STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155240	A. BUILDING 00 B. WING	01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYONS HEALTH AND LIVING CENTER	2417 S COUNTY ROAD 800 W LYONS, IN 47443

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 19, 20, 23, 24, 25, 26, and 27, 2017. Facility number: 000144 Provider number: 155240 AIM number: 100266760 Census bed type: SNF/NF: 48 Total: 48 Census payor type: Medicare: 2 Medicaid: 38 Other: 8 Total: 48 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Q.R. completed by 14466 on February 01, 2017.	F 0000	This plan of correction is to serve as Lyons Health and Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Lyons Health and Living or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	
F 0279 SS=D Bldg. 00	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate			

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	its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on interview and record review, the facility failed to ensure staff developed a care plan to address severe weight loss at the time of the assessed weight loss for 1 of 3 residents reviewed for nutrition. (Resident #68) Findings include: On 1/27/17 at 11:01 a.m., Resident #68's clinical record was reviewed. Diagnosis included, but were not limited to: pneumonia, weakness, and muscle wasting and atrophy. The resident was admitted on 8/30/16. Review of Resident #68's weights included but was not limited to the	F 0279	F279 483.20(d); 483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS The facility respectfully requests IDR on this citation Resident #68 no longer resides at the facility. All current residents have been reviewed for significant weight loss. Any resident with significant weight loss will have a care plan addressing the weight loss and current interventions. The systemic change includes:	02/17/2017

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	following: On 8/30/16 the resident weighed 128 pounds. On 9/19/16 the resident weighed 113 pounds. On 10/2/16 the resident weighed 112 pounds. On 10/7/16 the resident weighed 111 pounds. Resident #68's had an assessed 11.7% weight loss (severe), in 37 days. Review of Resident #68's care plans included but was not limited to: "Problem Start Date: 9/7/16. Resident is on a Regular Diet ... Goal: Resident will tolerate diet without complications or weight loss ... Approach ... Monitor/record weight routinely ..." "Problem Start Date: 10/6/16. Resident is at risk for weight loss R/T [related to]: COPD [Chronic Obstructive Pulmonary Disorder] and decreased appetite ... Approach ... Supplements as needed/ordered. Mighty shakes BID [twice daily] between meals."		·All scheduled weights will be reviewed weekly during the interdisciplinary at risk meeting to identify any significant weight loss. Any residents identified will then have an appropriate intervention put into place and the care plan updated to reflect the changes. Education will be provided to licensed nurses, and the Dietary Manger, regarding the facility policy for weight monitoring and the systemic change. A quality assurance tool will be utilized by the Director of Nursing, or designee, to audit for significant weight loss, timely intervention, and the care plan updated to reflect the weight loss and changes. This audit will be completed weekly for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 2/17/2017	

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	Resident #68's weight loss care plan was initiated 17 days after the assessed 15 pound weight loss. On 1/27/17 at 3:00 p.m., the Director of Nursing indicated the purpose of weighing the residents is to ensure optimal health and to identify care areas in need of addressing. If a resident lost 15 pounds, the weight loss is a problem. On 1/27/17 at 2:16 p.m., the Director of Nursing provided the facility policy "Nutrition (Impaired)/Unplanned Weight Loss--Clinical Protocol," revised December 2008, and indicated it was the policy currently being used by the facility. The policy indicated, "....1. The Physician and staff will closely monitor residents ... Such monitoring may include: a. Evaluating the care plan to determine if the interventions are being implemented and whether they are effective in attaining the established nutritional and weight goals..." 3.1-35(a)			
F 0282 SS=D Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the			

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	facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to provide non-pharmacological interventions as indicated by the care plan for 1 of 1 resident reviewed for pain (Resident #57). Findings include: On 1/25/17 at 10:40 A.M., Resident #57 indicated she experienced constant, lingering left shoulder joint pain from a past episode of shingles. She received scheduled pain medications three times daily, but these did not fully alleviate the pain. The resident did want to complain too much about it because she did not expect more medication. The resident wore a throw blanket around her shoulders because the warmth helped alleviate the left shoulder joint pain. She knew she was not allowed to have an electric heating pad, but would have liked other non-pharmacological interventions such as a lidoderm patch, thermal patch, warm rag. Staff had not offered her any of these options. The resident indicated she once took a baked potato from her	F 0282	F282 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSON/PER CARE PLAN Resident #57 is being provided with pain management consistent with professional standards of practice, the comprehensive care plan, and the resident's goals and preferences. Therapy will evaluate her for appropriate interventions for any further alternative pain control needed and per her preferences. All residents with pain will be evaluated for pain management per the resident's goals and preferences and appropriate interventions and care plan revisions will be made as needed. The systemic change includes: ·Any resident with new or worsening pain will have an assessment completed, as well as quarterly, which includes individualized strategies/preferences that reduce the pain. ·Residents with new or worsening pain will be reviewed during the facility's weekly interdisciplinary team meeting to discuss pain control and the resident's goals and preferences	02/17/2017

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	tray at dinner time and placed it under her shirt on her shoulder, and this gave her relief from the pain. On 1/26/17 at 11:30 A.M., the resident indicated she continued to have left shoulder joint pain despite receiving pain medication three times daily. On 1/26/17 at 12:00 P.M. LPN #1 administered pain medication (Norco 7.5-325 mg) for Resident #57. LPN #1 did not provide non-pharmacological options to the resident and indicated she did not believe heat was to be applied to a resident who has had shingles even if the resident had no shingles skin sores. Immediately following the pain medication administration, the resident indicated the medication slightly reduced her pain and lasted about 30 minutes. On 1/26/17 at 2:00 P.M., the clinical record of Resident # 57 was reviewed. Diagnoses included, but are not limited to weakness, diabetes, and chronic pain. MDS (Minimum Data Set) assessment, dated 11/21/16, section J indicated the resident had received scheduled pain medication and had the frequent presence of moderate pain. The Brief Interview of Mental Status score was 14, indicating the resident was cognitively intact.		as well as an appropriate intervention and care plan revision. Education will be provided to licensed nurses regarding completing a pain assessment when the resident has new or worsening pain and quarterly, as well as the need for pain management per the resident's goals and preferences. The interdisciplinary team will receive education on the systemic change. A quality assurance tool will be utilized by the Director of Nursing, or designee, to audit for completion of a pain assessment as needed and quarterly, an interdisciplinary review of new or worsening pain and an appropriate intervention and care plan revision per the resident's goals and preferences. This review will be completed weekly for 30 days, and then monthly for a duration of 12 months of monitoring. Compliance date 2/17/2017	

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	The current January 2017 physician's orders indicate Norco (hydrocodone-acetaminophen) 7.5-325 mg three times a day was ordered on 9/6/16. There were no as needed (PRN) pain medications ordered for the resident. Resident Care Plan with a Problem start date of 9/6/16, indicated the resident had a potential for pain related to herpes viral infection. The second approach relative to the problem indicated attempt non-medication intervention prior to administration of pain medications. On 1/27/17 at 2:45 P.M., the DON indicated there were non-pharmacological interventions that could have been offered to the resident, such as a warm rag, thermal pack, cold pack, or whatever might bring some relief to her shoulder joint pain, and indicated these options will be offered to the resident. 3.1-35(g)(2)			

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F 0309 SS=D Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to ensure the provision of pain management consistent with professional standards of practice, the comprehensive care plan, and the resident's goals and preferences for 1 of 1 resident reviewed for pain (Resident #57). Findings include:	F 0309	F309 483.24 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Resident #57 is being provided with pain management consistent with professional standards of practice, the comprehensive care plan, and the resident's goals and preferences. Therapy will evaluate her for appropriate interventions for any further alternative pain control	02/17/2017

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	On 1/25/17 at 10:40 A.M., Resident #57 indicated she experienced constant, lingering left shoulder joint pain from a past episode of shingles. She received scheduled pain medications three times daily, but these did not fully alleviate the pain. The resident did want to complain too much about it because she did not expect more medication. The resident wore a throw blanket around her shoulders because the warmth helped alleviate the left shoulder joint pain. She knew she was not allowed to have an electric heating pad, but would have liked other non-pharmacological interventions such as a lidoderm patch, thermal patch, warm rag. Staff had not offered her any of these options. The resident indicated she once took a baked potato from her tray at dinner time and placed it under her shirt on her shoulder and this gave her relief from the pain. On 1/26/17 at 11:30 A.M., the resident indicated she continued to have left shoulder joint pain despite receiving pain medication three times daily. On 1/26/17 at 12:00 P.M. LPN #1 administered pain medication (Norco 7.5-325 mg) for Resident #57. LPN #1 did not provide non-pharmacological options to the resident and indicated she		needed and per her preferences. All residents with pain will be evaluated for pain management per the resident's goals and preferences and appropriate interventions and care plan revisions will be made as needed. The systemic change includes: ·Any resident with new or worsening pain will have an assessment completed, as well as quarterly, which includes individualized strategies/preferences that reduce the pain. ·Residents with new or worsening pain will be reviewed during the facility's weekly interdisciplinary team meeting to discuss pain control and the resident's goals and preferences as well as an appropriate intervention and care plan revision. Education will be provided to licensed nurses regarding completing a pain assessment when the resident has new or worsening pain and quarterly, as well as the need for pain management per the resident's goals and preferences. The interdisciplinary team will receive education on the systemic change. A quality assurance tool will be utilized by the Director of Nursing,	

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	did not believe heat was to be applied to a resident who has had shingles even if the resident had no shingles skin sores. Immediately following the pain medication administration, the resident indicated the medication slightly reduced her pain and lasted about 30 minutes. On 1/26/17 at 2:00 P.M., the clinical record of Resident # 57 was reviewed. Diagnoses included, but are not limited to weakness, diabetes, and chronic pain. MDS (Minimum Data Set) assessment, dated 11/21/16, section J indicated the resident had received scheduled pain medication and had the frequent presence of moderate pain. Brief Interview of Mental Status score was 14, indicating the resident was cognitively intact. Current January 2017 physician's orders indicate Norco (hydrocodone-acetaminophen) 7.5-325 mg three times a day was ordered by the physician on 9/6/16. Resident Care Plan, with a Problem start date of 9/6/16, indicated the resident had a potential for pain related to herpes viral infection. The second Approach relative to the problem indicated attempt non-medication intervention prior to administration of pain medications. There		or designee, to audit for completion of a pain assessment as needed and quarterly, an interdisciplinary review of new or worsening pain and an appropriate intervention and care plan revision per the resident's goals and preferences. This review will be completed weekly for 30 days, and then monthly for a duration of 12 months of monitoring. Compliance date 2/17/2017	

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	was no documentation of non-pharmacological interventions found in the clinical record. On 1/27/17 at 2:45 P.M., the DON indicated there are non-pharmacological interventions that could have been offered to the resident, such as a warm rag, thermal pack, cold pack, or whatever might bring some relief to her shoulder joint pain, and indicated these options will be offered to the resident. 3.1-37(a)			
F 0323 SS=E Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side			

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	rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.			
	Based on observation, interview, and record review, the facility failed to ensure code locked laundry room doors were securely latched to prevent access to chemicals, electrical panels, and an outside access door for 13 of 48 residents of the facility. Findings include: On 1/19/17 at 11:40 A.M., one door on the 200 hall unit and one door in the hallway near the cafeteria were observed to be unlatched. Both doors had coded lock mechanisms. The doors gave access to the facility laundry equipment as well as bleach, carpet cleaner, and other assorted chemicals, water softeners, electrical panels, and an outside access door. There were 3 unaided, ambulatory	F 0323	F323 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The laundry room doors were repaired during the survey process. All secured doors were audited and found to be securely locked and functioning correctly. The systemic change includes: ·Housekeepers will check the laundry room doors daily for correct functioning and being secured. They will notify the Maintenance Director immediately of any functioning issues with the doors. ·The Maintenance Director will check the functioning of all secured doors weekly for correct functioning and securely locked. Any secured door with functioning	02/17/2017

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	residents observed walking by the two doors. On 1/20/17 at 11:15 A.M., the DON indicated there were 13 residents who ambulated unassisted throughout the facility. On 1/19/17 at 11:45 A.M., Housekeeper #1 indicated the doors were meant to be closed and locked but they seemed to frequently stop short of closing and needed to be pulled closed. On 1/19/17 at 12:05 P.M., the Maintenance Director indicated the two doors were supposed to be closed and locked to prevent resident access to the equipment and chemicals behind those doors. The door arm hinges were in need of adjustment in order for the doors to properly close and began working on the door arm hinges. On 1/26/17 at 2:15 P.M., the facility Administrator provided a copy of the Resident's Right's currently utilized by the facility. They indicated the the resident had a right to "....an environment that promotes maintenance or enhancement of your and every resident's quality of life..." 3.1-45(a)(1)		issues will be repaired. Education will be provided to housekeeping staff and the Maintenance Director regarding the systemic change. A quality assurance audit will be completed by the Administrator or designee to review for all secured doors being securely locked and functioning correctly. This audit will be completed daily, on random shifts (including weekends) for 4 weeks, then weekly for 4 weeks, then monthly for a duration of twelve months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 2/17/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155240	A. BUILDING 00 B. WING	01/27/2017

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F 0325 SS=D Bldg. 00	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to ensure staff timely identified severe weight loss and immediately provided treatment and services to prevent additional weight loss for 1 of 3 residents reviewed for nutrition. (Resident #68) Findings include: On 1/27/17 at 11:01 a.m., Resident #68's clinical record was reviewed. Diagnosis included, but were not limited to:	F 0325	F325 483.25 (g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE The facility respectfully requests IDR on this citation. Resident #68 are no longer resides at the facility. All current residents have been reviewed for significant weight loss. Any resident with significant weight changes has appropriate treatment and services put into place.	02/17/2017

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	pneumonia, weakness, and muscle wasting and atrophy. The resident was admitted on 8/30/16 and ordered a regular diet. Review of Resident #68's weights included but was not limited to the following: On 8/30/16 the resident weighed 128 pounds. On 9/19/16 the resident weighed 113 pounds,15 pound loss in 20 days (severe). On 10/2/16 the resident weighed 112 pounds,16 pound loss 32 days (severe). Nothing was updated in Resident #68's clinical record to address the weight loss. On 10/7/16 the resident weighed 111 pounds. Resident #68's had a assessed weight loss of 11.7%, in 37 days. Review of Resident #68's October, 2016 physician's orders included but was not limited to: On 10/7/16 the resident was ordered Mighty Shakes (a protein drink nutritional supplement) twice a day,		The systemic change includes: ·All scheduled weights will be reviewed weekly during the interdisciplinary at risk meeting to identify any significant weight loss. Any residents identified will then have an appropriate intervention put into place and the care plan updated to reflect the changes. Education will be provided to licensed nurses, and the Dietary Manager, regarding the facility policy for weight monitoring and the systemic change. A quality assurance tool will be utilized by the Director of Nursing, or designee, to audit for significant weight loss, and timely intervention for the weight change. This audit will be completed weekly for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 2/17/2017	

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	between meals. On 1/27/17 at 3:00 p.m., the Director of Nursing indicated the purpose of weighing the residents is to ensure optimal health and to identify care areas in need of addressing. If a resident lost 15 pounds it is a problem and should be addressed at the time it was detected, rather than 17 days later. On 1/27/17 at 2:16 p.m., the Director of Nursing provided the facility policy "Nutrition (Impaired)/Unplanned Weight Loss--Clinical Protocol," revised December 2008, and indicated it was the policy currently being used by the facility. The policy indicated, "1. The nursing staff will monitor and document the weight ... 2. The threshold for significant unplanned and undesired weight loss will be based on the following criteria ... a. 1 month - 5% weight loss is significant; greater than 5 % is severe ..." 3.1-46(a)(1)			
F 0456 SS=D Bldg. 00	483.90(c)(2)(d) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION			

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	(c)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (d) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. Based on observation and interview, the facility failed to repair or replace a meat slicer which was missing the meat grip and handle assembly, affecting 48 of 48 residents of the facility. Findings include: On 1/19/17 at 10:45 A.M., Cook #1 indicated there was a meat slicer in the kitchen which had a broken handle replaced by a long screw. She had cut her fingers on the slicer on two occasions, though she could not recall the dates, and she was afraid to use the slicer again. It was possible for blood or even part of a cut finger to have made contact with the meat being sliced on the slicer prior to being served to residents of the facility. On 1/19/17 at 10:50 A.M. the meat slicer was observed to be on the preparation countertop and was missing the meat grip handle assembly (the handle assembly which provides a guard for the hand). In place of the handle assembly was a long screw, which provided no	F 0456	F456 483.90(c)(2)(d) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The meat slicer was immediately removed during the survey process and a new slicer was already ordered prior to the survey process. An audit of all mechanical or electrical dietary equipment for safe operating condition will be completed and any concerns will be addressed. The systemic change includes: ·Dietary personnel will complete a work order for any electrical or mechanical dietary equipment for any item that is not functioning correctly and the equipment will be reviewed by the Maintenance Director. ·Any electrical or mechanical dietary equipment deemed unsafe per the Maintenance Director will not be used until the repair is complete. ·All electrical or mechanical dietary equipment will be routinely inspected monthly.	02/17/2017

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	protection from the slicing blade to the hand of anyone utilizing the slicer. On 1/19/17 at 11:00 A.M., the Dietary Manager indicated the meat slicer had been without the handle, with the screw in its place at least since she started working at the facility in 2012. She recalled Cook #1 cutting her fingers at some point in the past. The slicer is dangerous, and the workers prefer not to use it. A new slicer was ordered several weeks ago, and the Dietary Manager removed the slicer from the kitchen. On 1/19/17 at 11:15 A.M., the facility Administrator indicated the slicer was dangerous, should and would be removed, and a new slicer had been ordered several weeks ago. 3.1-19(bb)		Education will be provided to the Maintenance Director and Dietary staff regarding the systemic change. The Maintenance Director or designee will complete an audit for completion of work orders of any electrical or mechanical dietary equipment, and taking the equipment out of the work area or marking the equipment to not be used until repaired. This audit will be completed weekly for 30 days, and then monthly thereafter for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date 2/17/2017	