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OFFICE OF INSPECTOR GENERAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/05/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185318		12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF KUTTAWA, LLC	1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42055

(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 000	INITIAL COMMENTS A Recertification Survey/Abbreviated Survey investigating Complaint #KY24119 was conducted on 12/16/15 through 12/17/15 with deficiencies cited at the highest Scope and Severity of an "E". Complaint #KY24119 was substantiated with related deficiencies.	F 000	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Christian Care Center of Kuttawa of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Christian Care Center of Kuttawa files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225	**Corrective Actions for Targeted Residents** Resident #7 is non-interviewable. Resident #7 was physically assessed by the Assistant Director of Nursing on 12/1/15 and found to have shown no ill-effects from cited practice. Continues	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cindy Burton
TITLE: Adm. E.D.
(X6) DATE: 1.11.16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's "Abuse Protocols", it was determined the facility failed to ensure an alleged violation which involved mistreatment of a resident was reported immediately for one (1) of fifteen (15) sampled residents (Resident #7). On 12/01/15 at approximately 2:00 AM, Registered Nurse (RN) #1 yelled at Resident #7 and approached him/her in a threatening manner by slapping her hands down on the table in front of the resident. The staff (Certified Nurse Aides (CNA's)#1, #2, #3 and #4) who were aware of the incident failed to report the incident immediately. The findings include: Review of the facility's policy and procedure, titled, "Abuse Protocol-Kentucky Facilities", last revised 10/2002, revealed residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. All employees will report any incidents of abuse, neglect, involuntary seclusion, and misappropriation of resident property to their immediate supervisor and Supervisors will report to the Administrator or designee immediately. Further review revealed the policy did not address what staff should do if	F 225	Corrective Actions for Targeted Residents (Continued) When the Executive Director was made aware of the incident at 8:00am on 12/1/15, morning of incident, RN #1 was suspended immediately pending an alleged abuse investigation being conducted by the facility on this date. During a telephone interview with the Executive Director and the Director of Nursing on 12/1/15, RN #1 quit her job with the facility without notice. C.N.A.s #1, #2, and #4 received disciplinary action and C.N.A.s #1, #2, #3 and #4 were educated by the DON on 12/1/15 regarding the need to report any alleged violations involving resident mistreatment, neglect, or abuse to the facility Executive Director immediately, per State and Federal Regulations and per Facility Policy and Procedure. Identification of Other Residents with Potential to be Affected Facility residents have the potential to be affected by this practice. Facility Resident interviews were conducted by the Social Services Director on 12/1/15 regarding quality of care and staff member issues they might have encountered. Non-interviewable residents were physically assessed by the Assistant Director of Nursing and the Charge Nurse, LPN on 12/1/15. Continue	

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F 225	Continued the alleged perpetrator was the Immediate Supervisor. Record review revealed the facility admitted Resident #7 on 03/28/15 with diagnoses, which included Dementia, Psychotic Disorder with Hallucinations, Major Depressive Disorder, Generalized Anxiety Disorder, and Cerebral Palsy. Review of a quarterly Minimum Data Set (MDS) assessment, dated 10/06/15, revealed the facility was unable to complete a Brief Interview of Mental Status (BIMS) interview with Resident #7 but assessed the resident with impaired cognition and unable to make daily decisions. Review of a facility's Investigation Report, dated 12/01/15, revealed on 12/01/15 at approximately 2:00 AM, Resident #7 was sitting near the nursing desk, where RN #1 was sleeping behind the desk, and Resident #7 was yelling and screaming and was not able to be consoled. Further review of the report revealed RN #1 got up from behind the desk and approached Resident #7 and slammed her hands on the table in front of the resident and told him/her to "Shut that sh__ up or I am going to call the cops". Two (2) of the Certified Nursing Assistants (CNA's) working took Resident #7 to his/her room and attempted to calm him/her down. Further review of the report revealed the incident was not reported to the Director of Nursing (DON) or the Administrator (ADM) until later in the morning. Interview with CNA #1, on 12/16/15 at 4:11 PM, revealed she was walking down the hallway when RN #1 approached the table Resident #7 was sitting at and slammed her hands down on the table and told him/her to "Shut that sh__ up or I am going to call the cops". Further interview	F 225	**Identification of Other Residents with Potential to be Affected (Continued)** The results of these interviews and assessments were that no other findings of alleged mistreatment was noted. Education of Facility Staff was initiated on 12/1/15 by the DON regarding following the Abuse Prevention and Potential Abuse Reporting Policy to include- the need for separating the involved staff member from the involved resident immediately by sending the staff member home pending an alleged abuse investigation by the facility. Also, the need to report any alleged violations involving resident mistreatment, neglect, or abuse to the facility Executive Director immediately, per State and Federal Regulations and per Facility Policy and Procedure. **Systematic Changes** The Facility Abuse Protocol was revised on 1/11/16 with review and approval from the Quality Assurance Performance Improvement Committee and the Medical Director to address staff procedure should the alleged perpetrator of violations involving resident mistreatment, neglect, or abuse be their immediate Supervisor. Mandatory in-service was held on 1/8/16 by the Executive Director for Facility Staff regarding following the Abuse Prevention and Potential Abuse Reporting Policy. Continue	

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F 225	Continued revealed two (2) nights prior to this incident, she and another CNA left a note under the Director of Nursing's (DON) door to inform her of RN #1 sleeping while on duty and not performing job duties on night shift. She stated she did not report the incident that occurred on 12/01/15 because RN #1 had called the other CNA and cursed her out for reporting to the DON about her sleeping. She stated she felt intimidated by the nurse; however, she knew she should have reported the incident as she had been trained to do. Interview with CNA #2, on 12/16/15 at 12:18 PM, revealed she saw RN #1 come around to Resident #7 and slam her hands on the table. She stated RN #1 was hollering at the resident, she, and CNA #4 escorted Resident #7 to his/her room. She revealed RN #1's yelling appeared to make the situation worse and the resident was yelling and screaming. She stated she had been trained to get a resident to safety if suspected abuse had occurred and then report the incident to the supervisor. She stated she thought one of the other CNAs would report it. Interview with CNA #4, on 12/16/15 at 10:59 AM, revealed she heard RN #1 screaming at the resident, but was unsure of what was said because she was walking off. She stated Resident #7 was out of control and she and the other CNAs attempted to calm the resident down. Further interview revealed she had been trained to report suspected abuse; however, she had never had an allegation occur against her supervisor and was not sure how to handle the situation. Interview with CNA #3, on 12/16/15 at 10:15 AM, revealed she did not witness the alleged incident;	F 225	<u>Systematic Changes (Continued)</u> This includes- • The need for separating the involved staff member from the involved resident immediately by sending the staff member home pending an alleged abuse investigation by the facility. • Also, the need to report any alleged violations involving resident mistreatment, neglect, or abuse to the facility Executive Director immediately, per State and Federal Regulations and per Facility Policy and Procedure. This in-service will be repeated by the ED on 1/22/16 to ensure Facility Staff is educated. Newly-hired Facility Staff will be educated by the Human Resources Coordinator during their orientation period regarding following the Prevention Abuse and Potential Abuse Reporting Policy to include- the need for separating the involved staff member from the involved resident immediately by sending the staff member home pending an alleged abuse investigation by the facility. Also, the need to report any alleged violations involving resident mistreatment, neglect, or abuse to the facility Executive Director immediately, per State and Federal Regulations and per Facility Policy and Procedure.	

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F 225	Continued however, she was told about it from a co-worker. She stated she worked with RN #1 on a couple of occasions and every time she worked with RN #1, RN #1 was sleeping somewhere in the facility. She further stated she should have reported RN #1 for sleeping at work and what she had been told about the incident between RN #1 and Resident #7 but she thought the other CNAs had reported it. Interview with the Director of Nursing (DON) and Administrator, on 12/17/15 at 2:00 PM, revealed they expected the CNA's to report any allegation of abuse immediately regardless of who the accused was.	F 225	**Monitoring** A Mandatory, All Staff In-service is conducted quarterly by the Executive Director to educate, review, and discuss Abuse Prevention and Potential Abuse Reporting Policy. An investigation and follow-up of any alleged violations involving resident mistreatment, neglect, or abuse received by the facility will be conducted weekly by the Executive Director, promptly following each allegation, to ensure Prevention Abuse and Potential Abuse Reporting Policy is followed per State and Federal Regulations- to include the need to report any alleged violations involving resident mistreatment, neglect, or abuse to the facility Executive Director immediately. Findings from these investigations will be presented to the monthly Quality Assurance Performance Improvement Committee for review and recommendations until desired threshold of 100% compliance is met for 3 consecutive months; then audit will be conducted monthly by the ED. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.	1/29/16

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F 226 S9=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's "Abuse Protocol", it was determined the facility failed to ensure written policies and procedures were implemented that prohibited mistreatment of one (1) of fifteen (15) sampled residents (Resident #7). Certified Nurse Aides (CNA's) #1, #2 #3, and #4 failed to implement the facility policy to immediately report that Registered Nurse (RN) #1 had mistreated Resident #7 when she slammed her hands down on the table in front of the resident and screamed "Shut that sh__ up or I'm going to call the cops".	F 226	<u>Corrective Actions for Targeted Residents</u> Resident #7 is non-interviewable. Resident #7 was physically assessed by the Assistant Director of Nursing on 12/1/15 and found to have shown no ill-effects from cited practice. When the Executive Director was made aware of the incident at 8:00am on 12/1/15, morning of incident, RN #1 was suspended immediately pending an alleged abuse investigation being conducted by the facility on this date. During a telephone interview with the Executive Director and Director of Nursing on 12/1/15, RN #1 quit her job with the facility without notice. C.N.A.s #1, #2, and #4 received disciplinary action and C.N.A.s #1, #2, #3, and #4 were educated by the DON on 12/1/15 regarding the need to report any alleged violations involving resident mistreatment, neglect, or abuse to the facility Executive Director immediately, per State and Federal Regulations and per Facility Policy and Procedure. <u>Identification of Other Residents with Potential to be Affected</u> Facility residents have the potential to be affected by this practice. Facility Resident interviews were conducted by the Social Services Director on 12/1/15 regarding quality of care and staff member issues they might have encountered. Non-interviewable residents were physically assessed by the Assistant Director of Nursing and the Charge Nurse, LPN on 12/1/15.	

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F 226	Continued The findings include: Review of the facility's policy titled, "Abuse Protocol-Kentucky Facilities", last revised 10/2002, revealed all employees will report any incidents of abuse, neglect, involuntary seclusion, and misappropriation of resident property to their immediate Supervisor. Further review revealed and Supervisors will report to the Administrator or designee immediately; however, further review revealed the policy did not address what staff should do if the alleged perpetrator was the immediate Supervisor. Record review revealed the facility admitted Resident #7 on 03/28/15 with diagnoses, which included Dementia, Psychotic Disorder with Hallucinations, Major Depressive Disorder, Generalized Anxiety Disorder, and Cerebral Palsy. Review of the facility's Investigation Report, dated 12/01/15, revealed on 12/01/15 at approximately 2:00 AM, Resident #7 was sitting near the nursing desk, where RN #1 was sleeping behind the desk, and Resident #7 was yelling and screaming and was not able to be consoled. Further review of the report revealed RN #1 got up from behind the desk and approached Resident #7 and slammed her hands on the table in front of the resident and told him/her to "Shut that sh__ up or I'm going to call the cops". Two (2) of the Certified Nursing Assistants (CNA's) working took Resident #7 to his/her room and attempted to calm him/her down. Further review of the report revealed the incident was not reported to the Director of Nursing (DON) or the Administrator	F 226	**Identification of Other Residents with Potential to be Affected (Continued)** The results of these interviews and assessments were that no other findings of alleged mistreatment was noted. Education of Facility Staff was initiated on 12/1/15 by the DON regarding following the Abuse Prevention and Potential Abuse Reporting Policy to include- the need for separating the involved staff member from the involved resident immediately by sending the staff member home pending an alleged abuse investigation by the facility. Also, the need to report any alleged violations involving resident mistreatment, neglect, or abuse to the facility Executive Director immediately, per State and Federal Regulations and per Facility Policy and Procedure. **Systematic Changes** The Facility Abuse Protocol was revised on 1/11/16 with review and approval from the Quality Assurance Performance Improvement Committee and the Medical Director to address staff procedure should the alleged perpetrator of violations involving resident mistreatment, neglect, or abuse be their immediate Supervisor. Mandatory in-service was held on 1/8/16 by the Executive Director for Facility Staff regarding following the Abuse Prevention and Potential Abuse Reporting Policy. Continue	

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F 226	Continued (ADM) until later in the morning. Interview with CNA #1, on 12/16/15 at 4:11 PM, and interviews on 12/16/15 with CNA #2 at 12:18 PM and CNA #4 at 10:59 AM, revealed they were trained to report any suspected abuse to the supervisor and knew this was facility policy. The CNAs stated they should have reported the incident immediately per facility policy. CNA #4 stated she had never had an allegation of abuse against her supervisor and was not sure how to handle the situation. Interview with CNA #3, on 12/16/15 at 10:15 AM, revealed when she had worked with RN #1, the RN would go to sleep and she had heard about the incident between RN #1 and Resident #7. She stated she should have reported the nurse sleeping and what she was told about the incident between RN #1 and Resident #7 per the facility policy but she thought the other CNAs had reported it. Interview with the Director of Nursing (DON) and Administrator, on 12/17/15 at 2:00 PM, revealed they expected the CNA's to report any allegation of abuse immediately as per the facility policy regardless of who the abuser was.	F 226	Systematic Changes (Continued) This includes- • The need for separating the involved staff member from the involved resident immediately by sending the staff member home pending an alleged abuse investigation by the facility. • Also, the need to report any alleged violations involving resident mistreatment, neglect, or abuse to the facility Executive Director immediately, per State and Federal Regulations and per Facility Policy and Procedure. This in-service will be repeated by the ED on 1/22/16 to ensure Facility Staff is educated. Newly-hired Facility Staff will be educated by the Human Resource Coordinator during their orientation period regarding following the Prevention Abuse and Potential Abuse Reporting Policy to include- the need for separating the involved staff member from the involved resident immediately by sending the staff member home pending an alleged abuse investigation by the facility. Also, the need to report any alleged violations involving resident mistreatment, neglect, or abuse to the facility Executive Director immediately, per State and Federal Regulations and per Facility Policy and Procedure.	

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F 226	Continued	F 226	**Monitoring** A Mandatory, All Staff In-service is conducted quarterly by the Executive Director to educate, review, and discuss Abuse Prevention and Potential Abuse Reporting Policy. An investigation and follow-up of any alleged violations involving resident mistreatment, neglect, or abuse received by the facility will be conducted weekly by the Executive Director, promptly following each allegation, to ensure Prevention Abuse and Potential Abuse Reporting Policy is followed per State and Federal Regulations- to include the need to report any alleged violations involving resident mistreatment, neglect, or abuse to the facility Executive Director immediately. Findings from these investigations will be presented to the monthly Quality Assurance Performance Improvement Committee for review and recommendations until desired threshold of 100% compliance is met for 3 consecutive months; then audit will be conducted monthly by the ED. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.	1/29/16

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to ensure food was prepared and served under sanitary conditions. Observations revealed food items in the refrigerators and freezer opened and not labeled with a date as to when the items were opened and a Dietary Cook left the tray line with gloved hands to retrieve items from the refrigerator and returned to the tray line without changing gloves and washing her hands. Review of the facility's Census and Condition, dated 12/15/15, revealed fifty-eight out of fifty-nine (59) residents in the building received their meals from the kitchen. One (1) resident received tube feedings. The findings include: Review of the facility's policy, titled, "Food Storage", not dated, revealed, "All products should be dated upon receipt and when they are prepared", and to "Remember to cover, label and date". Further review revealed to wash hands before handling food and to keep work surfaces clean and orderly. Observation of the food service tray line, on 12/15/15 at 11:40 AM, revealed the Dietary Cook left the tray line with gloved hands to retrieve	F 371	**Corrective Actions for Targeted Residents** Food items in the refrigerators and freezer, opened and unlabeled with the date of opening, were discarded by the Dietary Manager on 12/15/15. Cited Dietary Cook was counseled by the Dietary Manager on 12/15/15 regarding the proper procedure for preparing and serving food under sanitary conditions; addressing the need to wash hands when changing gloves and after leaving tray line then returning to serve food. The C.N.A. noted retrieving a carton of milk from the refrigerator with her bare hands was counseled by the DON on 12/16/15 regarding allowing Dietary Staff to handle food items needed from the kitchen. **Identification of Other Residents with Potential to be Affected** Facility residents have the potential to be affected by this practice. No residents have shown ill effects from cited practice. In-services were initiated for Dietary Staff by the Dietary Manager regarding the need to ensure food is prepared and served under sanitary conditions. **Systematic Changes** A Mandatory Staff Meeting for Dietary Staff was conducted by the Dietary Manager on 1/5/16 regarding the need to prepare and serve food under sanitary conditions. This in-service addressed the need to cover, label, and date food items when prepared, per Facility Policy. Continue	

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CHRISTIAN CARE CENTER OF KUTTAWA, LLC	1250 LAKE BARKLEY DRIVE KUTTAWA, KY 42055

(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 371	Continued items from the refrigerator and returned to the tray line without changing her gloves and washing her hands. Further observation revealed a Certified Nursing Assistant (CNA) came into the kitchen area to retrieve a carton of milk from the refrigerator with her bare hands and the Dietary Cook went to the refrigerator with gloved hands and touched the refrigerator handles and returned to tray line without changing gloves and/or washing her hands. Interview with Dietary Manager, on 12/17/15 at 1:00 PM, revealed she expected for all food and liquids to be dated and initialed when opened. She stated Dietary staff should wash their hands when gloves were changed and after leaving tray line and then returning to serve food.	F 371	<u>Systematic Changes (Continued)</u> Also, education included the requirement to wash hands before handling food. Dietary Staff was instructed to wash hands when gloves are changed and after leaving tray line and then returning to serve food. This in-service will be repeated by the Dietary Manager on 1/22/16 to ensure Dietary Staff is educated. Newly-hired Dietary Staff will be educated during their orientation period by the DM regarding the need to ensure food is prepared and served under sanitary conditions. This education will include the need to cover, label, and date food items when prepared, per Facility Policy. Also, education will address the requirement to wash hands when gloves are changed and after leaving tray line and then returning to serve food. <u>Monitoring</u> Dietary Manager was instructed by the Executive Director on 12/15/15 regarding the need to inspect refrigerators and freezers to ensure food is covered, labeled, and dated when prepared on a daily basis. A weekly Sanitation Audit will be conducted by the contracted Registered Dietician and Dietary Manager to ensure food is prepared and stored under sanitary conditions. Continue	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185318		12/17/2015

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F 371	Continued	F 371	**Monitoring (Continued)** RD will inspect refrigerators and freezers weekly to ensure food is covered, labeled, and dated when prepared. RD will complete a weekly observation audit of tray line service to ensure staff washes their hands when changing gloves and after leaving the tray line and then returning to serve food, per Facility Policy. Results of these weekly audits will be presented by the Dietary Manager to the monthly Quality Assurance Performance Improvement Committee for review and recommendations. This will continue to be an ongoing weekly audit by the RD and DM. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.	1/29/16