

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155819	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/18/2015
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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 SOUTH DIXON ROAD KOKOMO, IN 46902
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint #I IN00175333.</p> <p>Survey dates: June 10, 11, 12, 15, 16, 17, and 18, 2015.</p> <p>Facility number: 013153 Provider number: 155819 AIM number: 201254360</p> <p>Census bed type: NF: 46 SNF/NF: 5 Residential: 22 Total: 73</p> <p>Census payor type: Medicare: 36 Medicaid: 5 Other: 10 Total: 51</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p><u>Survey Event ID GRVM11</u></p> <p>The submission of this Plan of Correction does not indicate an admission by Wellbrooke of Kokomo that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Wellbrooke of Kokomo. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs).</p> <p>To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p>	

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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F 0241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure residents environment during dining maintained their homelike atmosphere and maintained dignity. This deficient practice affected 1 of 30 residents eating in the main dining room (Resident #81).</p> <p>Findings include:</p> <p>During an observation of the main dining room on June 9, 2015 at 12:00 p.m., four residents were seated at a table prior to meal service. At the time of the food service three residents were served their meal. Resident #81 did not receive a meal until 28 minutes later. The other occupants at the table had been served dessert.</p> <p>During an interview with the Executive Director and Dietary Manager on 6/15/15 at 9:00 a.m., the Dietary Manger indicated residents in the past had</p>	F 0241	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Wellbrooke of Kokomo practice is to promote care in a homelike environment that maintains and enhances each resident's dignity. The residents of Wellbrooke of Kokomo requested through Chef Circle and Resident Council that we serve them on a first come first serve basis. Resident #81 did receive the meal they requested timely based on the special preparation and type of food.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All the other residents received their meals timely.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does</p>	07/18/2015

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F 0278 SS=D	<p>preferred a first come, first served food service. The extended wait time in this instance was unusual.</p> <p>During an interview with Resident #81 on 6/15/15 at 1:30 p.m., she indicated she had waited many times for food to be served while others at the table would have their meals.</p> <p>3.1-3(t)</p> <p>483.20(g) - (j) ASSESSMENT</p>		<p>not recur:</p> <p>The <i>Dining Service Guide</i> (Attachment A) was revised to Meal Manager/Nurse/ and or designee who serve the residents their meals will offer salad, vegetables and /or fruit to residents who come later and/or who are waiting for special food requested.</p> <p>DHS or designee will re-educate the nursing staff on the revised <i>Dining Service Guide</i>.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</p> <p>The DHS or designee will conduct a <i>Dining Service Audit</i> to ensure residents are receiving their meals in a timely dignified manor 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance. (Attachment B)</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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Bldg. 00	<p>ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review, and interview, the facility failed to correctly identify and accurately assess the residents' status regarding Hospice for 1 out of 1 resident reviewed for Hospice (Resident #88).</p> <p>Findings include:</p> <p>The record for Resident #88 was reviewed on 6/12/2015 at 1:00 p.m.</p>	F 0278	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Wellbrooke of Kokomo practice is to identify and accurately assess each resident. Resident #88 statuses were immediately assessed for Hospice with a prognosis of six month or less. Resident #88 MDS was immediately modified to reflect this status on 6/12/15.</p>	07/18/2015			

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	<p>Diagnoses included, but were not limited to, Urinary Tract Infection, Dementia with Behavioral disturbances, Anxiety, Aphasia, and Contracture of Left Hand with Splint Placement.</p> <p>A Physician's order, dated 3/13/2015, indicated admission to Hospice with diagnosis of dementia, and resident had prognosis of six months or less.</p> <p>A Quarterly Minimum Data Set Assessment (MDS), dated 5/6/2015, indicated Resident #88 was on hospice and did not have a prognosis of six months or less.</p> <p>During an interview with the MDS coordinator on 6/12/2015 at 1:45 p.m., regarding the hospice status of Resident #88, she indicated that hospice was noted on the MDS, but that Resident #88 did not have a prognosis of less than six months indicated on the MDS.</p> <p>3.1-31(a) 3.1-31(d)(3)</p>		<p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: A <i>Hospice MDS</i> udit completed by the MDS coordinator revealed no other resident were affected. (Attachment C)</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</p> <p>The MDS RAI manual Hospice assessment section was reviewed by the MDS and MDSA to ensure compliance.</p> <p>(Attachment D)</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</p> <p>The DHS or designee will complete a <i>Hospice MDS</i> audit 2 times per week times 8 weeks, then monthly times 4 months to ensure Hospice Assessments are in compliance. (Attachment C)</p> <p>The results of the audit observations will be reported, reviewed and</p>		

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F 0325 SS=G Bldg. 00	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review, and interview, the facility failed to assess and provide interventions to prevent weight loss for 1 of 3 residents reviewed for weight loss and nutrition (Resident #178). Resident #178 had a weight loss of 13.5% in 39 days without assessment or intervention</p> <p>Findings include:</p> <p>The clinical record for Resident #178 was reviewed on 06/17/2015 at 11:00 a.m. Diagnosis included, but were not limited to, mitral value disorder, congestive heart failure, proxysmal ventricular tachycardia, cardiomyopathy, difficulty in walking, muscle weakness, and heart</p>	F 0325	<p>trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Wellbrooke of Kokomo practice is to assess and provide interventions to prevent unplanned weight loss. Registered Dietitian was contacted and Resident #178 Dietary Care Plan was updated to address weight loss.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: A Resident <i>Weight Loss</i> audit was conducted and all other residents were assessed and interventions were in place to prevent weight loss. (Attachment E)</p>	07/18/2015	

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	<p>valve replacement.</p> <p>A record review of Resident #178 weights indicated a 13.5% weight loss in 39 days. The resident's weight record indicated on 5/8/2015, Resident #178's weight was 148 pounds and on 06/17/2015, Resident #178's weight was 128 pounds.</p> <p>An admission care plan for resident #178 indicated, "...maintain weight at healthy range without unwarranted significant weight change and remain at 90% of usual weight..." and "...please review my overall weight trends at least once monthly for any undesired weight change and make any necessary recommendations to my physician...."</p> <p>The most current nutrition assessment was dated 5/17/2015. No other dietary manager or registered dietician (RD) consultant assessment was found in Resident #178's clinical record for the weight loss.</p> <p>A nursing note dated 5/27/2015 indicated the resident had a 6.8 pound weight loss since 5/25/15. The resident's Physician was notified of weight loss but no new orders were indicated. The nursing note indicated "...provide resident with ensure after meals today and encourage her to</p>		<p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</p> <p>DHS or designee will assign a <i>Weight Champion</i> who is responsible to ensure weights are accurately obtained and properly recorded and reported. (Attachment F)</p> <p>A <i>Dietitian Visit List</i> form was developed to communicate any residents with weight loss. (Attachment G)</p> <p>DHS or designee will re-educate the nursing staff on the following guideline: <i>Guidelines for Weight Tracking</i>. (Attachment H)</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: A <i>Resident Weight Loss</i> audit will be conducted by the DHS or designee 2 times per week times 8 weeks for 5 residents, then monthly times 4 months to ensure assessments, care plans and interventions to prevent with loss are</p>	

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	<p>continue to drink supplement while appetite is suppressed...."</p> <p>No care plan for potential weight loss, was found for Resident #178 and Resident #178 continued to lose weight . Resident #178's weights record indicated, 5/26/2015 weight 140 pounds 6/1/2015 weight 130 pounds 6/10/2015 weight 131 pounds 6/15/2015 weight 129 pounds 6/17/2015 weight 128 pounds.</p> <p>During an interview on 6/17/2015 at 4:00 p.m., Resident # 178 indicated she was aware of her weight loss, that her family had brought in ensure for her to drink, and she would have liked to talk to the RD about ways to increase her appetite and stop losing weight.</p> <p>During an interview on 06/17/2015 at 4:45 p.m., RN #1 indicated there was no care plan for weight loss for Resident # 178.</p> <p>During an interview on 06/17/2015 at 5:18 p.m., RN #2 indicated she had spoken to the RD. The RD indicated she was not aware of the resident's weight loss and the RD was present in the facility on 6/12/2015.</p> <p>During an interview on 06/17/2015 at</p>		<p>in compliance. (Attachment E)</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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F 0371 SS=F Bldg. 00	<p>5:25 p.m., RN #2 indicated Resident #178 should have had a care plan for weight loss and an assessment by the RD, to address the resident's current weight loss.</p> <p>The policy and procedure titled "Guidelines For Weight Tracking," dated 11/07, updated 5/2014, received on 6/17/2015 at 4:45 p.m., from Registered Nurse (RN) #1 indicated, "...3. The facility dietician or representative will review the resident's nutritional status, usual body weight and current weight to implement a nutritional program when warranted...8. The physician, responsible party and dietician shall be notified of a weight variance of > [greater than] 5% (unless on a planned weight loss program)...."</p> <p>3.1-46(a)(1)</p> <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 on observation and interview, the facility failed to ensure that food was</p>	F 0371	Corrective actions accomplished for those residents found to be	07/18/2015

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	<p>labeled and dated in the dry storage area in 1 of 1 kitchen in the facility. This deficient practice had the potential to affect 51 of 51 residents who received meals from the kitchen.</p> <p>Findings include:</p> <p>During the tour of the kitchen on 6/10/2015 at 9:50 a.m., the dry storage area was observed to have packages of chocolate chips, beans and raisins opened and not dated.</p> <p>During an interview on 6/10/2015 at 10:00 a.m., with the Dietary Manager, he indicated the opened food should have been dated.</p> <p>A review of the guideline titled "Food Labeling Guideline," not dated, indicated "...once opened the item will have a second date mark to establish when it was opened and then discarded within 30 days or within the manufacturers use by or expiration date this will always superseded our date mark best practice...."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>		<p>affected by the alleged deficient practice: Wellbrooke of Kokomo policy is to label and date all food items. The raisins, chocolate chips and beans were thrown out.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All other dry storage food items were dated.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</p> <p>DFS or designee re-educated dietary staff on procedures for leftovers and food storage per the <i>Serv Safe Guideline</i>. (Attachment I)</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DFS or designee will conduct <i>Food Dated</i> audits of the dry storage rooms 2 times per week times 8 weeks, then 1 time per week times 4 weeks, then 1 time every other week times 6 weeks, then monthly times 4 months to ensure compliance. (Attachment J)</p>		

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F 0431 SS=D Bldg. 00	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>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.</p> <p>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</p>		The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	<p>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.</p> <p>Based on observation, record review and interview, the facility failed to ensure expired medications were removed from the medication room refrigerators, instructions for maintenance of medications based on manufacturers recommendations were followed and refrigerator temperatures were monitored for 2 of 2 refrigerators used for medication storage. (Residents #44, and #88)</p> <p>Findings include:</p> <p>During review of medication storage on 6/15/15 at 9:30 a.m., the following was observed:</p> <p>1. A box of Bisacoyl 10 mg (milligram) suppositories (laxatives) ordered for Resident #88 was found in the medication refrigerator. The expiration date on the suppositories was 3/2015. The order for the medication was current on the medication list for the resident.</p> <p>2. A foilpack of arformoterol tartrate inhalation solution (15 microgram in 2 milliliters) ordered for Resident #44 on 5/27/15, was found opened and undated. Instructions on manufacturers packaging</p>	F 0431	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Wellbrooke of Kokomo practice is to remove expired medications from refrigerators and to document and monitor refrigerator temperatures used for medication storage. The expired medication for resident #44 and #88 was immediately removed and the temperatures were taken on the refrigerators.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: No other medications were expired.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</p> <p>The <i>Medications Refrigerator Temperature Log</i> form was revised. (Attachment K)</p> <p>The DHS or designee implemented a <i>Midnight Shift Duties</i> in-service</p>	07/18/2015			

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	<p>stated medication expires 14 days after opening foilpack.</p> <p>3. A review of the daily audit for temperature logs for refrigerators in medication room for 100 hall indicated temperatures were not checked in May 2015 for 18 of 31 days and June 2015 for 7 of 15 days. The temperatures logs for 200 hall indicated temperatures were not checked in June,2015 for 4 of 15 days. The temperature log indicated refrigerator temperatures were to be checked daily.</p> <p>During an interview with District Nurse Consultant on 6/15/15 at 10:00 a.m., she indicated it is the expectation of the facility that refrigerator temperatures are monitored by the midnight shift nursing staff and storage of medications guidelines are followed.</p> <p>A review of policy titled "Medication storage in the Facility" dated 9/1/13, obtained from District Nurse Consultant on 6/15/15 at 10:46 a.m., indicated "Policy, Medications and biological's are stored safely, securely, and properly, following manufacturers' recommendations or those of the supplier... J. Medications requiring</p>		<p>which include educating the nurses on the revised <i>Medications Refrigerator Temperature Log</i> form, documenting temperatures daily, reporting any temperatures out of range to maintenance and removal of expired medication from refrigerators. (Attachment L)</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</p> <p>The DHS or designee will conduct the following audits 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance:</p> <p><i>Medications Refrigerator Temperature Log</i> audit (Attachment M)</p> <p><i>Expired Medications</i> audit on all medication refrigerators. (Attachment M)</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155819	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/18/2015
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R 0000 Bldg. 00	refrigeration or temperatures between 2 degrees Celsius (36 degrees fahrenheit) and 8 degrees Celsius (46 degrees fahrenheit) are kept in a refrigerator with a thermometer to allow temperature monitoring... L. outdated contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal..." 3.1-25(m) 3.1-25(o) This visit was for a State Residential Licensure Survey. Residential Census: 22 Sample: 9 These state findings are cited in accordance with 410 IAC 16.2-5.	R 0000	<u>Survey Event ID GRVM11</u> The submission of this Plan of Correction does not indicate an admission by Wellbrooke of Kokomo that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Wellbrooke of Kokomo. This facility recognized it's obligation to provide legally and medically	

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R 0156 Bldg. 00	<p>410 IAC 16.2-5-1.5(m) Sanitation and Safety Standards - Deficiency (m) The facility's food supplies shall meet the standards of 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to ensure that food was labeled and dated in the dry storage area in 1 of 1 kitchen in the facility. This deficient practice had the potential to affect 22 of 22 residents who received meals from the kitchen.</p> <p>Findings include:</p> <p>During the tour of the kitchen on 6/10/2015 at 9:50 a.m., the dry storage area was observed to have packages of chocolate chips, beans and raisins opened</p>	R 0156	<p>necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs).</p> <p>To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Wellbrooke of Kokomo policy is to label and date all food items. The raisins, chocolate chips and beans were thrown out.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All other dry storage food items were dated.</p>	07/18/2015

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	<p>and not dated.</p> <p>During an interview on 6/10/2015 at 10:00 a.m., with the Dietary Manager, he indicated the opened food should have been dated.</p> <p>A review of the guideline titled "Food Labeling Guideline," not dated, indicated " ... once opened the item will have a second date mark to establish when it was opened and then discarded within 30 days or within the manufacturers use by or expiration date this will always superseded our date mark best practice "</p>		<p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</p> <p>DFS or designee re-educated dietary staff on procedures for leftovers and food storage per the <i>Serv Safe Guideline</i>. (Attachment I)</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DFS or designee will conduct <i>Food Dated</i> audits of the dry storage rooms 2 times per week times 8 weeks, then 1 time per week times 4 weeks, then 1 time every other week times 6 weeks, then monthly times 4 months to ensure compliance. (Attachment J)</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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