STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355051	A. BUILDING _____ B. WING _____	04/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTON PRAIRIE VILLAGE	950 DAKOTA AVE HATTON, ND 58240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 04/24/17 and completed on 04/26/17, the sample included 2 residents for complete review, 8 residents for focused review, and 1 closed record for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an	F 156		4/26/17

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

Electronically Signed | 05/09/2017

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.

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F 156	Continued From page 1 assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning	F 156		

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F 156	Continued From page 2 November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law	F 156		

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F 156	Continued From page 3 provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and	F 156		

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F 156	Continued From page 4 obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide	F 156		

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F 156	Continued From page 5 notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A notices/files, the facility failed to provide adequate written notices for 4 of 4 residents (Resident #2, #4, #12, and #13) reviewed for termination of Medicare coverage. Failure of the facility to provide notices that contained the correct contact information for the intermediary review limits the residents' ability to exercise their rights related to Medicare Part A.	F 156	F156 - Notice 1. No resident was affected by the deficient practice because no resident appealed the termination of Medicare coverage. The address applies only when mailing in an appeal of termination of Medicare coverage. No resident made a decision on whether or not to appeal	

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F 156	Continued From page 6 Findings include: Review of Medicare billing records occurred on the afternoon of 04/25/17. The facility provided Resident #2, #4, #12, and #13 with a demand bill form. These forms lacked the correct contact information for the intermediary review.	F 156	based on an address. 2. Any resident appealing termination of Medicare coverage has the potential to be affected by the deficient practice. 3. Mailing address for appealing termination of Medicare coverage has been changed to the new address on the applicable form.	
F 323 SS=D	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 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.	F 323		5/31/17

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F 323	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide supervision and assistive devices necessary to prevent accidents for 2 of 7 sampled residents (Resident #4 and #8) dependent on staff for transfers and/or transport utilizing gait belts and wheelchairs. Failure to utilize a gait belt appropriately during transfer (Resident #8), utilize a wheelchair as a safety precaution as care planned (Resident #4), and/or provide wheelchair foot pedals during transport (Resident #8), may result in injury and/or falls. Findings include: The facility failed to provide a policy regarding transfers/transport per request. - Review of Resident # 8's medical record occurred on all days of survey. Medical diagnoses included Alzheimer's dementia, weakness, and difficulty walking. The significant change Minimum Data Set (MDS), dated 03/04/17, identified extensive assist of one or more persons with transfers and locomotion on/off the unit. The current care plan identified, ". . . [Resident #8] is unable to complete ADL's [activities of daily living] independently. . . . Extensive assist of two with transfers, pivot transfer . . . No leg rests on w/c [wheelchair], resident propels self and [is] able to lift feet when being propelled by staff (undated, handwritten entry). . . ." A "Therapy Standing Lift Screen," dated 12/22/16, identified, "During screen, resident	F 323	F323 - Free of Accident/Hazards 1. Corrective Action for Resident #8: Do consult with Physical Therapist to determine best/safest transfer and transport techniques for this resident. Update Resident #8's care plan, as needed, on transferring and transporting this resident. Mandatory refresher training by Physical Therapist for CNAs and nurses (including CNAs and nurse found deficient in transferring and transporting this resident)on correct transferring and transporting of residents, including transferring and transporting of Resident #8 and transferring Resident #4. Update Resident Transfer Technique list and shift assignment sheets to include any changes in transferring and transporting Resident #8 and Resident #4. Corrective Action for Resident #4: Mandatory refresher training for CNAs by DON on Resident #4's care plan regarding use of wheelchair in her bathroom. 2. All residents who need assistance with transferring and transporting have the	

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F 323	Continued From page 8 demonstrated full weight resting on sling during transfer. Resident unable to pull self up to stand despite verbal and tactile cues. Recommend discontinued use of E-Z stand and use of 2 person, stand pivot transfer to complete for the safety of the resident." Observations showed the following: * During the initial tour at 12:30 p.m. on 04/24/17, a nurse (#6) transported Resident #8 down the hallway in her wheelchair. Resident #8's shoes could be heard brushing the floor as the staff member transported her to the lounge. The staff member (#6) failed to cue Resident #8 to lift her feet and/or apply foot pedals during transport. * 04/24/17 at 4:00 p.m., two certified nursing assistants (CNAs) (#1 and #2) transferred Resident #8 from the recliner to her wheelchair. The CNAs (#1 and #2) placed both hands under Resident #8's axillas (armpits) and lifted her to a standing position. The CNA (#1) turned around and saw this surveyor observing the transfer and told the CNA (#2) to sit the resident back down. After the CNAs (#1 and #2) sat the resident back into the recliner, the CNA (#1) placed a gait belt around Resident #8's waist. Both CNAs (#1 and #2) then grabbed under Resident #8's axilla with both hands, lifted the resident to a standing position, and pivoted the resident into her wheelchair. The CNAs failed to appropriately utilize a gait belt. * 04/26/17 at 8:57 a.m., two CNA's (#3 and #4) transferred Resident #8 from her wheelchair to a recliner in the lounge. The CNAs (#3 and #4) placed a gait belt around Resident #8's waist and lifted her out of her wheelchair by placing one hand on the gaitbelt and the other under her axillas. The CNAs (#3 and #4) held onto the gait	F 323	potential to be affected by the deficient practices. 3. Develop policy on transferring and transporting residents. DON, Physical Therapist and Administrator will develop the policy. Mandatory refresher training of CNAs and nurses by Physical Therapist on transferring and transporting residents, including a review of the developed policy on transferring and transporting residents. CNAs and nurses will properly transfer and transport residents. Audit for 3 months CNAs and nurses transferring and transporting Resident #8 and transferring Resident #4, in accordance with the resident's care plan, on a random basis, but at least one CNA and/or nurse per day. Audit for an additional 3 months CNAs and nurses transferring and transporting Resident #8 and transferring Resident #4, in accordance with the resident's care plan, on a random basis, but at least one CNA and/or nurse per week. Audit for 3 months CNAS and nurses transferring and transporting other residents, in accordance with their care plans, on a random basis, but at least one CNA and/or nurse per day. Audit for an additional 3 months CNAs and nurses transferring and transporting other residents, in accordance with their care	

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F 323	Continued From page 9 belt, supporting Resident #8's weight throughout the transfer. Her heels did not touch the ground and the toes of her shoes drug on the floor as they lowered her into the recliner. The CNAs (#3 and #4) then lifted Resident #8 further back into the recliner by placing one hand on the gait belt and the other under the her axillas. The CNAs failed to cue Resident #8 to stand (bear her own weight) and placed pressure on her arms when they lifted her under the axillas. * On 04/26/17 at 10:17 a.m., two CNA's (#4 and #5) transferred Resident #8 from the recliner in the lounge back into her wheelchair. The CNAs (#4 and #5) placed a gait belt around Resident #8's waist and lifted her out of the recliner. The CNAs (#4 and #5) held onto the gait belt, supporting Resident #8's weight throughout the transfer. Her shoes drug on the floor as they lowered her into the recliner. The CNAs failed to cue Resident #8 to stand (bear her own weight). * On 04/26/17 at 10:50 a.m., two CNA's (#4 and #6) transferred Resident #8 from her wheelchair onto the commode in her room. The CNAs (#4 and #6) placed a gait belt around Resident #8's waist and lifted her out of her wheelchair. One of the CNAs (#6) held onto the gait belt while the other CNA (#4) placed one hand on the gait belt and one hand under the resident's right axilla. The CNAs (#4 and #6) also lifted Resident #8 further back onto the commode by placing one hand on the gait belt and the other under the her axillas. One of the CNAs (#4) commented, "I like three [staff members]. It is too hard for just two [staff members] to stand her and clean her up." The CNA (#4) then transported Resident #8 down the hallway. Resident #8 dropped her feet twice allowing them to brush along the floor before lifting them again. The CNAs failed to cue	F 323	plans, on a random basis, but at least one CNA and/or nurse per week. Audits will be done by LPNs and RNs. 4. QA Committee will review audit results weekly for 3 months. QA Committee will evaluate audit results to see if effective in correcting deficient practices.	

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F 323	Continued From page 10	F 323		

Resident #8 to stand (bear her own weight), placed pressure on her arms when they lifted her under her axillas, and failed to cue Resident #8 to lift her feet and/or apply foot pedals during transport.

During an interview on the afternoon of 04/26/17, an adminstrative nurse (#7) confirmed staff should utilize the gaitbelt for transfers, versus lifting under the resident's axillas.

- Review of Resident # 4's medical record occurred on all days of survey. Medical diagnoses included dementia, anxiety, history of right and left femur fracture, history of falls, and muscle weakness. The quarterly Minimum Data Set (MDS), dated 04/01/17, identified extensive assist of one person with bed mobility, transfers, walking in room and corridor, dressing, personal hygiene, and toileting. The current care plan stated, ". . . Problem . . . ADL functional/Rehabilitation Potential . . . is unable to perform ADL's independently R/T [related to]: Dementia, pain, osteoarthritis, h/o [history of] hip fractures, and weakness. . . . Approach . . . Extensive assist of one with locomotion on and off unit as needed. W/C [wheel chair] is primary means of locomotion. . . Problem . . . Urinary Incontinence . . . Occasional Incontinence of bowel and bladder. Extensive assist in toileting. Requests to go to toilet frequently. At times she requests to sit on toilet for long periods of time. . . . Approach . . . Extensive assist of one in toileting . . . IDT [interdisciplinary team] and family discussed frequent toileting and agreed resident may be left to toilet with call light within reach, sign posted reminding resident to use call light, w/c next to toilet at times when resident wants to

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F 323	Continued From page 11 sit for a long period of time. . . ." Observation on 04/24/17 at 4:24 p.m., showed a CNA (#2) transferred Resident #4 into the bathroom with a front wheel walker utilizing a gait belt. The CNA (#2) assisted Resident #4 onto the toilet, placed the front wheeled walker next to Resident #4, washed his hands, left the bathroom, and shut the bathroom door. The CNA (#2) failed to place the wheelchair in the bathroom as stated in the care plan if the resident is to be alone in the bathroom. Observation on 04/25/17 at 9:47 a.m., showed a CNA (#3) transferred Resident #4 to the bathroom utilizing a front wheeled walker with a gait belt. The CNA (#3) assisted Resident #4 onto the toilet, placed the front wheeled walker next to Resident #4, left the bathroom, and shut the bathroom door. The CNA (#3) failed to place the wheelchair in the bathroom as stated in the care plan if the resident is to be alone in the bathroom. During an interview on 04/26/17 at 12:45 p.m., an administrative staff (#4) stated Resident #4's care plan states to allow Resident #4 to be left alone in the bathroom. The nurse stated she expected staff to utilize Resident #4's wheelchair in the bathroom if she is left alone.	F 323		
F 363 SS=E	483.60(c)(1)-(7) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED (c) Menus and nutritional adequacy. Menus must- (c)(1) Meet the nutritional needs of residents in	F 363		5/31/17

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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
F 363	Continued From page 12 accordance with established national guidelines.; (c)(2) Be prepared in advance; (c)(3) Be followed; (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; (c)(5) Be updated periodically; (c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility menus, and staff interview, the facility failed to meet the nutritional needs of residents receiving modified diets by serving incorrect portions of puree foods during 1 of 2 observed meals (04/25/17 noon meal). Failure to follow the recommended portion sizes as outlined on menus may result in weight changes and/or inadequate nutritional intake for residents on a modified (puree) diet. Findings include: The facility failed to provide a policy regarding portion sizes of menu items per request. Observation of tray line occurred on 04/25/17 at	F 363	1. Mandatory refresher training of all cooks, cook's helpers and dietary aides by Dietary Manager and Consultant Dietician on correct portion sizes for each type of diet, use of correct scoops and importance to residents of correct portion size for each type of diet. 2. All residents have the potential to be affected because all residents eat meals. 3. Develop policy on correct portion sizes for each type of diet and use of correct scopes for each type of diet. Policy will be developed by Dietary Manager and Consultant Dietician.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355051	A. BUILDING _____ B. WING _____	04/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTON PRAIRIE VILLAGE	950 DAKOTA AVE HATTON, ND 58240

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F 363	Continued From page 13 11:45 a.m. during the noon meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: * Puree cranberry glazed chicken served with a 2 2/3 ounce (oz) scoop. The menu identified a 4 oz scoop. * Puree boiled potatoes served with a 2 2/3 ounce (oz) scoop. The menu identified a 4 oz scoop. * Puree green beans served with a 2 2/3 ounce (oz) scoop. The menu identified a 4 oz scoop. During an interview on the morning of 04/26/17, a managerial dietary staff member (#8) confirmed staff should follow the recommended portion sizes identified on the menus.	F 363	Mandatory refresher training of all cooks, cook's helpers and dietary aides by Dietary Manager and Consultant Dietician on correct portion sizes for each type of diet, use of correct scoops and importance to residents of correct portion size for each type of diet. Use by all cooks, cook's helpers and dietary aides of different colored scoops for different measurements of food. Audit cooks, cook's helpers and dietary aides for 3 months on use of correct scoop size on Mondays, Wednesdays and Thursdays, alternating meals. This schedule covers all dietary employees, including weekends, because all cooks, cook's helpers and dietary aides work weekend shifts. Audit cooks, cook's helpers and dietary aides for an additional 3 months on use of correct scoop size on either Monday, Wednesday or Thursday, alternating meals (i.e., one meal audited per week for 3 months). Audits will be done by Dietary Manager. 4. QA Committee will review audit results weekly for 3 months. QA Committee will evaluate audit results to see if effective in correcting deficient practice.	
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		5/31/17

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F 371	Continued From page 14 (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly maintain the walk-in freezer in 1 of 1 (main) kitchen during 2 of 2 observations. Failure to ensure staff properly maintained a walk-in freezer has the potential to affect the quality of the food consumed by residents. Findings include:	F 371	F371 Food Storage 1. Repair leak in walk-in freezer causing frozen condensation on food items located underneath the leak. 2. All residents have the potential to be affected by the deficient practice since food is used from the walk-in freezer to feed residents.	

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F 371	Continued From page 15 The facility failed to provide a policy regarding sanitation of the walk-in freezer per request. During the initial kitchen tour on 04/24/17 at 12:30 p.m., observation showed a pipe coming from the box fan located on the ceiling of the walk in freezer. Water condensation leaked from the pipe and froze onto the food items located underneath; a covered pail of soup on the top shelf, a closed box of mozzarella cheese on the second shelf, and a closed box of dessert bars on the third shelf. The managerial dietary staff member (#8) removed the ice-covered pail of soup from the freezer. During the kitchen tour on 04/25/17 at 11:45 a.m., observation showed a pipe coming from the box fan located on the ceiling of the walk in freezer. Water condensation leaked from the pipe and froze onto the food items located underneath; a closed box of mozzarella cheese on the second shelf, a closed box of dessert bars on the third shelf, a closed box of whole wheat rolls on the fourth shelf, a zip-lock baggie lying on top of a closed box of cinnamon rolls on the fifth shelf, and on the floor. During an interview on the afternoon of 04/25/17, a managerial dietary staff member (#8) stated, "We used to have a bucket under there. I don't know why someone removed it. I've had to throw other items away before." She confirmed the pipe connected to the box fan in the walk-in freezer did leak and the facility needed to have it repaired.	F 371	3. Develop policy on the sanitation of the walk-in freezer. Policy will be written by Dietary Manager, Consultant Dietician and Administrator. Audit walk-in freezer daily for 3 months to monitor for any leaks and for proper sanitation of the freezer, in accordance with the developed policy. Audit walk-in freezer weekly for an additional 3 months to monitor for any leaks and for proper sanitation of the freezer, in accordance with the developed policy. Maintain proper maintenance of walk-in freezer in accordance with developed policy and manufacturer's recommendations. 4. QA Committee will review audit results weekly. QA Committee will evaluate audit results to see if effective in correctly deficient practice.	