STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY HOME - CROWN POINT	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: November 7, 9, 10, 14, 16, and 17, 2016. Facility number: 000120 Provider number: 155214 AIM number: 100274780 Census bed type: SNF/NF: 147 SNF: 20 NCC: 3 Total: 170 Census payor type: Medicare: 27 Medicaid: 105 Other: 38 Total: 170 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 32883 on 11/21/16.	F 0000	St. Anthony Home - Crown Point ("the provider") submits this Plan of Correction ("POC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed finding: (1) are relied upon to adversely influence or serve as a basis, in any way, the selection and/or imposition of future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS"), the state of Indiana or any other entity; or (2) to serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.	

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

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F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review, and interview, the facility failed to ensure each resident had a comprehensive care plan related to a resident receiving a diuretic (water pill) medication for 1 of 16 residents whose plans of care were reviewed. (Resident #47)	F 0279	1:1 Resident #47, the Nurse Manager assessed this resident for adverse reactions related to her diuretic use without any abnormal findings. A diuretic care plan was completed and placed in the chart. 1:2 Resident Assessment Director/Nurse Manager designee reviewed the current	12/09/2016

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	Finding includes: Resident #47's record was reviewed on 11/14/16 at 11:24 a.m. Diagnoses included, but were not limited to, heart failure and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS) assessment completed on 8/3/16 indicated the resident had received a diuretic medication. The November 2016 Physician Order Sheet indicated an order for hydrochlorothiazide (diuretic, treats high blood pressure and fluid retention) 25 mg (milligrams) every day. The record lacked any indication a care plan for the diuretic medication with interventions to monitor side effects of the medication was in place. Interview with Unit Manager #1 on 11/15/16 at 11:15 a.m., indicated she was unable to find a diuretic care plan for Resident #47. The medication was usually addressed under the dietary care plan, but had not been addressed there either. 3.1-35(a)		residents care plans for inclusion of all areas pertinent to their plan of care with any deficiencies corrected at that time. 1:3 The Resident Assessment Director in-serviced the care plan team regarding diuretic care plans. The Resident Director/Designee will audit five (5) records of care plans for inclusion of all areas pertinent to their plan of care on each unit weekly for twelve (12) weeks, then monthly for six (6) months utilizing audit tool entitled Resident Assessment Director Audit Tool (enclosed attachment #1), for a diuretic care plan that is complete and accurate. 1:4 The Resident Assessment Director/Designee will report audit findings to QAPI Committee monthly for nine (9) months beginning December 2016. The QAPI Committee will monitor data presented for any trends and determine if further auditing is warranted. 1:5 Systemic changes will be completed by 12-9-16	

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F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to provide services in accordance with a resident's written plan of care related to lack of dialysis access site monitoring, post dialysis assessments, and dietary supplements not provided as ordered for 2 of 16 residents whose plans of care were reviewed. (Residents #18 and #65) Findings include: 1. On 11/10/16 at 3:00 p.m., Resident #18 was observed lying in bed. The resident had a bandage to the front of her right shoulder. She identified the bandaged area as a dialysis access site. The resident indicated the nurses in the facility would "sometimes" check her blood pressure before and after her dialysis appointments. The record was reviewed on 11/16/16 at 8:47 a.m. Diagnoses included, but were	F 0282	1:1 Resident #18, the Nurse Manager assessed the dialysis access site without abnormal findings. New orders were obtained from the Physician in accordance with the Facility policy on proper care and monitoring post dialysis. Resident #65's meal ticket was updated to include the supplements and other dietary interventions to prevent weight loss and was given the supplement when noticed missing. 1:2 Nurse Managers reviewed and found no other residents currently receiving dialysis services at this time. All resident meal tickets were reviewed for accuracy and completeness and no other deficiencies were found. 1:3 Director of Nursing/designee in-serviced the licensed staff regarding the Arterial/Venous Fistula Dialysis Catheter policy which includes requirements for dialysis site monitoring and post dialysis assessments. Director of Dining Services/designee in-serviced the	12/09/2016

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	not limited to, hypertension (high blood pressure) and end stage renal disease. A Care Plan indicated the resident had potential for complications related to dialysis. An intervention included to monitor the dialysis access port for signs and symptoms of infection. The November 2016 Physician Order Sheet (POS) indicated an order for dialysis treatments three times a week. The record lacked any indication the dialysis access site was being monitored or post dialysis assessments were being completed whenever the resident returned from dialysis. Interview with Unit Manager #1 on 11/16/16 at 11:00 a.m., indicated the nurses were supposed to check the access site for any bleeding or signs of infection every shift and also to complete vitals when the resident returned from dialysis and then document the assessments. She was unable to find any documentation the assessments were being completed. She indicated the order to do the assessments had been discontinued a while ago but it should not have been. 2. On 11/15/16 at 12:29 p.m., Resident #65 was observed sitting in a wheelchair		dietary staff on review of tray cards during meal service to ensure supplements and super foods are served as ordered by the physician. Director of Nursing/designee will audit all dialysis records weekly for twelve (12) weeks and then monthly of six (6) months utilizing audit tool entitled Nursing/Unit Manger Audit Tool (enclosed attachment #2) to ensure the policy and procedure for dialysis access site monitoring and post dialysis assessments are completed. Director of Nursing/designee will complete random rounds/audits on five (5) staff members on all shifts weekly for twelve (12) weeks and then monthly of six (6) months utilizing audit tool entitled Nursing/Unit Manger Audit Tool (enclosed attachment #2) to ensure the staff member is following the residents plan of care. Director of Dining Services/designee will audit 5 diet orders each week for twelve (12) weeks and then monthly for six (6) months against meal tickets and trays served utilizing audit tool entitled Director of Dining Services Audit Tool (enclosed attachment #3), to ensure accuracy and completeness. 1:4 Director of Nursing/designee and Director of Dining Services/designee will report audit finding to the QAPI Committee monthly for nine (9)	

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	in his room. A lunch tray was delivered to the resident by Unit Manager #2. The tray included noodles, chicken, zucchini, a glass of milk and a cup of coffee. The tray did not include mashed potatoes, pudding, or a shake. On 11/15/16 at 12:49 p.m., a CNA was observed carrying the resident's tray from the residents room. The tray did not include any mashed potatoes, pudding or a shake and the meal ticket did not have listed any supplements the resident was supposed to receive. The resident's record was reviewed on 11/15/16 at 11:24 a.m. record review on 11/15/16 at 11:24 a.m. Diagnoses included, but were not limited to hypertension, hyperlipidemia, atrial fibrillation and anxiety. A Care Plan indicated the resident had a history of poor appetite, meal intakes were varied, and had a weight loss. Interventions included to provide dietary supplements at meals. The November 2016 POS indicated orders for dietary supplements which included: - Super-Mashed Potatoes with lunch and dinner		months beginning December 2016. The QAPI Committee will monitoring data presented for any trends and determine if further auditing is warranted. 1:5 Systemic changes will be completed by 12-9-16	

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	- Fresh Benefits pudding with lunch and dinner - Mighty Shake with all meals Interview on 11/15/16 at 12:50 p.m. with RN #1 indicated the resident should have had his dietary supplements on the lunch tray and dietary was responsible for putting the supplements on the tray. Nursing was responsible to make sure the resident received the dietary supplements as well. Interview on 11/15/16 at 12:54 p.m., with Cook #1 indicated she was unaware the resident was suppose to receive any dietary supplements and if residents were to receive any supplements it would be on the meal ticket. Interview on 11/15/16 at 1:10 p.m. with Dietary Tech #1 indicated she was unaware the resident's ticket did not have listed the supplements which he was supposed to receive. A new diet order and ticket system had been put into place the day before and his supplements must have been missed being added to the ticket. Interview on 11/15/16 at 3:05 p.m. with the Dietary Service Manager indicated they had switched menu systems the day before and the resident's ticket was not			

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	updated with his supplements. He had reviewed all residents' tickets and this was an isolated incident with no other resident found having supplements missing from the meal tickets. 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to the lack of dialysis access site monitoring and post dialysis assessments were completed for 1 of 1 residents reviewed for dialysis of the 2 residents who met the criteria for dialysis. (Resident #18) Finding includes: On 11/10/16 at 3:00 p.m., Resident #18 was observed lying in bed. The resident had a bandage to the front of her right shoulder. She identified the bandaged	F 0309	1:1 Resident #18, the Nurse Manager assessed the dialysis access site without abnormal findings. New orders were obtained from the Physician in accordance with the Facility policy on proper care and monitoring post dialysis. 1:2 Nurse Managers reviewed and found no other residents currently receiving dialysis services at this time. 1:3 Director of Nursing/designee in-serviced the licensed staff regarding the Arterial/Venous Fistula Dialysis Catheter policy which includes requirements for dialysis site monitoring and post dialysis assessments. Director of Nursing/designee will	12/09/2016

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	area as a dialysis access site. The resident indicated the nurses in the facility would "sometimes" check her blood pressure before and after her dialysis appointments. The record was reviewed on 11/16/16 at 8:47 a.m. Diagnoses included, but were not limited to, hypertension (high blood pressure) and end stage renal disease. The Quarterly Minimum Data Set (MDS) assessment completed on 8/31/16 indicated the resident had a Brief Interview of Mental Status (BIMS) score of 15, and was cognitively intact. The resident had received dialysis treatments. A Care Plan indicated the resident had potential for complications related to dialysis. An intervention included to monitor the dialysis access port for signs and symptoms of infection. The November 2016 Physician Order Sheet (POS) indicated an order for dialysis treatments three times a week. The record lacked any indication the dialysis access site was being monitored or post dialysis assessments were being completed when the resident returned from dialysis.		audit all dialysis records weekly for twelve (12) and then monthly for six (6) months utilizing audit tool entitled Nursing/Unit Manager Audit Tool (enclosed attachment #2), to ensure the policy and procedure for dialysis access site monitoring and post dialysis assessments are completed. 1:4 Director of Nursing/designee will report audit findings to the QAPI Committee monthly for nine (9) months beginning December 2016. The QAPI Committee will monitor data presented for any trends and determine if any further auditing is warranted. 1:5 Systemic changes will be completed by 12-9-16	

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	Interview with Unit Manager #1 on 11/16/16 at 11:00 a.m., indicated the nurses were supposed to check the access site for any bleeding or signs of infection every shift and also to complete vitals when the resident returned from dialysis and then document the assessments. She was unable to find any documentation the assessments were being completed. She indicated the order to do the assessments had been discontinued awhile ago but it should not have been. A facility policy titled, "Arterial/Venous Fistula Dialysis Catheter", and received as current from the Administrator on 11/16/16 indicated, "...Procedure: Nursing Actions: 1. The following dialysis assessments are to be performed upon return to facility after dialysis and documented in the Nurses' Notes: a. Vital Signs..." "...b. Catheter site is free of bleeding. c. Dressing over perma cath or fistula is dry and intact. d. Arterial / venous access should be assessed with a stethoscope..." "...Observe for mental status changes and if noted, contact physician. 2. On every shift assess the access site...." 3.1-37(a)			

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F 0325 SS=D Bldg. 00	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (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 (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review and interview, the facility failed to provide dietary supplements at meal service as ordered by the Physician for 1 of 4 residents reviewed for nutrition of the 10 who met the criteria for nutrition. (Resident #65) Finding includes: On 11/15/16 at 12:29 p.m., Resident #65 was observed sitting in a wheelchair in his room. A lunch tray was delivered to the resident by Unit Manager #2. The tray included noodles, chicken, zucchini, a glass of milk and a cup of coffee. The tray did not include mashed potatoes, pudding, or a shake. On 11/15/16 at 12:49 p.m., a CNA was observed carrying the resident's tray from the resident's room. The tray did not include any mashed potatoes, pudding or	F 0325	1:1 Resident #65's meal ticket was updated to include the supplements and other dietary interventions to prevent weight loss and was given the supplement when noticed to be missing. 1:2 All resident meal tickets were reviewed for accuracy and completeness and no other deficiencies were found nor supplements missing. 1:3 Director of Dining Services/designee in-serviced the dietary staff on review of tray cards during meal service to ensure all supplements are served as ordered by the physician. Director of Dining Service/designee will audit five (5) diet orders each week for twelve (12) weeks and then monthly for six (6) months against meal tickets and trays served utilizing audit tool entitled Director of Dining Services Audit Tool (enclosed attachment #3), to ensure accuracy and	12/09/2016

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	a shake and the meal ticket did not have listed any supplements the resident was supposed to receive. The resident's record was reviewed on 11/15/16 at 11:24 a.m. record review on 11/15/16 at 11:24 a.m. Diagnoses included, but were not limited to hypertension, hyperlipidemia, atrial fibrillation and anxiety. A Care Plan indicated the resident had a history of poor appetite, meal intakes were varied, and had a weight loss. Interventions included to provide dietary supplements at meals. A Nutrition Assessment completed on 10/7/16 indicated a recommendation to add enhanced foods to provide adequate calories and protein. The assessment indicated to add Fresh Benefits pudding at lunch and dinner, Fresh Benefits cereal at breakfast, and Fresh Benefits mashed potatoes at lunch and dinner. Adequate with meals to promote stable weight and enhance texture tolerance. The November 2016 POS indicated orders for dietary supplements which included: - Super-Mashed Potatoes with lunch and dinner		completeness and that supplements are served as ordered. 1:4 Director of Dining Services/designee will report audit finding to QAPI Committee monthly for nine (9) months beginning December 2016. The QAPI Committee will monitor data presented for any trends and determine if any further auditing is warranted. 1:5 Systemic changes will be completed by 12-9-16	

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	- Fresh Benefits pudding with lunch and dinner - Mighty Shake with all meals Interview on 11/15/16 at 12:50 p.m. with RN #1 indicated the resident should have had his dietary supplements on the lunch tray and dietary was responsible for putting the supplements on the tray. Nursing was responsible to make sure the resident received the dietary supplements as well. Interview on 11/15/16 at 12:54 p.m., with Cook #1 indicated she was unaware the resident was suppose to receive any dietary supplements and if residents were to receive any supplements it would be on the meal ticket. Interview on 11/15/16 at 1:10 p.m. with Dietary Tech #1 indicated she was unaware the resident's ticket did not have listed the supplements which he was supposed to receive. A new diet order and ticket system had been put into place the day before and his supplements must have been missed being added to the ticket. Interview on 11/15/16 at 3:05 p.m. with the Dietary Service Manager indicated they had switched menu systems the day before and the resident's ticket was not			

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	updated with his supplements. He had reviewed all residents' tickets and this was an isolated incident with no other resident found having supplements missing from the meal tickets. 3.1-46(a)(1) 3.1-46(a)(2)			
F 0332 SS=D Bldg. 00	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 7 residents observed during 5 medication pass observations. Three errors in medications were observed during 26 opportunities for errors in medication administration. This resulted in a medication error rate of 11.5 %. (Residents #121 and #207) Findings include: 1. During a medication administration observation on 11/14/16 at 4:07 p.m., LPN #1 prepared Resident #121's	F 0332	1:1 Resident #121 and Resident #207 were both assessed by the Nurse without any abnormal findings. The Physicians for both residents were made aware of the medication errors and gave orders to change the times of the medication administration. 1:2 Nurse Manager in-serviced the License Nurse on the medication administration time policy. No other residents were affected at that time. 1:3 Director of Nursing/designee in-serviced the Licensed Staff and Qualified Medication Assistants regarding the Medication Administration Time policy and procedure. Director of Nursing/designee will	12/09/2016

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	155214	A. BUILDING 00 B. WING	11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY HOME - CROWN POINT	203 FRANCISCAN DR CROWN POINT, IN 46307

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	medications and administered the medications. A medication that was included in the administration was cevimeline hcl (treats dry mouth) 30 mg (milligrams). The LPN #1 had also administered artificial tears drops into the resident's eyes and indicated she would have to wait a little bit before she administered the resident's other eye drop medication. At 4:29 p.m., LPN #1 returned to Resident #121's room to administer her other eye drops. The eye drops administered were Restasis 0.05% 1 drop to each eye. Resident #121's record was reviewed on 11/14/16 at 4:44 p.m. Diagnoses included, but were not limited to, sicca syndrome (autoimmune disease that combines dry eyes and dry mouth) and hypertension. The November 2016 Physician Order Sheet (POS) included orders for Restasis 0.05% to give 1 drop to both eyes two times daily at 6:00 a.m. and 18:00 (6:00 p.m.), and cevimeline hcl 30 mg to give 1 capsule two times daily at 9:00 a.m., and 21:00 (9:00 p.m.). 2. During a medication administration observation on 11/14/16 at 4:13 p.m., LPN #1 prepared Resident #207's medications and administered the		complete a random medication pass with two (2) Licensed Staff or Qualified Medication Assistants weekly for twelve (12) weeks and monthly for six (6) months utilizing audit too entitled Nursing/Unit Manager Audit Tool (enclosed attachment #2), to ensure accurate medication administration times. 1:4 Director of Nursing/designee will report medication pass findings to the QAPI Committee monthly for nine (9) months beginning December 2016. The QAPI Committee will monitor data presented for any trends and determine if further monitoring/action is warranted.. 1:5 Systemic changes will be completed by 12-9-16.	

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	medications to the resident. A medication that was included in the administration was levetiracetam (for seizures) 1000 mg give in the evening. Resident #207's record was reviewed on 11/14/16 at 4:57 p.m. Diagnoses included, but were not limited to, epilepsy and hypertension. The November 2016 POS included an order for levetiracetam 1000 mg to give two times daily at 6:00 a.m. and 18:00. Interview with LPN #1 on 11/14/16 at 4:51 p.m., indicated the resident's eye drops were not supposed to be given until at least 5:00 p.m. and she had given them too early. The cevimeline hcl medication was not scheduled to be given until 9:00 p.m. and she must have looked at the order time wrong and should not have given the medication at that time. Interview with Unit Manager #3 on 11/14/16 at 5:00 p.m., indicated the nurse was allowed to give the medications one hour before or one hour after the medications were supposed to be administered. LPN #1 had administered the medications too early and should have waited until at least 5:00 p.m. to administer them. The medication that was not supposed to be administered			

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	until 9:00 p.m. was also given too early and the nurse just looked at the medication strip which said to administer in the evening, but should have checked the administration time in the computer. 3.1-25(b)(9) 3.1-48(c)(1)			
F 0364 SS=E Bldg. 00	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview, and record review, the facility failed to serve food at the proper temperature. This had the potential to affect 6 of the 10 residents who received food from 1A Dining Room. (1A Dining Room) Findings include: During an observation on 11/7/16 at 12:04 p.m., Dining Assist #6 obtained temperatures for the following foods on the steam table in the 1A Dining Room: - mashed potatoes: 136 degrees Fahrenheit	F 0364	1:1 Residents in the 1A Dining Room were not noted to have any adverse consequences resulting from the incorrect food temperatures. 1:2 No other residents were known to be affected by improper food temperatures. 1:3 Director of Dining Services in-serviced the Dining Assistant and other Dining staff regarding the policy and procedure for ensuring proper food temperatures before serving. Director of Dining Services/Designee will complete three (3) random dining room audits each week for twelve (12) weeks and monthly for six (6)	12/09/2016

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	- ground sausage: 130 degrees Fahrenheit - green beans: 101.5 degrees Fahrenheit Interview with Dietary Assistant #6 and Dietary Assist #7 at 12:10 p.m. on 11/7/16, indicated the food temperatures were at the proper temperature to be served. At 12:17 p.m., three plates were served to residents with ground sausage, mashed potatoes and green beans. At 12:33 p.m., three room trays which contained mashed potatoes and green beans were sent to residents. Interview with Dining Service Assistant (DSA) #1 on 11/7/16 at 12:42 p.m. indicated all food served should be at least 165 degrees Fahrenheit and Dietary Assistant #6 should not have served the food, but instead should have sent it back to the kitchen. The current policy tilted, "The 12 Fundamental Rules of Food Safety," provided by the Dietary Manager on 11/7/16 at 12:45 p.m. This policy stated, "Following the 12 fundamental rules of food safety will ensure our operations maintain an environment that protects food through the entire flow of food		months utilizing Director of Dining Services Audit Tool (enclosed attachment #3), to ensure proper food temperatures. 1:4 Director of Dining Services/designee will report audit findings to the QAPI Committee monthly for nine (9) months beginning December 2016. The QAPI Committee will monitor the data presented for any trends and to determine if further monitoring is warranted. 1:5 Systemic changes will be completed by 12-9-16	

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	process. Rule 1: Never abuse Time/Temperature rules. Always keep hot food above 141 degrees and cold food below 41 degrees. Maintain temperature logs through the entire flow of food process to ensure temperature abuse does not occur...." 3.1-21(a)(2)			