

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155496	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION VALLEY VIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 333 W MISHAWAKA RD ELKHART, IN 46517
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F000000	<p>This visit was for Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00133307, IN00134666 and IN00135065.</p> <p>IN00133307-Unsubstantiated due to lack of evidence. IN00134666-Unsubstantiated due to lack of evidence. IN00135065-Unsubstantiated due to lack of evidence.</p> <p>Survey dates: September 23, 24, 25, 26, 27, 30, and October 1, 2013.</p> <p>Facility number: 000523 Provider number: 155496 AIM number: 100266930</p> <p>Survey team: Julie Baumgartner RN-TC Shauna Carlson RN Sharon Ewing RN Shelly Vice RN (9/23, 9/24, 9/25, 9/27, 9/30, 10/1, 2013)</p> <p>Census bed type: SNF/NF: 104 Total: 104</p> <p>Census payor type:</p>	F000000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. This facility respectfully requests consideration for deletion</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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	<p>Medicare: 15 Medicaid: 74 Other: 15 Total: 104</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on October 18, 2013, by Brenda Meredith, R.N.</p>		<p>through the Informal Dispute Resolution process for citations related to F 224, F 226, F 250 and F 441. This facility respectfully requests a desk review for paper compliance with all citations related to this survey.</p>		

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F000155 SS=D	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Based on interview and record review, the facility failed to ensure the medical record accurately documented advanced directive and chosen code status for 3 of 10 residents reviewed for advanced directives. (Resident #115, Resident #17, and Resident #42)</p> <p>Findings include:</p> <p>1. On 9/26/13 at 10:30 AM, review of Resident #115's medical record was conducted. The medical record indicated her diagnoses included but were not limited to "...hypertension, asthma, diverticulosis, uterine cancer,</p>	F000155	F 1551. Resident #115, #17, and Resident #42 have all been discharged from the facility. 2. The Director of Nursing or designee will ensure the medical record accurately documents the advanced directive and chosen code status for all current residents. 3. The Staff Development Coordinator or designee will in-service licensed nurses on the Kindred policy and procedures related to obtaining code status orders and adding them to the POS. Kindred has removed the ability from the software program for code status to print on the physician's order sheet and on administration records. 4. The DNS or designee	11/09/2013			

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	<p>arthritis, hyperlipidemia, hypothyroidism, stroke...."</p> <p>Review of the "State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order" indicated it was signed by Resident #115 on 4/19/13, and signed by her physician on 4/24/13.</p> <p>Review of Physician Orders monthly printout, from 5/1/13 to 5/31/13, indicated on page 2 "...Code: DNR [Do Not Resuscitate]...Nursing Alert: CPR [Cardiopulmonary Resuscitation]...."</p> <p>Review of Resident #115's Advanced Directive care plan indicated "...4/24/13...Do Not Resuscitate...."</p> <p>Review of the Medication Record printout for Resident #115 from 5/1/13 to 5/31/13 indicated the only indicated code status information on the printout was "...Nurses Alerts: CPR [Cardiopulmonary Resuscitation]...." No where on the Medication Record printout was Resident #115 indicated to be a DNR.</p> <p>2. On 9/26/13 at 10:55 AM, review of Resident #17's medical record was conducted. The medical record indicated her diagnoses included but</p>		<p>will monitor through clinical meeting 5X/week all (re) admissions and significant changes of condition for accurate documentation of code status. MDSC will ensure review of code status quarterly through the RAI process. The results of these audits will be reviewed and analyzed with a subsequent plan of action developed and implemented as indicated at the monthly Performance Improvement Committee Meeting. The PI Committee will review monthly for 6 months. The Administrator is responsible for overall compliance. This facility respectfully requests a desk review for paper compliance with this citation.</p>				

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	<p>were not limited to "...gout, edema, neuropathy, diabetes...."</p> <p>Review of the "State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order" indicated it was signed by Resident #17 on 4/9/13, and signed by her physician on 4/10/13.</p> <p>Review of the Physician Orders monthly printout, from 7/1/13 to 7/31/13, indicated "...Nursing Alert: CPR [Cardiopulmonary Resuscitation]...."</p> <p>Review of Resident #17's Advanced Directive care plan indicated "...4/9/13...Do Not Resuscitate.... "</p> <p>Review of the Medication Record printout for Resident #17, from 6/1/13 to 6/30/13 and from 7/1/13 to 7/31/13, indicated " ...Nurses Alert...CPR [Cardiopulmonary Resuscitation].... " No where on the Medication Record printouts was Resident #17 indicated to be a DNR.</p> <p>3. On 9/26/13 at 11:10 AM, review of Resident #42 ' s medical record was conducted. The medical record indicated his diagnoses included but were not limited to " ...malignant neoplasm prostate.... "</p>						

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	<p>Review of the " State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order " indicated it was signed by Resident #42 ' s Power of Attorney on 6/21/13, and signed by his physician on 7/10/13.</p> <p>Review of the Physician Orders monthly printout, from 7/1/13 to 7/31/13, indicated " ...Nursing Alert: CPR [Cardiopulmonary Resuscitation].... "</p> <p>Review of Resident #42 ' s Advanced Directive care plan indicated " ...Do Not Resuscitate.... "</p> <p>Review of the Medication Record printout for Resident #42. from 7/1/13 to 7/31/13, indicated " ...Nurse ' s Alert...CPR [Cardiopulmonary Resuscitation].... " No where on the Medication Record printouts was Resident #42 indicated to be a DNR.</p> <p>4. On 9/30/13 at 10:00 AM, interview with the DON (Director of Nursing) indicated it has been a company wide problem that on the Medication record sheet and the physician order sheet it sometimes prints that the Resident is ordered CPR when they are actually a DNR. The DON indicated this problem is going to be fixed with the</p>						

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	next months printouts. 3.1-4(f)(5)			

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to revise and update the care plan after a resident fell to reduce the risk of future accident for 1 of 3 residents reviewed for falls. (Resident #67)</p> <p>Findings include:</p> <p>On 9/25/13 at 11:01 AM, interview with LPN #13 indicated Resident #67 fell on 9/2/13, when she was taking herself to the bathroom and her oxygen saturation dropped.</p> <p>On 9/29/13 at 10:30 AM, record review of Resident #67's chart</p>	F000280	F 280 1. Resident #67 has had her fall care plan reviewed and revised as needed. 2. The Director of Nursing Services or designee will review residents who have fallen in the last 60 days to ensure the care plans have been reviewed and updated as needed. 3. The Staff Development Coordinator or designee will in-service the Licensed Nurses and the IDT staff regarding the need for care plan revision after each fall. Licensed Nurses will initiate care plan interventions after each fall and document on the care plan. 4. The Director of Nursing or designee will review 5X/week through clinical meeting any falls	11/09/2013			

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	<p>indicated her diagnoses included but were not limited to "...chronic respiratory failure, obstructive sleep apnea, obesity, hypoventilation syndrome...."</p> <p>Review of nurses notes for Resident #67, dated 9/2/13, indicated "... [Residents name] was found on her room floor unresponsive and dusky in color...she had no O2 [oxygen] on her...head to toe assessment c [with] neuro [neurological] checks. Stats [sic] were up and down 48-58 on 15 L [liters] c [with] bipap [machine to assist breathing]...."</p> <p>Review of Resident #67's fall care plan, dated 1/11/12 and last updated 7/28/13, indicated "...At risk for fall related injury...Approach: Use fall risk screen to identify risk factors...Report falls to physician and responsible party. Observe for side effects of any drugs that can cause: gait disturbance, orthostatic hypotension, weakness, sedation, lightheadedness, dizziness, change in mental status. Report to physician any side effects associated with the residents medication use. Provide environmental adaptations: call light within reach. Provide/monitor use of adaptive devices: Walker/cane, wheelchair. Remind resident and</p>		<p>to ensure review and update of care plans has taken place. The results of these audits will be reviewed and analyzed with a subsequent plan of action developed and implemented as indicated at the monthly Performance Improvement Committee Meeting. The PI Committee will review monthly for 6 months. The Administrator is responsible for overall compliance. The facility respectfully requests a desk review for paper compliance with this citation.</p>				

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	<p>reinforce safety awareness: Lock brakes on bed, chair, etc, before transferring, When rising from a lying position, sit on the side of the bed for a few minutes before transferring/standing, Appropriate footwear. Give meds as ordered. Invite, encourage, remind, escort to activity programs consistent with resident's interests to enhance physical strengthening needs. Referral for screen & treatment as needed. Additional approaches: 7/28/13 Assist of one with gait belt and walker when transferring/ambulatory...."</p> <p>On 9/30/13 at 10:15 AM, interview with LPN #13 indicated after a resident falls she is to always notify the MD, family, DON (Director of Nursing) and Executive Director. LPN #13 indicated the DON and Executive Director are responsible for taking all the falls to the IDT (interdisciplinary team), "...they look at them every morning in the meeting, they let us nurses know what interventions are in place and which ones they will be adding...."</p> <p>On 10/1/13 at 10:00 AM, interview with the DON indicated it was the responsibility of the interdisciplinary team to update care plans and add</p>			

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	<p>interventions after a resident fall.</p> <p>On 10/1/13 at 10:30 AM, review of the "Post Fall Evaluation" policy received from the DON on 9/30/13 at 10:15 AM indicated "...revise the care plan to include recommended interventions...."</p> <p>3.1-35(d)(2)(B)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow physician's order related to a change in an antibiotic for 1 of 5 residents reviewed for unnecessary medications. (Resident # 32)</p> <p>Findings Include:</p> <p>1. Resident #32's record was reviewed 9/26/13 at 11:00 a.m. The residents diagnosis included, but were not limited to Alzheimer disease,diabetes mellitus type 2 without complication uncontrolled, secondary Parkinson, mild intellect disability, and schizoaffective disorder.</p> <p>A Urine culture report (a test to measure bacteria in the urine), dated 9/6/13, indicated an order, dated and signed on 9/11/13, to discontinue the Bactrim (an antibiotic) and to start Keflex (an antibiotic) 500 mg (milligrams) TID (three times per day) x (times) 7 days.</p> <p>Review of physician telephone orders</p>	F000282	<p>F 282 1. Resident #32 has had her orders for antibiotic medications reviewed with the physician and the orders have been clarified, along with a medication variance documented. 2. The Director of Nursing or designee will review physician orders for the past 60 days to ensure proper order transcription has taken place.</p> <p>3. The Staff Development Coordinator or designee will in-service the Licensed Nurses regarding the procedure on transcription of physician orders received via fax. Licensed Nurses will follow the procedure for transcription of physician orders received via fax. 4. The Director of Nursing or designee will review 5X/week through the clinical meeting physician orders and subsequent transcription of the orders to ensure physician orders are being followed. The results of these audits will be reviewed and analyzed with a subsequent plan of action developed and implemented as indicated at the monthly Performance Improvement Committee Meeting. The PI Committee will review monthly for 6 months. The Administrator is</p>	11/09/2013

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	<p>indicated an order for the administration of Bactrim (an antibiotic) DS (double strength) one po (by mouth) BID (2 times per day) x 7 days. There was lack of documentation to indicate the order to discontinue the Bactrim DS and to begin Keflex had been processed.</p> <p>Review of Medication Administration Record indicated an order for Bactrim DS to be given for 7 days. The record indicated the Bactrim was given 9/6/13, 9/7/13, 9/8/13, 9/9/13, 9/10/13, 9/11/13, 9/12/13 and 9/13/13. The record lacked documentation to indicated the antibiotic Keflex had been given to resident# 32.</p> <p>Review of resident progress notes, dated 9/6/13 through 9/13/13, indicated the lack of documentation to indicate a new order had been changed or written.</p> <p>During an interview 9/26/13 at 11:03 a.m., the DON (Director of Nursing) indicated that the order was the issue on the urine report and that she didn't know why resident #32's physician would change the antibiotic order because it (referring to the bacteria found in the urine at the time of lab) was sensitive to Bactrim (an</p>		responsible for overall compliance. The facility respectfully requests a desk review for paper compliance with this citation.				

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	antibiotic). The Director of Nurses then indicated she would fax him to notify him it wasn't given and to see why he would change the order. 3.1-35(g)(2)			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure 6 doors that should be locked were locked in order to keep the residents safe from hazardous materials. This occurred on 5 of 7 halls in the facility.</p> <p>Findings include:</p> <p>On 9/23/13 from 10:58 AM to 12:20 PM, initial tour of the facility was conducted and the following doors were observed to be unlocked: 700 hall clean utility room 700 hall dirty utility room 600 hall clean utility room 300 hall dirty utility room 300 hall clean utility room 200 hall clean utility room 200 hall dirty utility room 100 hall clean utility room</p> <p>On 9/23/13 at 12:01 PM, during the observation of the 300 hall unlocked dirty utility room the following were observed: On the right side of the room in an unlocked wood cabinet there was 1 bottle of unmarked clear</p>	F000323	<p>F 323 1. The following doors are now secured and locked as needed: 700 hall clean utility room 700 hall dirty utility room 600 hall clean utility room 300 hall dirty utility room 300 hall clean utility room 200 hall clean utility room 200 hall dirty utility room 100 hall clean utility room 2. The doors which provide access to areas containing hazards or do not have call systems have been inspected and are in proper operating condition. 3. The Staff Development Coordinator or designee will in-service the staff on the procedure keeping doors locked to areas which contain hazards or do not have call systems. All staff will ensure all unsupervised areas which may contain hazards are locked when unsupervised. 4. The Director of Maintenance or designee will inspect facility doors which provide access to areas containing hazards or do not have call systems 5X/week to ensure the doors are locking as required. The results of these audits will be reviewed and analyzed with a subsequent plan of action</p>	11/09/2013			

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	<p>liquid, 1 bottle labeled " Quat " disinfectant, and 1 bottle labeled "Virex 256 one step germicidal cleaner." On the left side of the room on top of the counter there was a sharps container observed full of needles with no lid covering it.</p> <p>On 9/23/13 at 12:20 PM, during the observation of the 200 hall unlocked dirty utility room the following were observed: In the unlocked wooden cabinet above the counter was 1 bottle labeled " fresh breeze " detergent and 1 bottle labeled disinfectant & deodorizer " country day scent... CAUTION: may cause eye and skin irritation."</p> <p>On 9/23/13 at 1:45 PM, interview with the ED (Executive Director) indicated the facility had been without a maintenance person since the previous week and all of the doors that were open should have been locked.</p> <p>On 9/23/13 at 2:00 PM, observation of Employee #14 and the DON (Director of Nursing) both attempting to lock the 300 hall dirty utility room with the key for that door and both were unable to do so. Interview with the DON at this time indicated the door was not able to be locked.</p>		<p>developed and implemented as indicated at the monthly Performance Improvement Committee Meeting. The PI Committee will review monthly for 6 months. The Administrator is responsible for overall compliance. The facility respectfully requests a desk review for paper compliance with this citation.</p>		

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	3.1-45(a)(1)			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure monitoring for side effects was completed for 1 of 5 residents reviewed for unnecessary medication in a sample of 40 residents.</p> <p>Findings Include:</p> <p>The record for resident # 44 was reviewed on 9/26/13 between 10:00 a.m. and 10:30 a.m. Diagnoses included, but were not limited to,</p>	F000329	F 329 1. The resident #44 has now received an AIMS assessment. No side effects were present. 2. The Director of Nursing Services or designee will review all residents receiving antipsychotic medication to ensure AIMS assessment completion within the last 6 months. 3. The Staff Development Coordinator or designee will in-service the Licensed Nurses on the policy and procedure for completion of AIMS assessments. Licensed Nurses will complete AIMS	11/09/2013			

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	<p>dementia with behavioral disturbances, depressive disorder, hypertension, hypothyroidism.</p> <p>Review of Medication Administration Records indicated on 8/7/13, the residents Risperdal (an antipsychotic medication) was increased to 2 milligrams by mouth at bedtime.</p> <p>Review of clinical record indicated a lack of documentation of any side effects monitoring assessment. The last AIMS assessment (tool used to monitor for side effects of an antipsychotic medication) found in the clinical record was dated 7/12.</p> <p>During an interview on 9/27/13 at 3:30 p.m., the Director of Nursing she indicated the former ADON (Assistant Director of Nurses) did the assessments but she was not able to locate them.</p> <p>A policy titled "Abnormal Involuntary Movement Scale," was provided by the Director of Nurses on 9/30/13 at 2:00 p.m. The policy indicated its purpose was to "Monitor the development of involuntary movement disorders from drug-induced Parkinsonian types of symptoms to tardive dyskinesia upon admission of a resident on an</p>		<p>assessments on all residents receiving antipsychotic medication quarterly per RAI schedule. 4. The Social Service Director or designee will conduct monthly audits of AIMS assessments to ensure the assessments are being done as scheduled. The results of these audits will be reviewed and analyzed with a subsequent plan of action developed and implemented as indicated at the monthly Performance Improvement Committee Meeting. The PI Committee will review monthly for 6 months. The Administrator is responsible for overall compliance. The facility respectfully requests a desk review for paper compliance with this citation.</p>				

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	antipsychotic medication (e.g., Risperdal, Thorazine, etc.), as a baseline upon initiation of an antipsychotic medication or a change in an antipsychotic medication, every 6 months thereafter." 3.1-48(a)(3)			

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F000371 SS=C	<p>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 Based upon observation and interview, the facility failed to ensure food was stored food properly in the dry food storage area. This had the potential to affect 104 of the 104 residents.</p> <p>Finding Includes:</p> <p>During a tour of the kitchen, on 9/23/13 at 11:30 a.m., a box of Quaker Medium Barley was observed in the dry storage room. The box was opened and lacked a date to indicate when it had been opened and the box was open to air. During an interview with the dietary manager she indicated the box of barley was not labeled and she did not know when it was opened. She then proceeded to throw the box of barley in the trash.</p> <p>A policy, titled "Food and Supply Storage Policy #628-11," dated 8/31/12, was provided by the dietary manager on 9/27/13 at 11:30 a.m.. Component #2 section 'a' indicated,</p>	F000371	F 371 1. The undated food item found in the dry food storage area has been disposed of. 2. The remaining food items have been inspected for proper storage and any needed corrections have been made. 3. The Nutrition Services Manager or designee will in-service the Dietary staff on the procedure for proper food storage, including dating opened food items. Dietary staff will ensure all items in dry storage are dated per policy. 4. The Administrator or designee will conduct 3X weekly audits of the kitchen to ensure food storage procedures are being followed. The results of these audits will be reviewed and analyzed with a subsequent plan of action developed and implemented as indicated at the monthly Performance Improvement Committee Meeting. The PI Committee will review monthly for 6 months. The Administrator is responsible for overall compliance. The facility respectfully requests a desk review for paper compliance with this citation.	11/09/2013			

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	"For food products that are opened and not completely used or prepared at facility and stored, the product should be labeled as to its contents and used by dates." 3.1-21(i)(3)			