

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155795	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2015
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NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: May 11, 12, 13, 14, 15, 18, and 19, 2015</p> <p>Facility number: 012766 Provider number: 155795 AIM number: 201051640</p> <p>Census bed type: SNF: 40 SNF/NF: 19 Residential: 56 Total: 115</p> <p>Census payor type: Medicare: 32 Medicaid: 13 Other: 11 Total: 59</p> <p>Residential sample: 8</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>This plan of correction is submitted by Avalon Springs Health Campus in order to respond to the alleged deficiencies cited during the Recertification and State survey which was conducted on May 29, 2015. Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of Federal and State law. Please accept this plan of correction as the provider's credible allegation of compliance effective June 18, 2015. Considering the volume, scope, and severity of the alleged deficient practice noted in the CMS-2567, Avalon Springs Health Campus respectfully requests a desk review for this survey. If approved, we would be willing to provide all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised, or implemented as part of this Plan of Correction.</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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F 278 SS=D Bldg. 00	<p>483.20(g) - (j) ASSESSMENT 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 ensure the Minimum Data Set (MDS) assessments were accurate related to falls for 2 of 14 residents reviewed for MDS assessments. (Residents #52 and #92)</p> <p>Findings include:</p>	F 278	<p>1. Resident #52 had MDS related to falls corrected prior to discharge as resident is no longer in facility at this time. Resident #92 had MDS related to falls corrected. 2. MDS assessments completed in the past 30 days for current residents are being audited for accuracy. Any deficiencies identified will be</p>	06/18/2015
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	<p>1. The record for Resident #52 was reviewed on 5/13/15 at 11:14 a.m. The Resident's diagnoses included, but were not limited to, hypertension and diabetes mellitus.</p> <p>Review of the Quarterly MDS assessment, dated 3/19/15, indicated the resident had no falls since admission or prior assessment. The most recent prior MDS assessment completed was the Quarterly assessment dated 12/20/14.</p> <p>Review of Fall Circumstance Assessment and Intervention forms indicated the resident had fallen on the following dates: 12/27/14, 1/1/15, 1/11/15, 1/13/15, 1/15/15, 1/24/15, 2/9/15, 2/11/15, 2/14/15, and 3/8/15.</p> <p>Interview with MDS Nurse #1 on 5/18/15 at 2:10 p.m., indicated there was an inaccuracy on the MDS related to falls and she would correct it.</p> <p>2. The record for Resident #92 was reviewed on 5/13/15 at 8:53 a.m. The resident's diagnoses included, but were not limited to, hypertension and right hemiplegia.</p> <p>Review of the Quarterly MDS assessment, dated 4/2/15, indicated the</p>		<p>corrected immediately. 3. DHS/Designee will in-service MDS nurses, Social Service, and Activities, regarding accurate assessments. MDS/Designee will audit assessments weekly for 6 months or until QAA states otherwise. 4. Audits to be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. 5. Date of Compliance 6.18.15</p>	

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F 329 SS=D Bldg. 00	<p>resident had one fall without injury since admission or prior assessment. The most recent prior MDS assessment completed was the Annual assessment dated 1/3/15.</p> <p>Review of Fall Circumstance Assessment and Intervention forms indicated the resident had fallen on the following dates: 1/31/15, 2/9/15, 2/20/15, 2/22/15, and 3/15/15.</p> <p>Interview with MDS Nurse #1 on 5/18/15 at 2:10 p.m., indicated there was an inaccuracy on the MDS related to falls and she would correct it.</p> <p>3.1-31(d)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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</p>			

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	<p>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 a resident's drug regime remained free of unnecessary medications related to the lack of an Abnormal Involuntary Movement Scale (AIMS) assessment completed for a resident receiving an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medication. (Resident #35)</p> <p>Finding includes:</p> <p>A record review was completed on 5/14/15 at 10:52 a.m., for Resident #35. Diagnoses included, but were not limited to, dementia with behavioral disorder, Parkinson's Disease, anxiety and depression.</p> <p>The Quarterly MDS (Minimum Data Set) assessment completed on 3/29/15, indicated the resident received an antipsychotic medication 7 times during the 7 day assessment period.</p> <p>Resident #35 was admitted back into the</p>	F 329	<p>1. Resident #35 has current AIMS assessment completed. 2. Other residents receiving antipsychotic medications were audited for AIMS assessment. All have current assessment completed. 3. DHS/Designee will in-service licensed nurses regarding completing AIMS assessments for residents receiving antipsychotic medication with dosage changes, and every 6 months. DHS/Designee will audit residents receiving antipsychotic medications monthly for current AIMS assessments for 6 months or until QAA states otherwise. 4. Audits to be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. 5. Date of Compliance 6.18.15</p>	06/18/2015

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	<p>facility on 10/26/14 after a hospital stay. The resident had an order for Seroquel (antipsychotic medication) 12.5 mg (milligrams) QD (every day) for dementia with behavioral disorder. An AIMS assessment had been completed on 10/26/14.</p> <p>A Physician Order dated 1/22/15 indicated Seroquel 25 mg one half tablet (12.5 mg) BID (twice a day). The record lacked any indication an AIMS assessment had been completed with the Seroquel dosage change.</p> <p>A Physician Order dated 3/2/15 indicated change Seroquel to 25 mg BID. The record lacked any indication an AIMS assessment had been completed with the Seroquel dosage change.</p> <p>Interview with the DHS (Director of Health Services) on 5/18/15 at 3:10 p.m., indicated the resident should of had an AIMS assessment completed with each Seroquel dosage change.</p> <p>A policy titled, "Guidelines For: Abnormal Involuntary Movement Scale (AIMS)," was received as current from the DHS on 5/15/15 at 3:30 p.m. The policy indicated, "Procedure: 2. The AIMS assessment will be completed if possible...with dosage changes...."</p>			

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F 371 SS=D Bldg. 00	<p>3.1-48(a)(3)</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 distribute food under sanitary conditions related to fluids uncovered during serving of the 200 Hallway room trays. This affected 1 of 2 hallways observed for room tray distribution. (200 Hallway Cart)</p> <p>Finding includes:</p> <p>During an observation of lunch service on 5/11/15 at 12:03 p.m., on the 200 Hallway, room trays were brought and placed at the nurse's station. RN #1 scooped ice from a cooler into a glass, then poured juice into the glass. RN #1 placed the glass onto the room tray and carried the tray down the hall with the drink uncovered to Room 205.</p> <p>During the same lunch service observation on 5/11/15 at 12:05 p.m., on</p>	F 371	<p>1. Residents on 200 hallway had no negative outcomes. 2. Staff were immediately in-serviced regarding proper serving of fluids with room trays. RN#1 was educated on covering fluids when serving room trays. 3. DHS/Designee will in-service staff on sanitary delivery of fluids on room trays. DFS/Designee will audit room service delivery weekly covering all meals for sanitary delivery of fluids for 6 months or until QAA states otherwise. 4. Audits to be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. 5. Date of Compliance 6.18.15</p>	06/18/2015

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F 441 SS=D Bldg. 00	<p>the 200 Hallway, RN #1 scooped ice from a cooler into a glass, then poured water into the glass. RN #1 placed the glass onto the room tray and carried the tray down the hall with the drink uncovered to Room 215.</p> <p>Interview with RN #1 on 5/11/15 at 12:07 p.m., indicated the drinks should have been covered before taking them down the hall.</p> <p>Interview with the Dietary Manager on 5/15/15 at 11:15 a.m., indicated when drinks are carried down the hall they need to be covered. She further indicated they did not have a specific policy related to covering drinks.</p> <p>3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection</p>						

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	<p>Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control practices and standards were maintained related to improper disposal of a glucometer test strip (a test strip used to test blood sugars). This had the potential to affect 3 residents that receive glucometer testing on the 100 Hallway. (100 Hallway)</p> <p>Finding includes:</p>	F 441	<p>1. Resident #78 had no negative outcome. 2. Other residents on 100 hallway had no issues. LPN #1 was educated on proper disposal of glucometer test strips. 3. DHS/Designee will in-service licensed nurses regarding proper disposal of glucometer test strips. DHS/Designee to audit blood glucose testing for proper disposal of glucometer test strips weekly covering all shifts for 6 months or until QAA states otherwise. 4. Audits to be</p>	06/18/2015

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	<p>During observation of Resident #78's glucometer testing (testing of blood for blood sugars) on 5/13/15 at 11:40 a.m., LPN #1 donned gloves, cleaned the resident's right 4th finger with an alcohol wipe, pricked the resident's finger with a lancet, then placed a drop of blood on the test strip. After the blood sugar reading was received, LPN #1 removed her gloves with the used test strip in the gloves and threw the gloves into the resident's garbage can.</p> <p>Interview with LPN #1 on 5/13/15 at 11:44 a.m., indicated she normally throws the used test strips into the garbage.</p> <p>Interview with the DHS (Director of Health Services) on 5/14/15 at 2:44 p.m., indicated the nurse was not supposed to throw the used test strip into the garbage. She further indicated the proper procedure was to throw the used test strip into a sharps/biohazard container.</p> <p>A policy titled, "Guidelines for Accuchecks," was received as current from the DHS on 5/14/15 at 3:15 p.m. The policy indicated, "...Procedure: 4. Testing supplies shall be properly disposed of in biohazard containers...."</p>		<p>reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. 5. Date of Compliance 6.18.15</p>	

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F 465 SS=E Bldg. 00	<p>3.1-18(a)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain a functional and safe environment related to gouged walls, a gouged footboard, a gouged door, and marred walls throughout the facility. (100 Hallway and 200 Hallway)</p> <p>Findings include:</p> <p>During an environmental tour with the Director of Plant Operations and the Director of Environmental Services on 5/19/15 at 11:05 a.m. through 11:20 a.m., the following was observed:</p> <p>1. 100 Hallway</p> <p>a. Room 106A: The wall behind the head of the bed was gouged. The walls throughout the room had black mars. One resident resided in the room.</p> <p>b. Room 107A: The wall on the right side of the bed near the bathroom was gouged. One resident resided in the room.</p>	F 465	<p>1. No resident had a negative outcome. 2. Rooms 106A, 107A, 109A, 207, 212B, 213A, 215 had marred and gouged walls repaired and repainted as appropriate. A new bathroom door was ordered to replace the one in room 207. The footboard of bed A in room 215 was sanded and restained. 3. DHS/Designee will in-service staff on reporting residents rooms with any marred/gouged walls, doors or footboards to maintenance by filling out a maintenance request form. DHS/Designee will in-service maintenance regarding maintaining a functional and safe environment by not having marred/gouged walls, footboards and doors. Executive Director/Designee will audit 3 rooms weekly for marred/gouged walls, gouged footboards and doors for 6 months or until QAA states otherwise. 4. Audits to be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. 5. Date of</p>	06/18/2015
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	<p>c. Room 109A: The wall on the right side of the bed near the bathroom was gouged. One resident resided in the room.</p> <p>2. 200 Hallway</p> <p>a. Room 207: The walls next to the room door and next to bed A were marred and gouged. The bathroom door frame was marred. The inside bottom of the bathroom door was gouged and scratched. The wall under the window was marred. Two residents resided in the room.</p> <p>b. Room 212B: The wall behind bed B was gouged. Two residents resided in the room.</p> <p>c. Room 213A: The wall next to the room door was marred and gouged. Two residents resided in the room.</p> <p>d. Room 215: The footboard of bed A was gouged and a piece was missing on the bottom corner. The wall next to the bathroom was gouged. The bathroom wall next to the vent was gouged. Two residents resided in the room.</p> <p>Interview with the Director of Plant Operations at the time of the tour</p>		Compliance 6.18.15	

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R 000 Bldg. 00	<p>indicated all above areas were in need of repair.</p> <p>3.1-19(f)</p> <p>This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey.</p> <p>Residential Census: 56</p> <p>Sample: 8</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p>	R 000	<p>This plan of correction is submitted by Avalon Springs Health Campus in order to respond to the alleged deficiencies sited during the Recertification and State survey which was conducted on May 29, 2015. Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of Federal and State law. Please accept this plan of correction as the provider's credible allegation of compliance effective June 18, 2015. Considering the volume, scope, and severity of the alleged deficient practice noted in the CMS-2567, Avalon Springs Health Campus respectfully requests a desk review for this survey. If approved, we would be willing to provide all documentation requested including, but not limited to:</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155795	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2015
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NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
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R 092 Bldg. 00	<p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance</p> <p>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:</p> <p>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on record review and interview the facility failed to invite the local fire department to a fire drill at least every 6 months.</p> <p>Finding includes:</p>	R 092	<p>education records, policies and procedures, checklists, and forms that have been completed, revised, or implemented as part of this Plan of Correction.</p> <p>1. No residents were affected. 2. Fire Department will be invited to attend a June 2015 Fire Drill. 3. DHS/Designee will in-service Maintenance Director regarding inviting the fire department to participate in a fire drill at least every 6 months and documenting the invitation. Executive</p>	06/18/2015

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R 273 Bldg. 00	<p>The fire drill records were reviewed on 5/19/15 at 1:45 p.m. There was lack of documentation to indicate the local fire department attended or was invited to a fire drill after 7/24/14.</p> <p>Interview with the Director of Plant Operations on 5/19/15 at 1:55 p.m., indicated he had invited the fire department to participate in the drill on 5/6/15 but had not documented it. He further indicated the last time he had invited the fire department to participate before that was 7/24/14.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, record review, and interview, the facility failed to store and distribute food under sanitary conditions related to food stored unlabeled, undated, and uncovered in the refrigerator, freezer and pantry in 1 of 2 kitchens, which had the potential to affect 26 residents who resided on the Legacy Unit. (Legacy Kitchen)</p> <p>Findings include:</p>	R 273	<p>Director/Designee will audit fire drill log monthly for invitation and documentation of the invitation of the fire department for 6 months or until QAA states otherwise. 4. Audits to be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. 5. Date of Compliance 6.18.15</p> <p>1. No residents on the Legacy unit were affected. 2. All food in the refrigerator, freezer and pantry of the Legacy unit were labeled, dated and/or discarded as appropriate. 3. DFS/ Designee to in-service dietary staff on proper storage, labeling, dating and covering of food. DFS/Designee to audit refrigerator, freezer and pantry of the Legacy unit for proper storage, covering, labeling and dating of food weekly for 6 months or until QAA states</p>	06/18/2015			

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	<p>During an observation with Cook #1 present on 5/19/15 at 9:45 a.m., the following was observed:</p> <ol style="list-style-type: none"> 1. In the stand up refrigerator there was: <ol style="list-style-type: none"> a. An uncovered plate of carrots and potatoes. Cook #1 indicated it was probably a resident's plate from dinner last night. 2. In the stand up freezer there was: <ol style="list-style-type: none"> a. An undated, unlabeled, twisted closed bag of chicken nuggets. b. An undated, unlabeled, twisted closed bag of fish sticks. c. An undated, open bag of Heath chocolate pieces inside of an open, undated, and unlabeled plastic bag. d. Two brown rolled up, undated, unlabeled bags. Cook #1 indicated the bags contained french fries. e. An unlabeled, undated, plastic bag with a pink orange substance in it. Cook #1 indicated she was unsure what it was but thought it might be chicken. f. An unlabeled, undated, twisted closed bag of biscuits. 		<p>otherwise. 4. Audits to be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. 5. Date of Compliance 6.18.15</p>	

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	<p>g. Breadsticks wrapped in plastic wrap that were unlabeled and undated.</p> <p>3. In the pantry there was:</p> <p>a. An undated, packet of gravy mix rolled up with plastic wrap.</p> <p>b. An open, undated box of creamy wheat sitting on a cart. Cook #1 indicated she had just used it earlier in the morning.</p> <p>c. Two undated, twisted closed packets of gelatin mix stored in a plastic container with no lid.</p> <p>A facility policy, dated 2009, and provided by the Dietary Manager as current, titled, "Storage Procedures," indicated, "Dry storage of food:...6. Open packages are labeled, dated, and stored in closed containers...Refrigerated storage:...5. Food is covered, dated and stored loosely to permit air circulation...Frozen storage:...3. All foods in the freezer are wrapped in moisture proof wrapping or placed in suitable containers, to prevent freezer burn. Items are labeled and dated..."</p>			
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