STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 04/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 04/01/19 - 04/05/19. The facility is in compliance with the requirements of CFR 483.73, Emergency Preparedness. Event ID: 5YSL11.	E 000		
F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation. Event ID: 5YSL11.	F 000		
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 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 record review and staff interviews, the facility failed to resubmit for Level II Preadmission Screening and Resident Review for 1 of 3 residents reviewed for Preadmission Screening	F 644	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth	5/2/19

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

Electronically Signed | 04/29/2019

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F 644	Continued From page 1 and Resident Review (Resident #18). Findings included: Resident #18 was admitted on 12/18/16. Resident #18's medical diagnoses were inclusive of complete atrioventricular block and schizophrenia. Review of the last quarterly minimum data set (MDS) dated 1/11/19 revealed Resident #18 was moderately cognitively impaired. During an interview with the Social Worker (SW) #1 on 4/3/19 at 11:00 AM, SW #1 stated she was responsible for resubmitting for Level II Preadmission Screening and Resident Review (PASARR). SW #1 stated the facility's administration had given her a list of residents in the facility to review for PASARR on 2/27/19. SW #1 reported she was in the process of reviewing the medical record of residents on the list. SW #1 stated she was informed by the facility's administration on 4/2/19 that Resident #18 was on the list she received on 2/27/19 to screen for Level II services due to a new diagnosis of schizophrenia on 2/8/19. On 4/3/19 at 12:12 PM, Administrator #2 stated his expectation was SW #1 should have completed a screening for Level II services and referred Resident #18 for evaluation. During an interview with Administrator #1 on 04/03/19 at 12:50 PM, she stated the facility was actively identifying residents with mental health diagnosis that require a screening for Level II services and a referral for evaluation. The Administrator stated her expectation was	F 644	in the statement of deficiencies. This plan of correction is solely prepared because it is required by the provision of the Federal & State Law. F644 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; A pre-admission screening and resident review (PASARR) was sent in for a level II determination for Resident #18 on April 4, 2019 by the Social Worker. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On April 8, 2019 all active resident's diagnoses were reviewed by the social worker, staff development coordinator, director of nursing and assistant administrator to determine if any resident has a new diagnosis of serious mental illness within the last 12 months or upon admission if residing less than 12 months in the facility. Any resident identified with a new diagnosis of serious mental illness will be sent for review to PASARR by a Social Worker. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;	

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F 644	Continued From page 2 Resident #18 with a new mental health diagnosis of schizophrenia should have been screened by the SW for Level II services and referred for an evaluation.	F 644	Facility Social Workers (SW) were educated on April 4, 2019 by Administrator on the requirements regarding evaluations for PASARR. Effective April 8, 2019, new diagnoses will be added to daily clinical meetings Monday-Friday by the Director of Nursing (DON), Assistant of Nursing (ADON), Unit Coordinators (UC), Social Worker (SW), Assistant Administrator and Administrator to discuss the need for PASARR review based on the new diagnosis of serious mental illness. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Effective April 8, 2019 The Director of Social Services, Director of Nursing, Assistant Director of Nursing, Assistant Administrator or Administrator will audit the daily clinical meeting results pertaining to PASARR Evaluation. This audit will be completed weekly for twelve weeks, ending on June 30,2019. The SW and/or Administrator will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action determined by the QAPI team. Dates when corrective action will be completed; Date of Compliance May 2, 2019	
F 761	Label/Store Drugs and Biologicals	F 761		5/2/19

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F 761 SS=D	Continued From page 3 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 observations, staff interviews, and review of manufacturer recommendations, the facility failed to 1) store medications with a date of expiration (laxative), 2) store medications upright (nasal spray) and 3) remove loose pills and debris from 2 of 3 medication carts; additionally the facility failed to 4) store medications refrigerated 36 - 46 degrees Fahrenheit for 1 of 2 medication storage rooms.	F 761	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is solely prepared because it is required by the provision of the Federal & State Law. F761	

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F 761	Continued From page 4 The findings included: 1 a. An observation and interview with Nurse #1 of a medication cart for the 100/200 halls occurred on 04/04/19 at 10:13 AM and revealed the following: - One Bisacodyl 10 mg suppository was observed stored outside of original packaging. There was no date of expiration. Nurse #1 stated during the observation that she was uncertain why the suppository was stored on the medication cart outside of original packaging and she did not know when it expired. She further stated that the medication cart was last checked/cleaned one day last week. An interview occurred on 04/04/19 at 11:07 AM with unit coordinator #1 (UC#1). UC #1 stated all nurses were responsible to check medication carts at least twice weekly for improperly stored medications and to check daily while the cart was in use. UC #1 stated all medications should be stored with a date of expiration. An interview with the Director of Nursing (DON) occurred on 04/04/19 at 03:21 PM and revealed medications should be stored per manufacturer guidelines. The DON stated that nursing staff should monitor the medication carts twice weekly to ensure medications were stored per manufacturer guidelines and with a date of expiration. An interview with Administrator #1 and Administrator #2 occurred on 04/04/19 at 04:05 PM. Both Administrators stated that the medication carts and storage rooms should be checked twice per week for medications stored	F 761	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; 1.On 4/4/19 the Fluctiacasone Propionate, 120 Metered Nasal Spray was discarded and reordered by the Licensed Nurse. 2.On 4/4/19 the 13 Bisacodyl 10 mg Suppositories were discarded and reordered by the Licensed Nurse. 3.On 4/4 the one Purified Protein Derivative, four prefilled 5 ml pens of Novolog, four prefilled 5 ml pens of Lantus, five 1 ml vials of Lorazepam and one multi-dose vial of Influenza were discarded and reordered by the licensed nurses. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 4/4/19 it was determined by the facility□s interdisciplinary team that 100% of residents have the potential to be affected. 1.On 4/4/19 the Director of Nursing, Assistant Director of Nursing, Unit Manager #1, Unit Manager #2 and Unit Manager #3 audited all medication carts, medication rooms and Medication Room Refrigerators to ensure all medications were labeled and dated appropriately, no loose pills were present and all	

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F 761	Continued From page 5 outside of manufacturer guidelines and should include a date of expiration. 1 b. An observation and interview with Nurse #2 of a medication cart for the 100 hall occurred on 04/04/19 at 10:35 AM and revealed the following: - Flucticasone Propionate, 120 metered nasal spray was stored on its side. Manufacturer guidelines recorded on the bottle recommended to store upright. - Twelve Bisacodyl 10 mg suppositories were observed stored outside of original packaging. There was no date of expiration. - 9 loose pills (different sizes, shapes and colors), 4 half pills (different sizes, shapes and colors), and debris Nurse #2 stated during the observation that the nasal spray should be stored upright and was usually stored in a cup to keep the nasal spray upright. Nurse #2 stated that she did not know that the suppositories were stored on the medication cart and she did not know when they expired. Nurse #2 stated she could not identify the loose pills or explain the debris. An interview with the DON occurred on 04/04/19 at 10:57 AM and revealed that the nasal spray should be stored upright per manufacturer recommendations. She stated all medications should be stored with a date of expiration. The DON stated that any loose pills found on the medication cart should be destroyed and that nursing staff should monitor the medication carts to ensure medications were not stacked too tightly to prevent pills from coming out of the medication cards. An interview occurred on 04/04/19 at 11:07 AM	F 761	medications including nasal sprays were stored in the appropriate manner. As a result of the audit there were no negative findings. 2.On 4/4/19 Director of Maintenance audited all Medication Room refrigerators for proper temperature. As a result of the audit there were no negative findings. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; 1.On 4/4/19 the Staff Development Coordinator began in-servicing all licensed nurses and medication aides on the proper storage and labeling of medications. 100% of licensed nurses and medication aides to include Full-time, Part-time, Weekend, and PRN staff will be in-serviced by 5/2/19. No licensed nurses or medication aides will be allowed to work until receiving this education. 2.Medication Storage and labeling guidelines will be stored on each medication cart for reference by the licensed nurse and/or medication aide. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Beginning 4/8/19 the Medication carts and Medication Rooms will be audited by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator,	

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F 761	Continued From page 6 with UC#1. UC #1 stated all nurses were responsible to check medication carts at least twice weekly for improperly stored medications and cleanliness and to check daily while the cart was in use. UC #1 stated all medications should be stored with a date of expiration and all loose pills should be discarded. UC #1 further stated nurses should dispense medications into a cup and store medication cards loosely to minimize the loss of pills. An interview with Administrator #1 and Administrator #2 occurred on 04/04/19 at 04:05 PM. Both Administrators stated that the medication carts and storage rooms should be checked twice per week for medications stored outside of manufacturer guidelines and include a date of expiration. 2. An observation of Station #1 medication storage room with UC #1 occurred on 04/04/19 at 11:14 AM. The refrigeration temperature was 49 degrees Fahrenheit. The following medications were stored with manufacturer instructions to "Refrigerate, store 36 - 46 degrees Fahrenheit": - One unopened vial of Purified Protein Derivative (vaccine used to test for Tuberculosis). - Four prefilled 5 ml pens of Novolog (insulin). - Four prefilled 5 ml pens of Lantus (insulin). - Five, 1 ml vials of Lorazepam (antianxiety) - 1 unopened multi-dose vial of Influenza (flu vaccine) An interview with UC #1 during the observation and review of the April 1 - 3, 2019 temperature log for the refrigerator revealed temperatures were recorded between 42 - 46 degrees Fahrenheit. UC #1 stated that the refrigeration temperatures were checked nightly by nursing	F 761	Unit manager, Nursing Supervisor or Charge nurse 3 x weekly x 12 weeks ending . The results of these audits will be recorded on the Medication Storage Audit Tool and brought by the Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action determined by the QAPI team. Beginning 4/8/19 the refrigerators in each medication room will be audited to ensure temperatures are within the required range of 36-46 degrees Fahrenheit and that staff are checking temperatures on a daily basis. These audits will be conducted by the Maintenance Director, Maintenance Assistant, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Assistant Administrator twice daily for 12 weeks. The Director of Maintenance, Maintenance Assistant or Assistant Administrator for will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action determined by the QAPI team. Date of Completion: 5/2/19	

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F 761	Continued From page 7 staff and that the items stored in refrigeration should be stored 36 -46 degrees Fahrenheit. A follow up observation of the refrigerator in the medication storage room of Station #1 and interview with UC #1 occurred on 04/04/19 at 11:31 AM and revealed a temperature of 51 degrees. The same items were stored. The UC #1 stated that it could not be determined how long the items stored in refrigeration were stored above 46 degrees so the items would be discarded and re-ordered. An interview with the DON occurred on 04/04/19 at 03:21 PM and revealed medications should be stored per manufacturer guidelines. The DON stated that if medications were stored outside of manufacturer temperature guidelines, the medications should be not be administered, but rather discarded and re-ordered. The DON stated the refrigerators in the medication storage rooms should be checked nightly to monitor for correct temperatures. An interview with Administrator #1 and Administrator #2 occurred on 04/04/19 at 04:05 PM. Both Administrators stated that the medication carts and storage rooms should she checked twice per week for medications stored outside of manufacturer guidelines.	F 761		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national	F 803		5/2/19

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F 803	Continued From page 8 guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of menus, the facility failed to serve ½ cup serving of corn per the menu to 4 residents for 1 of 2 tray line observations. The findings included: An observation of the lunch meal tray line occurred on 04/01/19 from 12:17 PM until 12:30 PM. During the observation, dietary staff (DS) #2 was observed at 12:30 PM to plate corn for Residents #5, #95, #97, and #98. DS #2 was observed to plate corn from a 4 ounce (1/2 cup) serving utensil, but only filled the serving utensil approximately half full for Residents #5, #95, #97 and #98. An additional pan full of corn was	F 803	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is solely prepared because it is required by the provision of the Federal & State Law. F803 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;	

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F 803	Continued From page 9 observed stored on the stove. Review of the menu revealed residents were to receive ½ cup portion of corn. A half cup portion was not plated. During the observation, DS #2 stated that she was attempting to serve the remaining corm left in the pan before she began serving from the second pan of corn. The surveyor brought this observation to the attention of the certified dietary manger (CDM) on 04/01/19 at 12:31 PM. The CDM stated all residents should receive portions of food per the menu. He stated that he monitored the tray line when he was in the kitchen but due to additional responsibilities he did not always have an opportunity to monitor the tray line for correct portions served. The CDM was observed to instruct DS #2 to plate a full serving of each food item to residents. An interview with Administrator #1 and Administrator #2 occurred on 04/04/19 at 1:17 PM. During the interview both Administrators stated they expected residents to receive portions of food per the menu. A telephone interview occurred on 04/05/19 at 12:51 PM with the registered dietitian (RD). During the interview, the RD stated she rounded in the facility weekly, but had not noticed concerns with residents receiving incorrect portions of food. The RD stated she expected dietary staff to provide residents portions of food according to the menu.	F 803	On 4/4/19 dietary manger delivered 1 cup serving of corn to resident #5, #95, #97 and #98 to ensure each resident received appropriate serving size for their lunch. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The facility'□s interdisciplinary team identified all residents to have the potential to be affected. On 4/4/19 Dietary manager educated dietary staff #2 on appropriate serving sizes to ensure all other residents received the appropriate serving size for their meals. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 4/4/19, Dietary manager began educating all dietary staff regarding using the appropriate serving utensils and filling them to the rim to ensure all residents get the appropriate serving size. All dietary staff was educated by 5/2/19. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Beginning 4/2/19 Dietary Manager or Dietary Cook will audit dietary staff during serving of breakfast, lunch and dinner to ensure proper utensils and appropriate	

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F 803	Continued From page 10	F 803	serving sizes are being plated for each meal. The results of this audit will be recorded on the Proper Serving Utensils & Portion Sizes Audit Tool. The audit will occur three times a day for four weeks, then three times a day/three days a week for four weeks, then three times a day/once per week for four weeks. The Dietary Manager will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action determined by the QAPI team. Dates when corrective action will be completed; Date of Compliance May 2, 2019	
F 812 SS=F	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.	F 812		5/2/19

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F 812	Continued From page 11 §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, staff interviews and review of facility records, the facility failed to 1) air dry dishes (cups), 2) store cold/frozen foods in a closed container (pancakes, lettuce), with a date of opening (lettuce, ham, diced potatoes), at least 41 degrees Fahrenheit (F) or below on the tray line (Cesar salad), and 3) maintain the chemical sanitizing concentration in the 3 compartment sink between 150 - 400 parts per million (PPM), per manufacturer recommendations. The findings included: 1. An observation of the lunch meal tray line occurred on 04/01/19 at 12:20 PM and revealed the following items were stored wet: - 6 clear plastic cups were stored wet and ready for use on resident lunch meal trays - 18 clear plastic cups were stored wet and ready for use on the tray line An interview with the certified dietary manager (CDM) on 04/01/19 at 12:20 PM revealed new cups were implemented into the facility's dish rotation that day. The CDM stated the cups were washed that day around 11:00 AM or 11:30 AM which did not allow sufficient time for the cups to air dry before use. He stated that the tray line typically started around 11:15 AM. The CDM further stated that the cups should have been washed in sufficient time to allow them to air dry before use.	F 812	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is solely prepared because it is required by the provision of the Federal & State Law. F812 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; 1.On 4/1/19 all cups were removed from the trays affected and replaced with dry cups. 2.On 4/1/19 the Dietary Manager discarded the package of pancakes, shredded lettuce, ham, diced potatoes and Caesar salad. 3.On 4/1/19 the three compartment sink was drained and refilled. Dietary manager checked level of chemical with reading of 400 Parts Per Million which is within manufacturers recommendations. Utensils were removed on 4/1/19 by the Dietary Manager and rewashed and sanitized.	

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	345155	A. BUILDING _____ B. WING _____	C 04/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 12 2. An observation of the walk-in freezer occurred on 04/01/19 at 12:32 PM, an observation of the walk-in refrigerator occurred on 04/01/19 at 12:33 PM and an observation of the lunch meal tray line occurred on 04/04/19 at 12:02 PM. The observations revealed the following cold foods stored open to air, stored without a date of opening, or stored on the tray line above 41 degrees F: Freezer- approximately 12 pancakes were stored in a plastic bag that was open to air Refrigerator- Shredded lettuce was stored in a plastic bag that was open to air and without a date of opening, ham was stored wrapped in plastic wrap without a date of opening, and diced potatoes were stored in a plastic bag without a date of opening Temperature monitoring of Cesar salad (Romaine lettuce mixed with parmesan cheese and an egg and dairy based dressing) stored on the lunch meal tray line revealed a temperature range of 43 - 45.8 degrees F. The instructions on the bottle of dressing recorded "shelf stable, refrigerate after opening." The CDM stated on 04/01/19 at 12:33 PM that cold foods should be stored in closed containers, not exposed to air and with a label that recorded the date of opening. He stated that the cold storage units had just been monitored for items stored, but he could not explain how these items were missed. An interview on 04/04/19 at 12:02 PM with the CDM and district dietary manager (DDM) revealed that although the salad dressing was shelf stable until opened, once opened and mixed with the salad, temperature monitoring was required and the Cesar salad should have been	F 812	Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The facility□s interdisciplinary team identified all active residents to have the potential to be affected. 1.On 4/1/19 the Dietary Manager audited kitchen was to ensure all dishware, drink ware, cookware and utensils are being dried appropriately. As a result of the audit there were no negative findings. 2.On 4/1/19, the Dietary Manager audited the kitchen□s walk-in refrigerator, walk-in freezer, reach in refrigerators and dry storage to ensure that all food was stored, labeled and dated appropriately. As a result of the audit there were no negative findings. 3.On 4/1/19 the three compartment sink was drained and refilled. Dietary manager checked level of chemical with reading of 400 Parts Per Million which is within manufacturers recommendations. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; 1.On 4/2/19 the Dietary Manager educated all dietary staff regarding the proper way to dry all dishware, drink ware, cookware and utensils. All dietary staff were educated by 5/2/19.	

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F 812	Continued From page 13 maintained at least 41 degrees F or below. 3. An observation of the 3 compartment manual hand washing sink, while in use, occurred on 04/01/19 at 12:42 PM. Dietary staff (DS) #1 was observed to place serving utensils into the sink with a chemical sanitizing solution. The chemical sanitizing solution was observed to be 500 PPM. The utensils were removed and stored ready for use without rinsing. DS #1 stated on 04/01/19 at 12:43 PM that he set up the manual hand washing sink that morning, but did not recall what time. He stated that he did not check the concentration of sanitizing solution at the time he set up the sink and had not checked the concentration since he started using the sink again. DS #1 further stated it was not his practice to check the chemical concentration of the sanitizing sink before use. He stated he was not certain what the concentration of sanitizing solution should be, but thought it should be either 200 PPM or 400 PPM, but that he was not certain. Interviews occurred on 04/01/19 at 12:44 PM with the CDM and DDM. The DDM stated in interview that the chemical concentration of the sanitizing solution should be at least 200 PPM. The CDM stated that the chemical concentration of the sanitizing sink at 500 PPM was correct. Follow up interviews and an observation of the manual hand washing sink, while in use, occurred on 04/04/19 at 11:49 AM. The chemical concentration of the manual hand washing sink was 400 PPM. During the interview a review of manufacturer recommendations revealed the concentration of chemical sanitizer should be 150	F 812	2.On 4/2/19 the Dietary Manager educated all dietary staff regarding proper storage, labeling and dating of food items. All dietary staff were educated by 5/2/19. 3.On 4/2/19 Dietary Manager educated all dietary staff regarding utilization of the three compartment sink, how to test the chemical levels, recording the results on the Pot sink Sanitation Record Log and steps to take if level is not within proper levels. All dietary staff were educated by 5/2/19. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; 1. Beginning 4/2/19 The dietary manager or cook will audit dietary staff to ensure all dishware, drink ware, cookware and utensils are being dried properly. The results of these audits will be recorded on the Wet Nesting/Air Drying Audit Tool. These audits will be completed three times a day/daily for 4 weeks, then three times a day/three times a week for four weeks, then three times a day/once per week for four weeks. 2. Beginning 4/2/19 The dietary manager or cook will audit the dietary staff to ensure that staff is properly storing, dating and labeling all food items appropriately. The results of these audits will be recorded on the Dating and Labeling Audit Tool. These audits will be completed three times a day/daily for 4 weeks, then three	

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F 812	Continued From page 14 - 400 PPM. The DDM stated he was unaware that the chemical concentration could be too strong with the potential of leaving chemical residue on dishes if the dishes were not rinsed after sanitizing. An interview with Administrator #1 and Administrator #2 occurred on 04/04/19 at 1:17 PM and revealed they expected cold foods to be stored in closed containers, with a date of opening, on the tray line at appropriate temperatures and the sanitizing sink to have the correct chemical concentration.	F 812	times a day/three times a week for four weeks, then three times a day/once per week for four weeks. 3. Beginning 4/11/19 The dietary manager or cook will audit dietary staff to ensure that staff is checking the chemical level properly. The results of these audits will be recorded on the Proper Chemical Levels in 3 Compartment Sink Audit Tool. These audits will be completed three times a day/daily for 4 weeks, then three times a day/three times a week for four weeks, then three times a day/once per week for four weeks The Dietary Manager will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action determined by the QAPI team. Dates when corrective action will be completed; Date of Compliance May 2, 2019	