

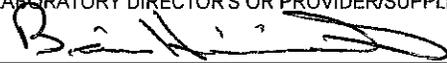
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/26/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ARMOUR	STREET ADDRESS, CITY, STATE, ZIP CODE 106 BRADDOCK POST OFFICE BOX 489 ARMOUR, SD 57313
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(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
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F 000	<p><i>*Addendums noted w/ an asterisk per 9/15/15 from facility DON per telephone JT/SDP/EL</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 32331 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/24/15 through 8/26/15. Golden LivingCenter - Armour was found not in compliance with the following requirements: F323, F371, and F431.</p>	F 000	F 323	OCT 13, 2015
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on record review, interview, and policy review, the provider failed to supervise one of one sampled resident (11) who had an elopement (leaving facility without staff knowing). Findings include:</p> <p>1. Review of resident 11's medical record revealed: *He had been admitted from another facility on 6/27/14 to provide the necessary supervision he required. *He was unable to make safe decisions for himself according to their assessments. *He would wander and try to leave the facility. He had a history of that.</p>	F 323	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:</p> <ol style="list-style-type: none"> Resident 11's care plan was reviewed and communicated to _____ staff on August 26, 2015 the requirement's off his care plan and having staff remain with him at all times while outside due to being at risk for elopement. Facility will implement morning Clinical Start-Up on September 22, 2015 by DNS with all elopement risk resident Care Plans discussed and communicated to all nursing 	

*all
JT/SDP/EL
by the
DNS and
ED.
JT/SDP/EL*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 9-16-15
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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.

SEP 18 2015

SD DOW 100

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ARMOUR		STREET ADDRESS, CITY, STATE, ZIP CODE 106 BRADDOCK POST OFFICE BOX 489 ARMOUR, SD 57313		
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F 323	<p>Continued From page 1</p> <p>*He wore a Wanderguard (a device that would set off an alarm as he passed through an exit door).</p> <p>Review of resident 11's 9/12/14 incident report revealed an elopement with the following documentation.</p> <p>*He had left the facility grounds and crossed a highway before he had been found and brought back to the facility. A kitchen staff had not seen him until he was crossing the highway.</p> <p>*He had not been hurt, but could have been due to the large trucks that would travel on the highway.</p> <p>*He had been allowed to sit outside the facility unsupervised. That had been allowed by staff several times since his admission, even though they were aware he was an elopement risk.</p> <p>*After his elopement the staff were told by administration he needed to be supervised when outside.</p> <p>Review of resident 11's 8/25/15 care plan revealed:</p> <p>*He was "At risk for elopement." **"Wanderguard in place. Check per schedule." ***"Staff to remain with resident while outside."</p> <p>Interview on 8/26/15 at 9:30 a.m. with certified nursing assistant (CNA) C regarding resident 11 going outside of the facility revealed:</p> <p>**"[Staff are] not always outside with him." ***"He goes out, but we keep an eye on him from inside."</p> <p>Interview on 8/26/15 at 9:40 a.m. with CNA D regarding resident 11 going outside without staff revealed:</p> <p>**"We keep an eye on him." *When asked by this surveyor what happens if</p>	F 323	<p>staff working each day. Any nursing staff not present at morning Clinical Start-Up will receive communication by means of communication binder and/or directly from charge nurse or DNS.</p> <p>3. Morning Clinical Start-Up will be facilitated by DNS and/or her designee each day. All licensed nursing staff members will be in-serviced September 21, 2015 on the Clinical Start-up process and checklist of resident care items to be covered with resident Care Plans.</p> <p>4. DNS and/or her designee will check daily clinical follow up log twice per week for two months. Then once per week thereafter to ensure all elopement risk residents are discussed, care plan reviewed for accuracy, and communicated to nursing staff is completed. The data collected will be presented to the Quarterly Quality Assurance committee by the ED and/or DNS. It will be reviewed/discussed and at that time the QA committee</p> <p><i>by the DNS JT/SPD/H/EL</i></p> <p><i>by their next shift and at Orientation. JT/SPD/H/EL</i></p> <p><i>for one year JT/SPD/H/EL</i></p>	

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F 323	Continued From page 2 staff keeping an eye on him would look away or need to do another task she replied "We would tell someone else. A lot of times the kitchen staff would watch him [from inside]." Interview on 8/26/15 at 1:15 p.m. with the director of nursing regarding resident 11 revealed: *Sometimes staff were outside with the resident, and sometimes not. *She agreed that was not what his care plan had stated nor what the recommendations had been after his elopement. The provider's undated policy on Elopement did not address residents who needed a Wandergaard being allowed outside unattended.	F 323	will make a decision/recommendation regarding follow-up or changes.		
F 371 SS=E	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 This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and policy review, the provider failed to: *Ensure proper storage and maintenance in a sanitary manner of utensils, pans, and supplies in eight of sixteen drawers located in the kitchen.	F 371	F371 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. Eight of the sixteen drawers identified as being uncleanable surfaces each contained chipped, peeled, and cracked areas on the inside. -Six containing utensils including scoops, tongs, whips, and other utensils -One containing small steam-table pans	OCT 13, 2015	

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F 371	<p>Continued From page 3</p> <p>*Ensure proper thawing of turkey in the kitchen. Findings include:</p> <p>1. Observation on 8/24/15 from 3:45 p.m. through 4:06 p.m. in the kitchen revealed: *Eight of sixteen drawers that contained numerous cooking utensils, small steam table pans, and coffee supplies had chipped, peeled, and cracked areas inside the drawers making them uncleanable surfaces. -Six of those drawers contained utensils including scoops, tongs, whips, and other utensils. -One of those drawers contained small steam-table pans. -One of those drawers contained coffee supplies. *Each of those above drawers contained chipped, peeled, and cracked areas inside the drawers making them uncleanable surfaces.</p> <p>Interview on 8/26/15 at 10:15 a.m. with the CDM (certified dietary manager) regarding the above drawers in the kitchen that contained cooking utensils, small steam table pans, and coffee supplies revealed she agreed each of those above drawers contained chipped, peeled, and cracked areas that were no longer a cleanable surface.</p> <p>Interview on 8/26/15 at 12:30 p.m. with the CDM regarding the above drawers in the kitchen revealed she did not have a policy specific to the storage and cleaning of those drawers.</p> <p>2. Observation on 8/24/15 from 3:45 p.m. through 4:06 p.m. in the kitchen revealed four packaged frozen turkey breasts thawing on a blue tray located on the counter next to the three compartment sink.</p>	F 371	<p>-One containing coffee supplies</p> <p>2. All drawers identified as uncleanable will be repaired to become compliant with federal requirements. Bids will be obtained for possible replacement of cupboards in the future. <i>by October 3, 2015</i></p> <p>3. ED will monitor progress for <i>JT/SPD/H/EL</i> the repair of the eight out of sixteen drawers to ensure compliance by <i>3rd October 2015</i>.</p> <p>4. Cook B was observed for <i>JT/SPD/H/EL</i> improper thawing of potentially hazardous foods. Cook B was immediately verbally inserviced and trained on proper methods and procedures for thawing of foods.</p> <p>5. All staff will be in-serviced on September 21, 2015 on safe thawing procedures. <i>All dietary and food handling employees will also received in-service training on food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling</i></p>		

by the dietary manager. JT/SPD/H/EL

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F 371	<p>Continued From page 4</p> <p>Observation on 8/24/15 at 5:40 p.m. in the kitchen revealed:</p> <ul style="list-style-type: none"> *The four packaged turkey breasts continued to thaw on a blue tray located on the counter next to the three compartment sink. *The above turkey breasts had been on the above counter for approximately two hours. *The turkey meat was partially thawed on that tray. <p>Interview on 8/24/15 at the above time and location with cook B regarding the above four packaged turkey breasts revealed:</p> <ul style="list-style-type: none"> *He had removed those turkey breasts from the freezer to thaw that afternoon. *He had placed them on the blue tray to thaw. *Those turkey breasts were scheduled to be served at the noon meal on 8/25/15. *He had planned to place the blue tray that contained the turkey meat into the refrigerator before he completed his shift that evening by 7:30 p.m. *This surveyor recommended cook B place the turkey breasts in the refrigerator for proper thawing. *He stated he was unaware the turkey breasts were not to have been placed on the counter for thawing. -Cook B then placed the turkey in the bottom shelf of the refrigerator. *He was unaware of the provider's thawing procedures. <p>Interview on 8/25/15 at 2:30 p.m. with the CDM regarding the four packaged turkey breasts that had been placed on the counter for thawing in the kitchen revealed:</p> <ul style="list-style-type: none"> *The turkey breasts were not to have been thawed on the counter. 	F 371	<p>policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.</p> <p>6. Dietary manager and/or designee will monitor 2 dietary staff twice per week for two months. Then one ^{randomly} dietary staff once per ^{Selected} week for two months for safe food handling procedures. JT/SDD/H/EL</p> <p>The data collected will be presented to the Quarterly Quality Assurance committee ^{by} the dietary manager or ED. It will be reviewed/discussed and at that time the QA committee will make a decision/recommendation regarding follow-up or changes.</p> <p><i>for one year</i> JT/SDD/H/EL</p>	
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F 371	Continued From page 5 *She agreed the provider's thawing procedures for the turkey had not been followed. Review of the provider's 2011 Thawing policy revealed: *Potentially hazardous foods must have been thawed in a method to ensure food remains at a continuous safe temperature of 41 degrees Fahrenheit (F) or below during the thawing process. *The director of dining or designee was to have ensured food was thawed properly. *Guidelines to thaw frozen foods had included: -"Thaw frozen foods under refrigerator that maintains the food temperature at 41 degrees F or lower. -Thaw foods in shallow pans to catch drippings. -Identify food with date placed in refrigerator for thawing and use by date. -Thaw at least three days prior to use. -Raw meats must be thawed on the bottom shelf under and away from ready-to-eat cooked items or fresh produce." *Guidelines for emergency thawing had included: -"Thaw completely submerged under cold running water (at a temperature of 70 degrees F or less) with sufficient water velocity [speed] to agitate and float off loose particles in an overflow. -Monitor temperature of food to assure that no part exceeds 41 degrees F. -Thawing must not exceed two hours, if product exceeds 41 degrees during thawing process. -Item must be cooked immediately after thawing." *Never to have thawed any food item at room temperature.	F 371	.		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431			

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F 431	<p>Continued From page 6</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on medication cart review, interview, and policy review, the provider failed to ensure</p>	F 431	<p>F431</p> <p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:</p> <ol style="list-style-type: none"> 1. Medication storage procedures have been review and in-service for all staff authorized to complete medication passes will be in-serviced on proper storage and destruction of medications September 21, 2015. 2. DNS and/or designee will review 4 random resident medication blister packs each week 	OCT 13, 2015

Resident 6 and 12 and all residents who receive medications.
JT/SDDH/EL

by the DNS and the consultant pharmacist.
JT/SDDH/EL

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F 431	<p>Continued From page 7</p> <p>medication that had been removed from single-use medication blister packs (a type of medication packaging) were appropriately destroyed for two of two randomly observed for residents' 6 and 12 blister packs (in one of two medication carts). Findings include:</p> <p>1. Medication cart review and interview on 8/25/15 at 2:00 p.m. with certified nursing assistant (CNA) A revealed: *One hydrocodone tablet (a narcotic pain medication) that belonged to resident 6, had been punched out, was placed back into the blister pack, and was secured with tape. *One atorvastatin (lowers cholesterol) that belonged to resident 12 had been punched out, was placed back into the blister pack, and was secured with tape. *CNA was unsure why the medication had been taped back into the blister pack after it had been removed.</p> <p>Interview on 8/25/15 at 2:20 p.m. with the director of nursing (DON) regarding the above medications revealed she agreed that was not appropriate storage of medication. Medications not used should have been wasted appropriately and not placed back into the blister pack.</p> <p>Interview on 8/26/15 at 1:05 p.m. with the administrator and the administrator's preceptor revealed they agreed that was not an appropriate method of storing medication. The medication should have been wasted appropriately.</p> <p>Review of the provider's May 2012 Storage of Medication policy revealed there was no mention of repackaging medication back into the blister pack. Nursing staff should have however have</p>	F 431	<p>for proper storage and destruction of medications for two months. Then 4 resident medication blister packs twice per month for two months.</p> <p>The data collected will be presented to the Quarterly Quality Assurance committee by the [redacted] or ED. It will be reviewed/discussed and at that time the QA committee will make a decision/recommendation regarding follow-up or changes.</p> <p><i>DNS</i> <i>JT/SPROT/EL</i></p>	

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F 431	Continued From page 8 consulted with the pharmacist with questions.	F 431			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435057	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/26/2015
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/26/15. Golden LivingCenter-Armour was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 8/26/15.</p> <p>Please mark an "F" in the completion date column for the deficiency identified as meeting the FSES in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
K 033 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to maintain a protected path of egress from the basement to the exterior of the building. One of two basement stairways (west stairway)</p>	K 033		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Ben King* TITLE *Executive Director* (X6) DATE *9-16-15*

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SEP 18 2015

SD DON L&C

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435057	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/26/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ARMOUR		STREET ADDRESS, CITY, STATE, ZIP CODE 106 BRADDOCK POST OFFICE BOX 489 ARMOUR, SD 57313		
(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
K 033	<p>Continued From page 1</p> <p>discharged onto the main level and was not provided with a one hour fire resistive enclosure to the exterior of the building. Findings include:</p> <p>1. Observation at 11:30 a.m. on 8/26/15 revealed the west basement stairway discharged onto the main level of the building without maintaining one hour fire rated assemblies to the exterior of the building. Review of the previous life safety code survey confirmed that condition had existed since the building had been constructed in 1967.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.</p>	K 033		

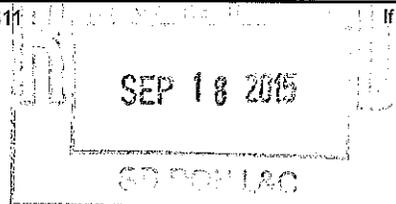
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10593	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/26/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ARMOUR	STREET ADDRESS, CITY, STATE, ZIP CODE 106 BRADDOCK POST OFFICE BOX 489 ARMOUR, SD 57313
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S 000	<p>Initial Comments <i>*Addendums noted w/ an asterisk per 9/25/15 from facility DOR per telephone. JT Spowell</i></p> <p>Surveyor: 32331 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/24/15 through 8/26/15. Golden LivingCenter - Armour was found not in compliance with the following requirement: S301.</p>	S 000	S301	OCT 13, 2015
S 301	<p>44:04:07:16 Required dietary in-service training</p> <p>The dietary manager or the dietitian in ...nursing facilities...shall provide ongoing in-service training for all dietary and food-handling employees...Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure four of nine required annual in-service training sessions (food safety, food-borne illness, leftover food handling policies, and time and temperature controls for food preparation and service) were offered for all food-handling staff yearly. Findings include:</p> <p>1. Record review of the required in-service training sessions from July 2014 through 8/26/15 for all food handling staff revealed:</p>	S 301	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:</p> <ol style="list-style-type: none"> Four of nine annual required training had not been completed. All staff will be in-serviced on September 21, 2015. All dietary and food handling employees will receive in-service training on food safety, handwashing, food handling and preparation techniques, food-borne illnesses, <p><i>by the dietary manager, DNS, and ED. JT Spowell</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Executive Director	(X6) DATE 9-16-15
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S 301	<p>Continued From page 1</p> <p>*Those staff had received no annual training on the following: -Food safety. -Food-borne illness. -Leftover food handling policies. -Time and temperature controls for food preparation and service.</p> <p>Interview on 8/25/15 at 2:30 p.m. with the certified dietary manager (CDM) and on 8/26/15 at 9:30 a.m. with the director of nursing (DON), administrator, and administrator's preceptor regarding required annual in-service training sessions for all food handlers revealed: *Food handling staff were identified as dietary, nursing, and activities by the CDM. *Food handling staff were identified as dietary and nursing by the DON. *There had not been an in-service on food safety, food-borne illnesses, leftover food handling policies, and time and temperature controls for food preparation and service for nursing and activities staff. *They had not known that all food handling staff were to have received that annual in-service training.</p> <p>Review of the provider's revised 1/5/15 Inservice Training policy revealed employees would have received training according to the company, state, and federal requirements.</p>	S 301	<p>servicing and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. To ensure all food handling staff have been effectively trained and understand all topics required.</p> <p>3. Dietary Manager will ensure required annual dietary training to all food handler staff annually to not exceed 12 months from the last date of inservice training.</p> <p>The data collected will be presented to the Quarterly Quality Assurance committee by the dietary manager or ED. It will be reviewed/discussed and at that time the QA committee will make a decision/recommendation regarding follow-up or changes.</p>	

*for one year.
JT/SDOH/EL*