STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 00 B. WING	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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: December 11, 12, 13, 16, and 17, 2024 Facility number: 000269 Provider number: 155400 AIM number: 100267720 Census Bed Type: SNF/NF: 70 Total: 70 Census Payor Type: Medicaid: 61 Other: 9 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 31, 2024.	F 0000	January 13, 2025 Ms. Brenda Buroker Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204 Re: Survey Event ID **0I6311** Dear Ms. Buroker: Please find attached my Plan of Correction for deficiencies cited during our Annual Survey. I am respectfully requesting paper compliance. If you have any questions, please feel free to contact me. Sincerely, Shannon Harris Administrator	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on observation, interview and record review, the facility failed to provide dementia services related to intrusive wandering for 1 of 1 residents reviewed for a unit relocation due to wandering. (Resident 33)	F 0744	PROPOSED PLAN OF CORRECTION F744	01/15/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shannon Harris		01/13/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Finding includes: Resident 33's clinical record was reviewed on 12/12/24 at 3:05 p.m. Current diagnoses included, Alzheimer's disease, restlessness and agitation, and generalized anxiety disorder. The resident had a current care plan problem/need regarding wandering, entering other's room and rifling through belongings with no real objective or motive, initiated 9/11/23. The goal for this need was for the resident to remain safe from wandering. An 11/10/24 at 3:44 a.m., Late Entry, "Behavior Note" indicated the resident was up all night wandering in and out of other resident rooms. An 11/12/24 at 1:19 a.m.,"Behavior Note" indicated the resident continued to wander at night with multiple redirections required. The resident also continued to wander into other residents' rooms causing agitation in residents attempting to sleep. Resident 33 was redirected multiple times to their room and common area to watch TV, and given multiple snacks, but continued to wander unit. All interventions were attempted without success. An 11/18/24 at 8:08 p.m., "Behavior Note" indicated the resident was noted to be wandering in and out of resident rooms attempting to rummage through belongings. The resident only remained seated for 10-15 minutes then got distracted and got up and began wandering again. The resident did not tire out until morning time when it was time to get up for breakfast. An 11/21/24 at 3:40 a.m., "Behavior Note"		It is the practice of this facility to ensure a resident diagnosed with dementia receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. 1 – What corrective action will be accomplished for those residents found to have been affected by the deficient practice: a Upon notification of alleged deficient practice, the facility placed the Resident 33 on 15 min checks for 72 hours to help acclimate the resident to his new room. b Social Services assessed for psychosocial distress. c Resident 33 had been moved to the new room for safety reasons related to a reportable event. 2 – How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a All residents have the potential to be affected by the alleged deficient practice. 3 – What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: a An in-service with Social Services and Nurse Managers	

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	indicated the resident woke up around 3:30 a.m. when he began wandering. Resident 33's clinical record indicated he was moved to a room on the secured behavior unit on 12/12/24 following intrusive wandering concerns on his hall of residence. Following the resident's move to the secured behavioral unit on 12/12/24, Resident 33's clinical record lacked documentation of a plan to reduce risks, increase safety, or reduce risk of injury due to intrusive wandering in his new environment and/or increase his potential for a successful transition into a new room and unit. During an observation, on 12/13/24 at 10:19 a.m., Resident 33 was in the lounge on the secured unit. He was watching TV and talking about the TV program. A 12/6/24, annual, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired and wandered daily through the assessment period. A 12/15/24 at 12:05 a.m., "Progress Note" indicated employees had heard loud resident voices and Resident 33 was standing in the doorway of another resident's room. Resident 33 was bleeding from the side of his mouth. The nurse observed a small cut inside the residents mouth. The resident was moved off the secured unit and placed in a room on his previous hall and 15 minute checks were initiated. A 12/15/24 facility reported incident indicated Resident 33 had been smacked in the face by another resident after he had wandered into another resident's room and rummaged through		occurred on 1/6/2025 to formulate a plan for new residents and/or residents with rooms changes to help provide orientation to their new surroundings. b 15-min checks for 72 hours will be implemented for any new resident and residents who change rooms. c Social Services will assess for psychosocial distress and adjustments for 72 hours. 4 – How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place: a The Social Services Director or designee will conduct an audit of all newly admitted residents or residents with room changes to ensure 15-min checks for 72 hours and assessments related to psychosocial distress and adjustment were complete. This audit will then be conducted once per week for 12 weeks and then monthly ongoing. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased	

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	his belongings. A 12/16/24 at 2:39 a.m., "Behavior Note" indicated the resident was awake almost the entire shift. He required frequent redirection. He had not slept yet. The staff had to repeatedly encourage the resident to stay out of other resident rooms. On 12/17/24 at 11:30 a.m., 1:26 p.m., and 2:00 p.m., he was seated in a recliner in the 200 hall ,watching TV. During an interview on 12/17/24 at 11:35 a.m., the Administrator indicated the facility did not put a plan in place to help the resident successfully establish himself on his new unit nor ensure his safety when he was known to have a history of intrusive wandering. A current, undated, facility policy, titled "Dementia Resident Care Policy", which was provided by the Administrator on 12/17/24 at 12:18 p.m., indicate the following: "...Offering more activities and meaningful interactions assists with... preventing (or even reducing) disturbing behaviors...." 3.1-37(a)		on the basis of compliance. 5 – Corrective action completed by 01/15/2025	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to label medications with resident identifying information in 1 of 3 medication carts (East 100 Unit Cart) and 1 of 2 medication storage rooms (200 Unit Storage Room) reviewed for medication storage. This had the potential to affect 19 residents who received medications from the 100 East Cart and 5 residents whose diabetic	F 0761	PROPOSED PLAN OF CORRECTION F761 It is the practice of this facility to ensure drugs and biologicals used in the facility must be labeled in	01/15/2025

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	medications were stored in the 200 Medication Storage Room. Findings include: 1. During an observation, accompanied by LPN 5 on 12/13/24 at 9:16 a.m. , the 100 East Unit medication cart top right drawer contained 2 medication cups. One of the cups contained two pills with no resident identifiers. The other cup contained 7 pills with no resident identifier. She indicated the medication were pre-set because the resident was not out of bed yet. LPN 5 indicated she was aware who the medications belonged to. Since the medications were not labeled with any resident identifiers, others would not have any way to identify which medications were in the cups, nor who they belonged to. She indicated all medications in the medication cart should have been labeled. 2. During an observation of the 200 Unit Medication Storage Room, accompanied by LPN 7 on 12/13/24 at 10:19 a.m., the following was observed: a. One unopened Trulicity (injectable medication for diabetes) single dose pen, 0.75 milligrams(mg)/0.5 milliliters (ml), was in the medication refrigerator and unlabeled with any resident identifier or instructions for administration. b. One unopened Trulicity (injectable medication for diabetes) single dose pen , 3 mg/0.5 (ml), was in the medication refrigerator and unlabeled with any resident identifier or instructions for administration. During an interview at the time of observation,		accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 1 – What corrective action will be accomplished for those residents found to have been affected by the deficient practice: a Upon notification of alleged deficient practice, the facility destroyed the medication in question and reordered. 2 – How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a All residents have the potential to be affected by the alleged deficient practice. b An audit was completed and no further issues identified of alleged deficient practice. 3 – What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: a The facility held an in-service for nurses and QMAs regarding proper medication labeling. b The facility was in contact with the house pharmacy to ensure that all medication that comes in a box also comes with a	

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	LPN 7 indicated she would not have a way to know who the medication belonged to since it was not labeled. During an interview on 12/13/24 at 10:30 a.m., LPN 7 indicated all medications in the medication storage room refrigerator should have been labeled with the resident name and instructions for administration. She indicated they would now have to be destroyed since they were not labeled. During an interview on 12/17/24 at 10:30 a.m., the Administrator indicated medications in the medication carts and medication storage rooms should have been labeled. A current facility policy, revised April 2019, titled "Labeling of Medication Containers," provided by the Administrator on 12/17/24 at 10:50 a.m., indicated the following: "Policy Statement... All medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations...." 3.1-25(j)		label on the actual medication inside the box in the event the box is destroyed. 4 – How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place: a The DON or designee will conduct an audit of medication rooms/refrigerators for appropriate labeling of medications randomly 2 times per week for 6 weeks and then 1 time per week for the following 6 weeks. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 01/15/2025.	
F 0803 SS=D Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed Based on observation, interview, and record review, the facility failed to ensure a resident with a dairy allergy was not served food containing	F 0803	PROPOSED PLAN OF CORRECTION	01/15/2025

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	dairy for 1 of 1 resident reviewed for food allergies. (Resident 72) Finding includes: Resident 72's clinical record was reviewed on 12/12/24 at 2:53 p.m. Current diagnoses included psychotic disorder and depression. The resident had a documented intolerance of dairy products, entered in the record on 2/29/24. A 11/26/24, quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. The resident had a current, 3/4/24, care plan problem/need regarding a potential alternation of nutrition related to multiple heath conditions and food allergies to egg, dairy, peanuts and seafood. During a meal service observation on 12/16/24 at 11:36 a.m., Dietary Aide 13 placed a container of sherbet on Resident 72's meal plate. Resident 72's meal ticket was observed and listed no dairy products due to allergies. The sherbet container's (which was placed on the resident's meal tray) label was reviewed for listed ingredients. Whey (milk protein) and skimmed milk were listed as ingredients in the sherbet. Cook 12, Dietary Aide 13, the Dietary Manager, and Registered Dietitian, were present in the kitchen when the sherbet container was placed on Resident 72's tray. Following the review of the ingredients labeled on sherbet, none of the four dietary employees indicated an understanding of sherbet containing dairy products. A current facility policy, dated 2017, titled, "Food		F803 It is the practice of this facility to follow all dietary guidelines and restrictions related to resident preferences and allergies. 1 – What corrective action will be accomplished for those residents found to have been affected by the deficient practice: a Upon notification of alleged deficient practice, Resident 72 was not handed the food noted to have an allergy to. 2 – How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a All residents have the potential to be affected by the alleged deficient practice. b An audit was completed to ensure that all residents identified with food allergies are listed on the tray card. No further issues were identified. 3 – What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: c An in-service with all dietary employees was conducted on 1/8/2025 to educate on dietary guidelines related to restrictions	

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	Allergies and Intolerance", which was provided by the Dietary Manager 12/16/2024 at 2:26 p.m., indicated the following: "...Residents with foods allergies and/or intolerance's are identified upon admission and offered food substitutions of similar appeal and nutritional value. Steps are taken to prevent resident exposure to the allergie(s)...." 3.1-20(i)(2)		and allergies. 4 – How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place: d The Dietary Manager or designee will conduct 10 audits (on random days and random meals) per week to ensure food offered and served to residents meet the guidelines, preferences and allergies. This audit will continue for 12 weeks. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 01/15/2025.	
F 0809 SS=E Bldg. 00	483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime Based on interview and record review, the facility failed to provide evening snacks for 1 of 4 residents reviewed for nutrition (Resident 35) and for 7 of 7 residents in resident group interview with the resident council. Findings include:	F 0809	PROPOSED PLAN OF CORRECTION F809 It is the practice of this facility to ensure residents receive evening	01/15/2025

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	1. Resident 35's clinical record was reviewed on 12/12/24 at 3:03 p.m. Current diagnoses included dementia, type II diabetes without complications, and moderate protein calorie malnutrition. A current physician's order, dated 5/10/24, indicated to offer peanut butter and jelly at bedtime for nutrition from supplies located in the pantry to make sandwiches. A Nurse's Note, dated 11/29/24 at 9:01 p.m., indicated the order for peanut butter and jelly at bedtime for a nutritional supplement was not provided. A Nurse's Note, dated 11/30/24 at 9:49 p.m., indicated there was no supply to offer peanut butter and jelly at bedtime for a nutritional supplement. A Nurse's Note, dated 12/1/24 at 7:42 p.m., indicated there was no supply to offer peanut butter and jelly at bedtime for a nutritional supplement. A Nurse's Note, dated 12/15/24 at 9:11 p.m., indicated the supplies to make sandwiches were not delivered from the kitchen for administration. During an interview on 12/17/24 at 10:45 a.m., the Dietary Manager indicated she had never been informed there were concerns regarding availability of bedtime snacks and peanut butter and jelly. It should have been in the pantry on the unit. Staff should have asked when items were unavailable. During an observation at the time of interview on 12/17/24 at 10:53 a.m., Unit Manager 11 indicated		snacks for nutrition. 1 – What corrective action will be accomplished for those residents found to have been affected by the deficient practice: a Upon notification of alleged deficient practice, the facility always has snacks available in the pantries or directly from the kitchen. We also provided an audit, asking residents if they had been offered a snack. However, we did not document if the residents refuse the snacks offered. 2 – How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a All residents have the potential to be affected by the alleged deficient practice. 3 – What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: a An in-service was conducted with staff related to offering snacks in the evenings to each resident. If the resident refuses the snack, it is to be documented. 4 – How the corrective action(s) will be monitored to ensure the deficient practice will not recur,	

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	she believed the snack issue was due to staff's lack of going further when they could not find something as peanut butter and jelly was currently in the Swan Unit pantry. They were supposed to go to another pantry and ask dietary if they had a concern. 2. During a confidential Resident Council group interview on 12/13/24 at 2:02 p.m., seven out of seven residents in the Resident Council Group meeting indicated snacks were unavailable at bedtime. This was an ongoing concern and had been discussed at multiple resident council meetings. They were unaware of what had been done to resolve the problem. The residents were told by staff, as frequent as 5 out of 7 days of the week, when they requested snacks, that bedtime snacks were unavailable. The snacks were requested on the 100 and 200 Units. Staff did not pass bedtime snacks and the residents did not have any access to get the snacks themselves. Resident Council Minutes, identified by the Activity Director (AD) as November 2024 minutes, indicated the group had a concern regarding a lack of passing bedtime snacks. Review of the December 2024 minutes, lacked any documentation of old business reviewed and or responses provided to the resident council group concerns regarding a lack of bedtime snacks. Review of a Grievance Form, dated 11/22/24, indicated the resident council group were concerned that bedtime snacks were not passed. Section 2 of the form, dated 11/22/24, indicated the dietary was working on a new available snack menu for bedtime to allow staff availability to make snacks of choice available to the residents if an alternate was requested. Section 3 of the form, follow up, was blank. There was no indication that		i.e, what quality assurance program will be put into place: a The DON or designee will conduct an audit of 10 residents per week to see if they were offered an evening snack for 6 weeks. They will also audit the documentation if the resident refused the snack. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 01/15/2025.	

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	anyone received a response to the concern. Section 4 was signed by the Administrator and indicated the concern was resolved. Review of an "HS [bedtime] Snack Audit," dated 11/25/24, indicated 2 out of 15 residents audited did not get bedtime snacks and 4 out of 15 residents sometimes received bedtime snacks. Confidential interviews were held during the survey and indicated the following information: There were days the residents were told by staff that snacks were unavailable because they ran out. This was an ongoing concern and it happened at least one day every week. This happened on all of the units in the building rather than one particular unit. The nurses were aware of the ongoing problem. Snacks were available on this day. There have been a handful of times that snacks were not available on the Swan Unit. This happened weekly. On uncertain dates, the lack of unavailable snacks had been reported to Dietary Aide 17, QMA 14, and QMA 16. She believed they had concerns with snacks on the behavior unit because they issued more snacks to the residents for a diversion on that unit and dietary staff were not restocking the snacks. The dietary staff were supposed to restock the snacks every night before they left because no one on night shift had access to the kitchen. This included night shift managers. Some staff members wound not go to the trouble of searching for snacks on other units when the snacks were not available in the pantry for the Swan Unit. Education had not been provided regarding availability of night time snacks for the residents.			

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	Residents with diabetes have reported frustration and agitation due to a lack of available peanut butter and jelly sandwiches. A staff member had to use their own money on several different occasions to purchase snacks out of the vending machines that were significant for diabetic residents. Staff, to include night shift management, lacked access to the kitchen when peanut butter and jelly sandwiches were not available. Dietary staff were unable to understand the importance of having available snacks for the residents. The above mentioned concerns had been brought to management in the morning meeting in early November and multiple other times where the Administrator, DON and other department managers were in attendance. The pantry on this date was unusually well stocked which was believed to be a result of the regulatory visit from the Indiana Department of Health. Peanut butter and jelly had been unavailable in the pantry when requested as recent as within the last week. During an interview on 12/16/24 at 11:49 a.m., the AD indicated the resident council meeting were held on the following dates: 9/4/24, 10/9/24, 11/21/24, and 12/9/24. She took minutes for the resident council meetings, typed up notes, and sent them out to all the department heads after each meeting. The minutes were required to include all the information discussed during the resident council meetings. She indicated she did not have any responses or feedback documented in the resident council minutes for months from September through December 2024 because she was instructed not to keep the feedback forms by management like she had done in the past. She only had documented new business for said months. All resident council concerns each			

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	155400	A. BUILDING 00 B. WING	12/17/2024

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	month should have been placed on a concern/grievance form. During an interview on 12/16/24 at 5:22 p.m., the Administrator was requested to provide the resident council follow responses/feedback to the resident council concerns from September through December 2024. Further documentation of resident council feedback/responses regarding bedtime snacks were not provided prior to exit on 12/17/24. During an interview on 12/17/24 at 2:02 p.m., the AD indicated the facility could not provide any resident council feedback forms. She indicated the resident council group had mentioned concerns regarding unavailable bedtime snacks during the October and November 2024 resident council meetings. Snacks were really important to the residents. Bedtime snacks were not discussed during the December 2024 resident council meeting. During an interview on 12/17/24 at 1:48 p.m., the Dietary Manager denied any knowledge of any type of available snack menu for bedtime snacks. A current, undated, facility policy, titled "Snacks (Between Meal and Bedtime) Policy," provided by the Administrator on 12/17/24 at 12:18 p.m., indicated the following: "Policy Statement...The purpose of this procedure is to provide the resident with adequate nutrition. 1. Review the resident's care plan and provide for any special needs of the resident...4. Snacks can be found on each unit in nursing/nourishment pantries. 5. Snacks may also come from the dietary department. 6. Report any problems or complaints made by the resident related to the snack. .. 8. Report other information in			

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	accordance with facility policy and professional standards of practice...." 3.1-21(e)			
F 0812 SS=C Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview and record review, the facility failed to ensure food was served in a manner to prevent possible food contamination. This deficient practice had the potential to impact 69 residents, who ate meals prepared in the facility kitchen. Finding includes: During a continuous observation on 12/16/24 from 11:36 a.m. to 11:47 a.m., the following concerns regarding food handling were observed during lunch meal service: Cook 12 used her gloved hands to pick up a bread bag making contact with the external portion of the bag. With the same contaminated gloved hands, she picked up individual slices of bread and placed them individually into single slice plastic serving bags. She then held a baked potato with the same contaminated gloves and scooped out the interior of the potato placing it on a plate. This process continued with her touching bread, the bag, and potatoes with the same soiled gloves. She additionally touched utensils, plate, bowls, and trays with the same gloves. At 11:44 a.m., the cook removed her gloves, washed her hands, and placed on new clean gloves. With her freshly gloved hands, she again touched the outside of the bread bag, bread, plastic bags, potatoes, utensils, plates, and bowls using the same process as she had prior to	F 0812	PROPOSED PLAN OF CORRECTION F812 It is the practice of this facility to ensure food is served in a manner to prevent possible food contamination. 1 – What corrective action will be accomplished for those residents found to have been affected by the deficient practice: a Upon notification of alleged deficient practice, Employee 12 changed gloves and washed hands after touching a slice of bread and then a baked potato. 2 – How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a All residents have the potential to be affected by the alleged deficient practice. 3 – What measures will be put into place and what systemic	01/15/2025

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	washing her hands and changing gloves. During an interview on 12/16/24 at 11:47 a.m., Cook 12 indicated she did not realize she had contaminated her gloves when touching multiple items and also contaminated the food. A current facility policy, dated April 2019, titled, "Food Preparation and Service", which was provided by the Dietary Manager on 12/16/24 at 1:10 p.m., indicated the following: "...Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single-use items and discarded after each use...." 3.1-21(i)(1)		changes will be made to ensure that the deficient practice does not recur: a An in-service was held with all dietary employees on 1/8/25 regarding facility policy for handling food. 4 – How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place: b The Dietary Manager or designee will conduct 10 random observation audits of food prep, food services and food cleanup for 6 weeks. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 01/15/2025.	