education will be completed on or before 2-24-22. Dietary staff was educated (by the administrator on 2-9-22 and 2-10-22 on their responsibility to check refrigerators daily and to discard all unlabeled or out of date food. Resident food that is placed in the pantry refrigerators are to be dated and labeled with the residents□ name and date when placed in the refrigerator. Food will be discarded after 72 hours. Staff food items are not to be stored in pantry or kitchen refrigerators. Food items that are placed in the kitchen refrigerator are to be dated when opened or according to storage guidelines. Food that is not labeled will be discarded when found. 100 hall, 300 hall, and kitchen refrigerator will be audited for unlabeled food 5 x week x 4 weeks, then 3 x week x 4 weeks then 2 x week x 4 weeks. Auditing will be completed by administrator /DON/Dietary manager Administrator / Dietary manager will review Audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Administrator and/or the Dietary manager will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Completion date 2-24-22	

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F 812	Continued From page 14 During an interview with the Administrator on 1/27/2022 at 12:42 pm, she confirmed the food items were not labeled with names and dates. She then stated employees were educated on the proper way to store food items in the refrigerator. She further stated she would have expected the employees to have followed the protocol for food storage. She stated the Dietary Manager, or a designated person was responsible for checking the refrigerators for proper food storage.	F 812		