MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55PR	A. BUILDING: _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

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M 000	Initial Comments The State Agency (SA) conducted a licensure survey at the facility 10/30/17 to 11/2/17. During the survey, the SA determined the facility was not in compliance with State Licensure Regulations for the Aged or Infirm, and cited State Statutes at M635, M640, M815, and M840. The census at the time of the survey was 97 and the facility held a license for 120 beds.	M 000		
M 635	45.21.7 Gastric feeding Gastric feeding. Residents who are eating alone or with assistance are not fed by a gastric tube unless their clinical condition indicates that the use of a gastric feeding tube is unavoidable. The residents who are fed by a gastric tube receive the treatment and services to prevent complications or to restore if possible, normal eating skills. This Statute is not met as evidenced by: Level II Based on observation, record review, staff interview and facility policy review, the facility failed to administer each medication separately and flush the Percutaneous Endoscopic Gastrostomy (PEG) tube between each medication administration for one (1) of three (3) residents observed with feeding tubes, Resident#12. Findings Include: Review of the Facility's policy on Medication Administration - General Guidelines", dated	M 635	This Plan of Correction is submitted under Federal and State Regulations and status applicable to Long Term Care Providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the scope and severity regarding any of the deficiencies are cited correctly. Rather, it is submitted as confirmation of our ongoing effort to comply with all State and Federal regulatory requirements.	11/30/17

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M 635	Continued From page 1 09/25/15, revealed administering the medication separately (via feeding tube) aids in avoiding interactions and clumping. The medication cup is rinsed with water to ensure the entire dose of medication has been administered. The enteral tubing is flushed with at least 5 milliliters (ml)of water between medication administrations. Review of Mosbey's Pocket Guide to Nursing Skills and Procedures, Perry and Potter, eighth edition, page 334, revealed under the oral medications through Gastric Tubes: To administer more than one (1) medication, give each separately, and flush between medications with 15 to 30 ml of water. The rationale included: Allows for accurate identification of medication if the medication is spilled, and in addition, some medications may be incompatible. It maintains patency of the tube. Review of Resident 12's Physician's Orders, dated October 2017, revealed to check for placement of the feeding tube by aspiration/auscultation (hearing) before and after administering flushes or medications. There was no order for flushing between medications or administering each medication separately via the feeding tube. Observation of the medication pass, on 10/31/17 at 8:00 AM, revealed Licensed Practical Nurse (LPN #4) mixed Vasotec and Coreg together, Cerovite and Keppra together, Zoloft and Trilafon together, Plavix and Sardil together, and Bacid and Lipitor together in medication cups. LPN #4 poured the mixed medications into resident #12's feeding tube and flushed with 10 cubic centimeters (cc) of water after each mixed medication. LPN #4 did not administer each medication separately.	M 635	1) On 11/4/2017, LPN #4 was provided with education regarding the policy "Medication Administration, Enteral Tubes." The Education was provided by the Assistant Director of Nursing. 2) The facility recognizes that all Residents with a PEG Tube had the potential to have been affected by the alleged deficient practice. 3) On 11/21/17, All Nursing Staff were provided education by the Staff Development Nurse on the policy and procedure titled "Medication Administration: Enteral Tubes". On 11/27/17, the Staff Development Coordinator will begin monitoring nurses administering medication to Residents with PEG Tubes, 3 times a week for 3 weeks and then 2 times a week for 2 weeks to ensure the administration of the medications are performed correctly. The audits will be given to the QAPI Committee for review. 4) The results of the audits will be brought to the Quality Assurance Performance Improvement Committee and corrective action will be monitored and evaluated by the Committee at least quarterly and more often as necessary. If any revisions of the plan of correction are needed, the revisions will be developed and approved by the OAPI Committee to ensure the plan of correction is achieved and sustained.	

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M 635	Continued From page 2 During an interview on 10/31/17 at 4:00 PM, LPN #4 confirmed she failed to administer each medication separately and flush the tube between each medication for Resident #12. LPN #4 said she combined the medication because of the quantity of meds. LPN #4 said she is not familiar with facility policy on giving meds via tube and she had not talked to pharmacy about interactions of medications. During an interview on 11/1/17 at 9:00 AM, the Pharmacy Consultant stated he did not review Resident #12's feeding tube medications for interactions. The Pharmacist said the best practice is to give the medications one (1) at a time and flush after each medication. The Pharmacist also said that if Resident #12 coughed and the medication came out of the tube, the nurse would not know what medication the Resident lost. In an interview, on 11/1/17 at 11:12 AM, LPN #1 said that the medication administered through the tube should be crushed and placed into individual cups. The tube should be flushed after each individual medication. During an interview, on 11/1/17 at 11:35 AM, LPN #3 said that the medication should be crushed and place into individual cups and the tube should be flushed after each individual medication. In an interview, on 11/1/17 at 12:10 PM, the Director of Nursing (DON) confirmed LPN #4 failed to correctly administer medication via feeding tube by not administering the medication individually and flush after each medication. The DON said the nurse should have called pharmacy and checked to see if any of the medications	M 635		

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M 635	Continued From page 3 interacted with each other before combining them. The DON said the nurse's train each other when they are first hired. Review of the facility's face sheet revealed the facility readmitted the resident on 08/01/17. Resident #12's diagnoses included Alzheimer Disease, Hypertension, Hyperlipidemia, Depression, Chronic Obstructive Pulmonary Disease and Kidney Disease. Review of the Minimum Data Set, with an Assessment Reference Date of 09/22/17, revealed staff assessed Resident 12 with severely impaired cognition.	M 635		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based upon observation, record review, and staff interview the facility failed to secure an oxygen (O2) tank on a rolling walker to prevent accidents or to ensure other cognitively impaired residents did not tamper with the oxygen tank and accidentally drop the tank, for one (1) of 10 residents with continuous oxygen, Unsampled Resident #E, Findings include:	M 640	1) On 11/3/2017, an employee of the Maintenance Department placed a safety strap on the oxygen tank and secured it to the rolling walker of Unsampled Resident E. 2) The facility recognizes that all Residents who ambulate with a rolling walker and an oxygen tank had the potential to have been affected by this alleged deficient practice.	11/25/17

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M 640	Continued From page 4 No policy was provided by the facility for securing oxygen tanks. An observation, on 10/30/17 at 4:30 PM, revealed Unsampled Resident #F was handling a rolling walker with an unsecured small O2 tank in the buggy part of the walker. Unsampled Resident #F leaned down and attempted to pick up the oxygen tubing that was hanging down to the floor from the unsecured O2 tank sitting on the rolling walker in the hallway of Nursing Station #2. Observation on 10/30/17 at 4:45 PM and 5:00 PM, revealed an unsecured O2 tank sitting on the seat of a rolling walker in the hallway outside of room 207. The oxygen tubing was connected and hanging to the floor. The rolling walker was identified, by Licensed Practical Nurse (LPN) #4, as belonging to Unsampled Resident #E. During an observation on 11/01/17 at 11:30 AM, Unsampled Resident #E ambulated with a rolling walker in the hallway of Nursing Station # 2. An unsecured O2 tank sat in the basket of the rolling walker. During an interview, on 10/30/17 at 5:00 PM, LPN #4, confirmed that there was an O2 tank sitting on the seat of a rolling walker in the hallway. LPN #4 stated that she was not sure who put it there, but that happened all the time. LPN #4 stated that Unsampled Resident E used the rolling walker, carrying the O2 tank, while ambulating to activities and other areas of in the facility. LPN #4 stated that the O 2 tank was never secured that she was aware of. LPN #4 stated, "That's the way we always do it." LPN #4 stated she would try to find a way to secure the O2 tank to keep it from falling. LPN #4 also stated that Unsampled	M 640	3) The Nursing Supervisor will monitor Unsampled Resident E, 3 days a week for 3 weeks and then 2 days a week for 2 weeks to ensure that Unsampled Resident E is using the rolling walker with the oxygen tank secured with a safety strap while ambulating. The audits will be given to the QAPI Committee for review. 4) The results of the audits will be brought to the Quality Assurance Performance Improvement Committee and corrective action will be monitored and evaluated by the Committee at least quarterly and more often as necessary. If any revisions of the plan of correction are needed, the revisions will be developed and approved by the OAPI Committee to ensure the plan of correction is achieved and sustained.	

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M 640	Continued From page 5 Resident F wanders around the facility in a wheel chair, but that she has never noticed Unsampled Resident #F messing with that rolling walker or the O2 tubing that is connected to it, but that it was a possibility. During an interview on 10/31/17 at 3:40 PM, Registered Nurse #2 confirmed that keeping an unsecured O2 tank on the rolling walker, that Unsampled Resident #E used to ambulate, was not a safe practice or intention of the facility. RN #2 stated that the facility did not have a policy on the use of O2 tanks related to the placement of an O2 tank in a resident's rolling walker used for ambulation. During an interview, on 11/2/17 at 11:00 AM, Unsampled Resident #E confirmed that she used the rolling walker to ambulate to activities and other areas of the facility. Unsampled Resident #E confirmed that the O2 tank on the rolling walker was never secured when used. Unsampled Resident #E also stated that there was one (1) occasion, when she was coming in from outside, that the O2 tank fell off the rolling walker. Unsampled Resident #E stated that she kept the rolling walker in the hallway because she didn't really have a place in her room for storage. During an interview, on 11/2/17 at 12:45 PM, the Director of Nursing (DON) confirmed that Unsampled Resident #E used an O2 tank on her rolling walker to ambulate inside the facility, and that she preferred to keep it parked in the hallway next to her room. The DON confirmed that the O2 tank needed to be secured to the rolling walker for safety purposes. The DON stated that she did not know the tank had not been secured. A review of the face sheet revealed the facility	M 640		

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M 640	Continued From page 6 admitted Unsampled Resident #E on 08/13/15, with diagnoses to include Chronic Obstructive Pulmonary Disease and Essential Hypertension. A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/22/17, revealed Unsampled Resident #E's Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. A review of the face sheet revealed the facility admitted Unsampled Resident #F on 01/29/13, with diagnoses to include Alzheimer's Disease and Delusional Disorder. A review of the Significant Change in Status MDS with an ARD of 08/04/17, revealed Unsampled Resident #F's BIMS score of 5, indicating severe cognitive impairment.	M 640		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observation, staff interviews, facility policy review, and record review, the facility failed to cover and date food stored in the walk-in cooler and refrigerator, maintain consistent cleaning schedules and tray line temperatures records, failed to remove food particles from the stand mixer and a panini press for one (1) of three (3) kitchen observations and failed to	M 815	1) On 10/31/17 the Dietary Manager removed the dried food particles from the stand mixer, and the panini sandwich press. The bowl of Shrimp, cooked spinach, 4 boxes of raw chicken, the three (3) pink colored pies, three packages of ground beef and the one carton of liquid eggs were discarded on 10/31/17 by the Dietary Manager. The package of ham and the package of turkey were discarded	11/30/17

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M 815	Continued From page 7 deliver trays in a timely manner to maintain temperature for one (1) of three (3) dining observations for two (2) of seven (7) halls, specifically the 200 halls. Approximately one (1) and one-half (1/2) hours elapsed from the time the meal tray was delivered on the 200 hall until the last resident was served. Findings Include: Review of the facility's policy, "Program: Cleaning and Sanitizing", no date, revealed, "All food service departments must have an effective cleaning program that includes a cleaning schedule." "Sanitize Cleaning Schedule. The cleaning schedule must: Identify: the cleaning jobs in each area of the kitchen. Assign: cleaning responsibilities to each job position. Schedule: the time the cleaning is to be done and/or completed." "Preparing: TCS Food. When preparing TCS food-food requiring time and temperature control for safety-team members must protect food from cross-contamination and/or time/temperature abuse. Label and date. Label and date-mark prepared salad leftovers using the ingredient with the earliest discard date or seven (7) days after the earliest original preparation date of any TCS food." The facility did not provide a policy related to the delivery of food trays. Observation on 10/30/17, with the corporate chef on the initial kitchen tour at 10:35 AM, revealed dried food particles on the stand mixer. A panini sandwich press was covered and stored on the table underneath the stand mixer. There were food particles on the contact plates of the sandwich press.	M 815	on 10/31/17 by the Dietary Manager. The crack in the sink was fixed and the standing water was cleaned by the Maintenance Director on 10/31/17. The two (2) containers of cut tomatoes and cucumbers were discarded by the Dietary Manager on 10/31/17. Starting on 11/06/17 the tray line temperature records will be consistently filled out correctly and monitored by the Dietary Manager. Starting on 11/06/17 the cleaning logs will be followed and filled out correctly and monitored by the Dietary Manger. Starting on 11/06/17 the Patient Tray Cart-Delivery Time Log will be completed for each meal period and this will be monitored by the Dietary Manager. 2) The facility recognizes that all Residents had the potential to have been affected by this alleged deficient practice. 3) The Company Resource Manager will do an in-service on checking for cleanliness of equipment, labeling and dating of stored food, and ensure trays are delivered on time this will be done on 11/25/17. The Dietary Manager will do rounds in the kitchen to check for cleanliness of equipment, labeling and dating of stored food, and ensure trays are delivered on time 5 days a week for 3 weeks, and then 3 days a week for 2 weeks. The results of the findings will be reported to the Quality Assurance Performance Improvement Team. The audits will be given to the QAPI Committee for review. 4) The results of the audits will be brought	

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M 815	Continued From page 8 In an interview on, 10/30/17 at 10:35 AM, Dietary Personnel #6, stated the stand mixer had not been used this date, "No, that was yesterday." The Corporate Chef confirmed the unclean sandwich press. Observation of the walk-in refrigerator and storage cooler, on 10/30/17 at 10:35 AM, revealed a large aluminum bowl which contained pink colored shrimp. The bowl was covered with plastic wrap but not dated. There was a bowl which contained what resembled cooked spinach, not dated, four (4) boxes of undated raw chicken, with no received or discard by date, three (3) pink colored pies with no dates, three (3) packages of ground beef which were undated, and one (1) carton of liquid eggs with no use by date. Interview with the Corporate Chef, on 10/30/17 at 10:35 AM, confirmed the foods were undated and would not be able to tell when the shrimp or spinach had been cooked. He further stated the foods should have been dated with received and use by dates. Observation in the kitchen, on 10/31/17 at 9:00 AM, revealed one (1) package of sliced ham in a plastic bag and one (1) package of sliced turkey in a plastic bag, both undated. Interview on 10/31/17 at 9:20 AM, with the Food Service Director, confirmed the undated sliced meats in plastic bags. Observation in the kitchen, on 10/31/17 at 9:25 AM, revealed standing water on the floor near the three (3) compartment sink. Dietary Cook #3 was present and stated the sink had been leaking "too long."	M 815	to the Quality Assurance Performance Improvement Committee and corrective action will be monitored and evaluated by the Committee at least quarterly and more often as necessary. If any revisions of the plan of correction are needed, the revisions will be developed and approved by the QAPI Committee to ensure the plan of correction is achieved and sustained.	

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M 815	Continued From page 9 Observation on 10/31/17 at 9:25 AM, of the two (2) compartment cooler, revealed two (2) containers of cut tomatoes and cucumbers with no covering or dates. Cook #2 stated, when asked when the tomatoes and cucumbers had been prepared or when they were to be used, "That's a good question." In an interview, on 10/31/17 at 9:50 AM, the facility Administrator revealed the facility was under contract with a food service and had been aware of some problems in the dietary department. Had recently had two (2) employees in the kitchen leave. In an interview, on 11/1/17 at 3:15 PM, Registered Nurse #1, Quality Assurance Nurse, stated the kitchen concerns had not been brought to Quality Assurance. In an interview, on 11/2/17 at 11:45 AM, the Registered Dietitian revealed she had just recently become aware of problems in the kitchen. She stated she expected food to be dated, labeled, and covered in the refrigerator and had observed for cleanliness. She stated there were forms to be used to record tray line temperatures and would have to retrain the kitchen staff if they were not following the recipes. Review of the tray line temperature records dated 10/28/17-11/2/17 had not been consistently filled out. Review of the cleaning logs had not been documented as done. Handwritten statement from Maintenance Supervisor #1 revealed on 10/30/17 it had been reported that the triple sink in the kitchen was cracked and leaking and this was the first report of problems to maintenance. On 10/30/17 maintenance welded the crack in the	M 815		

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M 815	Continued From page 10	M 815		

sink and tested for further leaks. No work orders were produced to the surveyor.

A review of a record titled "Patient Tray Cart-Delivery Time Log" was provided by the facility for three (3) of the days of survey with the dates of 10/30/17, 10/31/17, and 11/01/17 without the dinner meal included.

An observation on 10/30/17 at 4:15 PM, revealed dinner meal trays were delivered to Station 2 in a large covered delivery cart. The meal trays were handed out to the resident's located in the dining room. Trays were left on the delivery cart with the doors closed. Residents were fed in the dining room and down the 200 hall while the trays remained on the delivery cart.

An observation on 10/30/17 at 5:20 PM, revealed dinner meal trays were delivered down the 200 hall serving Unsampled Resident A and Unsampled Resident B in Room 220 and Unsampled Resident C. The tea and water glasses were noted to have melted ice in both cups.

An observation on 10/30/17 at 5:30 PM, revealed dinner meal trays were delivered down 200 hall short hall to Unsampled Resident D in Room 232 and Resident #9 in Room 233. The tea and water glasses did not have any ice noted in the cups. This was approximately one (1) and one-half (1/2) hours after the cart was sent to the floor.

An interview on 10/30/17 at 5:20 PM, with Unsampled Resident A and B, confirmed the trays were late for this meal, and the food on the tray was cold, which included chicken pot pie, green beans and soup that was served in a cup on the

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M 815	Continued From page 11 side of the plate. Unsampled Resident A said even the plate was cold the food was on. Unsampled Resident B confirmed his pureed food was not warm. In an interview on 10/31/17 at 5:30 PM, Resident #9 said the food "tasted like crap" and wasn't cold or hot. Resident #9 requested another meal. In an interview on 10/31/17 at 5:30 PM, Unsampled Resident D said she was used to waiting to last for her meals. Unsampled Resident D said the food was usually cold and there was no use to ask for the staff to warm it. In an interview on 11/1/17 at 12:30 PM, Certified Nursing Assistant (CNA) #1 said she did not know how long the delivery cart would hold the food hot. She thought about an hour. CNA #1 said the trays were different every day on the cart, and they never knew whose tray would be on the carts. In an interview on 11/1/17 at 4:00 PM, the Director of Nursing (DON) said the facility did not have a policy/procedure for delivery of food trays. The DON said the expectation was to deliver the trays as soon as possible but no longer than 30 minutes. The DON said the training of the staff would not include the delivery timing of the trays but she expected it to be understood to deliver "as soon as possible." In an interview on 11/01/17 at 4:40 PM, the District Dietary Manager (DDM) said the common practice was to deliver the whole tray including liquids and dessert on the delivery cart. The DDM said the cart was not heated but used "Pellets" that the plate sits on and said it should hold the food above 140 degrees Fahrenheit. The	M 815		

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	55PR	A. BUILDING: _____ B. WING _____	11/02/2017

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M 815	Continued From page 12 DDM said she expected the food and the ice to hold their temperatures if the delivery flow was continuous. The DDM said she was looking for the dining delivery sheets for the meals served at night. In an interview on 11/02/17 at 10:00 AM, the DON said that the facility could not locate the sign in sheets for any of the dinners served on the dates of 10/30/17, 10/31/17, or 11/1/17. A review of the manufacture recommendations of the pellets revealed the pellets would hold the temperature of food above 140 degrees Fahrenheit for 45 minutes. A review of the manufacture recommendations of the delivery cart did not mention time frame for length of holding heat or cold on the cart. A review of the facility's face sheet revealed the facility admitted Unsampled Resident A on 02/01/12. Unsampled Resident A's diagnoses included Diabetes Mellitus and Congestive Heart Failure. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/13/17, revealed Unsampled Resident A's Brief Interview for Mental Status (BIMS) was 6, which indicated severely impaired cognition. A review of the facility's face sheet revealed the facility admitted Unsampled Resident B on 08/12/15. Unsampled Resident B's diagnoses included Diabetes Mellitus and Hypertension. The MDS, with an ARD of 09/29/17, revealed Unsampled Resident A's BIMS was 13, which indicated intact cognition.	M 815		

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M 815	Continued From page 13 A review of the facility's face sheet revealed the facility admitted Unsampled Resident D on 07/24/12. Unsampled Resident D's diagnoses included Iron Deficiency Anemia and Essential Hypertension. The MDS, with an ARD of 10/20/17, revealed Unsampled Resident C's BIMS was 15, which indicated intact cognition. A review of the facility's face sheet revealed the facility admitted Resident #9 on 09/28/17. Resident #9's diagnoses included Chronic Kidney Disease and Diabetes Mellitus. The MDS, with an ARD of 10/09/17, revealed Unsampled Resident A's BIMS was 11, which indicated moderately impaired cognition.	M 815		
M 840	45.30.4 Menu Menu. The menu shall be planned and written at least one week in advance. The current week's menu shall be approved by the dietitian, dated, posted in the kitchen and followed as planned. Substitutions and changes on all diets shall be documented in writing. Copies of menus and substitutions shall be kept on file for at least thirty (30) days. This Statute is not met as evidenced by: Level II Based on observation, resident group interviews, staff interviews, record reviews, and the facility policy review, the facility failed to follow the menu for fried chicken and creamed spinach for one (1) of three (3) dietary observations.	M 840	1) Cook #2 was educated on the importance of following the recipes to include measuring ingredients. The education was provided on 11/1/17 by the Dietary Manager. 2) The facility recognizes that all	11/30/17

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M 840	Continued From page 14 Findings Include: Review of the facility's policy, "(Name of Vendor), Inc. Standardized Recipes" effective 01/01/99, revealed, "1. Standardized recipes will be used to prepare each menu item. 2. Recipes will include the following information: A. Recipe Name, B. Number and Size of portions, C. List and quantity of ingredients, D. Cooking temperature and time, E. Preparation steps, F. Critical control points." Review of the Production Recipe, for 11/1/17 for Fried Chicken, revealed the ingredients and instructions for 44 pound fresh cut chicken, three (3) quart and ½ cup of all purpose flour, one (1) cup and two (2) tablespoons of cornstarch, ¼ cup and two (2) tablespoons of ground paprika, ¼ cup and two (2) tablespoons of garlic powder, two and ¾ teaspoon of poultry seasoning, one (1) and 1/3 teaspoon of ground thyme, one (1) and 1/3 tablespoon of ground black pepper and three (3) quarts and ½ cup of buttermilk. Instructions included to combine flour, cornstarch, dry seasonings, salt and pepper. The chicken was to be dredged into the seasoned flour and then dipped into the buttermilk and then dredged again. The chicken was to then be placed on a rack and allowed to rest for 20 minutes. Observation on 11/1/17 at 10:25 AM, revealed a container of raw chicken which was being seasoned. Cook #2 picked up containers of lemon pepper, seasoned salt, and onion powder. Cook #2 shook each seasoning without measuring into a container of flour. Cook #2 placed the pieces of chicken which had been coated in the flour into the deep fryer. She did not dip the chicken into buttermilk before adding to the deep fryer. Cook #2 looked at the time on	M 840	Residents had the potential of being affected by this alleged deficient practice. 3) The Food Service Director will conduct observations of Cooks while preparing a meal on 8 meals for three weeks and then 5 meals for two weeks to ensure recipes are being followed to include measuring ingredients. The audits will be given to the QAPI Committee for review. 4) The results of the audits will be brought to the Quality Assurance Performance Improvement Committee and corrective action will be monitored and evaluated by the Committee at least quarterly and more often as necessary. If any revisions of the plan of correction are needed, the revisions will be developed and approved by the QAPI Committee to ensure the plan of correction is achieved and sustained.	

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M 840	Continued From page 15 a battery operated wall clock. Interview on 11/1/17 at 10:30 AM, with Cook #2, revealed she did not measure the seasonings before adding to the flour. Cook #2 stated, "I guess I should have." Cook #2 also stated she had not dipped the chicken in the buttermilk. Stated she was just nervous. Interview on 11/1/17 at 10:30 AM, with Food Service Director #1, revealed they were out of paprika, garlic powder and black pepper. Food Service Director #1 stated she had been helping since last week due to the last manager had walked out. Review of the recipe for the creamed spinach revealed one (1) and ½ ounce of margarine, three (3) and 1/3 tablespoon of all purpose flour, one (1) and ¼ cup plus two (2) tablespoons of skim milk, one (1) tablespoon plus ¾ teaspoon of gluten free low sodium chicken soup base and three (3) pounds and four (4) ounces of frozen chopped spinach. The instructions included to mix the margarine, milk, and flour and then the chicken base and cook until thickened. The spinach was to be drained and squeezed to remove excess liquid and then stirred into the sauce. Observation on 11/1/17 at 10:45 AM, revealed a large aluminum pot which contained a white creamy liquid with particles of green. The substance had the appearance and texture of a thin soup. Cook #2 stirred the liquid and said it was creamed spinach. Cook #2 stirred the liquid and then used a plastic disposable spoon to taste. Cook #2 stated, "It's too salty." Interview on 11/1/17 at 10:50 AM, with Food	M 840		

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M 840	Continued From page 16 Service Director #1 revealed another cook had made the creamed spinach but he was already gone. She stated the recipe was not followed and they would remake the creamed spinach. In an interview on 11/1/17 at 10:50 AM, Cook #2 revealed they did not have a timer. Review of the facility menu, for 11/1/17, revealed Fried Chicken, Creamed Corn, Collard Greens, Lemon Cake with Glaze, Cornbread, Iced Tea, Margarine, Sugar Packet, Salt Packet and Pepper Packet. The Alternate Menu revealed Swiss steak, White Rice, and Creamed Spinach.	M 840		