STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165324	A. BUILDING _____ B. WING _____	C 11/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF PLEASANTVILLE, LLC	909 NORTH STATE STREET PLEASANTVILLE, IA 50225

(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 Correction date: 12/23/16 The following deficiencies result from the investigation of Incident #63926-I, Complaint #63409-C & #62138-C conducted on November 3-28, 2016. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by Accura of Pleasantville of the facts alleged, or conclusions set forth in this statement of deficiencies. Accura Healthcare of Pleasantville maintains that these alleged deficiencies do not individually or collectively jeopardize the health and/or safety of its residents, nor are they of such character so as to limit this facility's capacity to provide quality care.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop an initial plan of care sufficient to meet the needs of one newly admitted residents (Resident #1). The facility reported a census of 45 residents. Findings include: The Fall Risk Assessment dated 10/10/16 indicated Resident #1 scored a 22. According to the assessment form, a prevention protocol should have been initiated immediately for any resident that scored 10 or more, a score of 10 or above indicates the Resident is at high risk for falls. The Initial Nursing Assessment dated 10/10/16	F 281	The services provided by the facility do meet professional standards of quality. Resident #1 passed away 12/23/16. Any new residents have had an initial careplans developed to meet the needs of the resident. DON/RN/MDS Coordinator were educated on process of completion of an initial careplan upon admission. Nursing staff was educated on 12/22/16 regarding development of the initial care plan upon admission in the absence of the DON or MDS Coordinator, were to find a careplan, and where to find information regarding care of a new admission. DON and/or designee will randomly audit admits to ensure that initial careplans are completed to meet the residents level of care. Any concerns will be taken through the assurance meeting and addressed in a timely manner.	12/22/16

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

Nicole Behrens; Executive Director | 12/28/16 | ~~12/21/2016~~ ERROR

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.

OK CS 12/29/16

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F 281	Continued From page 1 indicated that Resident #1 required extensive assistance of 2 staff for bathing, dressing, transfers and toileting. The Nursing Assessment noted the resident had right and left lower extremity weakness, a history of falls which included the last 30 days, bladder incontinence and a lethargic level of consciousness. The Initial Care Plan with a goal date of 10/30/16 noted the prevention of injury or harm had been the goals related to falls/safety risk, but only listed "encourage to use call light" and "Physical Therapy referral" as the interventions to attain that goal. An interview on 11/16/16 at 12:10 p.m., and subsequent interviews Staff C, CNA (certified nursing assistant), stated she had been told by the previous shift at report that Resident #1 should have been alarmed upon admission because he/she had been transferred from their corporate affiliate in Knoxville where he/she had previously been alarmed. When asked how she knew how to care for a newly admitted resident, the CNA stated, if it had not been passed on during shift report, she could not be sure how things were supposed to be done upon their arrival. An interview on 11/16/16 at 1:30 p.m. Staff B, CNA, stated she relied solely on the previous shift to report details related to the care of a newly admitted resident. In a subsequent interview, the CNA stated she used her own judgment for the first couple days after the arrival of a newly admitted resident until the development of an initial care plan had been completed. She said she could not remember what the previous shift	F 281		

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F 281	Continued From page 2	F 281		

reported to her about Resident #1. The CNA said earlier on the day of 10/11/16, the resident had been lethargic, so they used 2 staff and a gait belt to transfer and walk with him/her.

An interview on 11/17/16 at 9:45 a.m. and subsequent interviews the DON, (Director of Nursing), revealed Resident #1 had been very lethargic when he/she arrived on 10/10/16. She stated initially the resident required transfer assistance of 2 staff and a gait belt, but had not been equipped with a safety alarm because of the resident's lethargic state and because their facility had a locked unit. She stated they do not resort to alarms if they are adequately staffed. Regarding the Fall Risk Assessment that instructed staff to immediately implement a prevention protocol if a resident scored 10 or more, the DON stated they did not a protocol. She stated they assess every resident on an individual basis. The DON revealed she expected everyone to follow the care plan.

An interview on 11/23/16 at 6:55 a.m., Staff A, CNA, stated she had never met the resident, and he/she had been asleep on the couch in the lounge when her shift began. During shift report, the CNA said she heard the resident had been unsteady, very restless and did not like to stay in one place. According to the CNA, nobody told her how many people were required to transfer the resident. The CNA admitted that a reference sheet related to new admissions could be found in the ADL book, but she had not looked at it before her shift began. She did not think she needed to because typically only residents that require the assistance of one staff are on the memory unit. She agreed that obviously there are exceptions like in that situation. She said typically

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F 281	Continued From page 3 one person can deal with most of the residents, so they only ask for help when a resident becomes combative.	F 281		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide adequate supervision to protect one (1) of three (3) residents from hazards during transfers. Resident #1 fell and sustained a hip fracture on 10/12/16, two days after admission. Record review revealed Resident #1's care plan had not addressed how Resident #1 should have been transferred. Staff interviews revealed they previously transferred Resident #1 on multiple occasions with less assistance than the initial Nursing Assessment indicated and there transferred. The facility reported a census of 45 residents. Findings include: The discharge Minimum Data Set (MDS) assessment dated 10/12/16 noted Resident #1's admission date as 10/10/16, and listed the resident's diagnoses as Alzheimer's Disease, Parkinson's Disease, and orthostatic hypotension	F 323	The facility does ensure that the residents remain as free of accident hazards as is possible; and each resident recieves adequate supervision and assistance devices to prevent accidents. Resident #1 passed away on 12/23/16. Staff educated on 12/22/16 on where to find careplans and how to read them on how to care for the residents. Alarms are available as needed for resident care and staff are aware of where they are located. DON/designee will do random audits will to ensure all nursing staff know where to find individual resident's care plans and know how to read the resident's individual care plan. Any concerns will be taken through the quality assurance meeting and addressed in a timely manner.	12/22/16

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F 323	Continued From page 4 (drop in blood pressure related to standing after sitting or lying down). The MDS indicated Resident #1 had either not walked in the corridor, or family and/or non-facility staff provided care 100% of the time during the assessment period. The MDS also indicated Resident #1 depended on the extensive assistance of staff to provide all ADLs (activities of daily living), which included weight bearing support to walk in the room. According to the MDS, staff assessed Resident #1 as having an altered level of consciousness, a memory problem, inattention, disorganized thinking and moderately impaired cognitive skills for daily decision making. The October TAR (Treatment Administration Record) from the previous facility where Resident #1 resided noted that upon admission, the resident required a wanderguard and pressure alarm safety device at all times. The Discharge Instructions dated 10/10/16 from the facility where Resident #1 previously resided, noted the resident required the assistance of 2 staff due to activity limitations. The Fall Risk Assessment dated 10/10/16 indicated Resident #1 scored 22. According to the assessment form, a prevention protocol should have been initiated immediately for any resident that scored 10 or more. The initial Care Plan with a goal date of 10/30/16 noted the prevention of injury or harm had been the goals related to falls/safety risk, but only listed "encourage to use call light" and "Physical Therapy referral" as the interventions to attain that goal.	F 323		

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F 323	Continued From page 5 The Quality Assurance Monitoring Tool dated 10/12/16 at 3:15 a.m. indicated Resident #1 attempted to transfer him/herself. A newly implemented intervention called for one on one monitoring of the resident until an alarm could be obtained. The Final Report document dated 10/12/16 indicated Resident #1 sustained a mildly displaced oblique intratrochanteric acute fracture proximal left femur (fractured upper thigh bone). The Final Report dated 10/13/16 indicated Resident #1 had undergone a surgical pinning of a left hip fracture. The initial Nursing Assessment dated 10/10/16 indicated that Resident #1 required extensive assistance of 2 staff for bathing, dressing, transferring and toileting. The Nursing Assessment noted the resident had right and left lower extremity weakness, a history of falls which included the last 30 days, bladder incontinence and a lethargic level of consciousness. Though the initial care plan had not addressed how Resident #1 should have been transferred, staff interviews revealed they were not sure how Resident #1 should have been transferred, and admitted they had previously transferred Resident #1 on multiple occasions with less assistance than the initial Nursing Assessment indicated as follows: An interview on 11/16/16 at 9:35 a.m. with Staff F, LPN (licensed practical nurse), revealed that sometimes they only schedule one person on the memory unit, but believed they make every attempt to have two back there on overnights.	F 323		

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F 323	Continued From page 6 She thought that had been their policy. According to the LPN, staff calls back and forth between the nurses ' stations as their way of corresponding, or they simply go to the memory unit and check on things. She stated the facility told them they could not carry their cell phones, but she told them she believed it was a safety issue by not carrying it. The LPN said they no longer use walkie talkies, so she relies on her cell phone in the event of an emergency. According to the LPN, if an only person in the memory unit could not reach someone at the nurses ' station and did not have a cell phone, they better hope they could leave the emergency long enough to get help, or hope someone came soon. An interview on 11/16/16 at 12:10 p.m., and subsequent interviews with Staff C, CNA/CMA (certified nursing aide/certified medication aide), revealed she worked on the memory unit from 10:00 p.m. on 10/11/16 until 6:00 a.m. on 10/12/16. She stated newly admitted residents are not typically equipped with alarms right away because they reserve the use of alarms as an intervention after a fall. According to the CNA, she had been told by the previous shift at report that Resident #1 should have been equipped with an alarm upon admission because he/she had been transferred from their corporate affiliate in Knoxville where he/she previously had an alarm. The CNA stated the resident had not been equipped with an alarm upon admission because the facility did not have an extra alarm. According to the CNA, if the resident had been equipped with an alarm, the fall might have been prevented because they respond so quickly when they hear an alarm sounding. When asked how she knew how to care for a newly admitted resident, the CNA stated, if it had not been passed on during	F 323		

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F 323	Continued From page 7 shift report, she could not be sure how things were supposed to be done upon their arrival. In a subsequent interview, the CNA stated working shorthanded had been an issue approximately a month before. She said it had been common for only one staff member to be scheduled up front with the nurse and one on the memory unit. According to the CNA, the nurse came to the memory unit from time to time, but usually just called unless there had been problems. Staff C stated the night nurse spent the majority of her time up front, and staff on the memory unit called the nurses ' station up front if necessary. When two staff members are scheduled on the memory unit, she said they relieve each other for breaks. The CNA expressed concern about being left alone in the memory unit. She said sometimes residents get up in the night and go outside in the courtyard. According to the CNA, a resident might make a round out there, come back in and fall asleep on the couch or just roam around. Staff C mentioned the alarm sounded on the unit and up front when the door opened. She also stated that staff that work up front call the unit when they hear the alarm, and someone came to the memory unit if they were not able to reach someone. According to Staff C, the thought of a resident falling asleep outside while she assisted other residents concerned her the most. The CNA said the night Resident #1 fell, she took her 30 minute break about 1:30 a.m. and the other CNA on the memory unit took hers about 2:30 or 2:45 a.m. Both were left alone on the unit during their breaks. Fortunately, staff C said 15 minute checks on Resident #1 had just been implemented about 3:00 or 3:15 a.m. and the nurse had just gotten to the unit about 5 minutes before Resident #1 fell. Staff C said the nurse remained on the unit until about 4:00a.m., Staff A	F 323		

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F 323	Continued From page 8 remained in the unit until she went up front about 5:00 a.m. to help Staff D and she remained on the memory unit for the remainder of that shift. She stated Staff D had been left alone up front while the three of them were back in the memory unit. Staff C said before the nurse left the unit, she told Staff C to administer Tylenol and call her if the resident complained of pain. Staff C said she attempted to call the nurse about 5:20 a.m., but had not been able to reach her. She said the phones at the nurses ' stations are the designated means of communication. The CNA/CMA said if she were alone in the memory unit during an emergency, she would just keep trying until she could reach someone. An interview on 11/16/16 at 12:40 p.m. with Staff D, CNA revealed she worked up front from 10:00 p.m. on 10/11/16 until 6:00 a.m. on 10/12/16. She stated she first realized Resident #1 had fallen when the nurse came to the front to get the equipment to do vital signs. According to the CNA, the nurse stated she would be tied up on the memory unit due to the fall. When asked about her opinion, the CNA stated they are adequately staffed. When the CNA had been informed that another staff member spoke of working short staffed, she became more open. She stated they did not take breaks back in July, August and September because there had only been one staff member scheduled up front, one scheduled in the memory unit and one nurse over the entire facility. She stated falls occurred simply because of being short staffed. The CNA said the facility did not have enough alarms to go around. She stated that she and other staff members heard that Resident #1 should have been alarmed, but due to a shortage of alarms, he/she had not. According to her, the facility has used	F 323		

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F 323	Continued From page 9 safety alarms for a very long time. An interview on 11/16/16 at 1:30 p.m. with Staff B, CNA revealed that she worked on the memory unit from 6:00 a.m. to 10:00 p.m. on 10/11/16. According to Staff B, she relied solely on the previous shift to report details related to the care of a newly admitted resident. In a subsequent interview, the CNA stated she used her own judgment for the first couple days after the arrival of a newly admitted resident until the development of an initial care plan had been completed. She said she could not remember what the previous shift reported to her about Resident #1. The CNA said earlier in the day of 10/11/16, the resident had been lethargic, so they used 2 staff and a gait belt to transfer and walk with him/her. According to the CNA, the resident became more active during the evening and kept trying to self-transfer, so staff had to follow the resident around in an attempt to keep him/her safe. In an effort to describe how much better the resident walked that evening compared to that morning, the CNA said when he/she got up alone to walk to the bathroom; she reached out and assisted the resident by herself. When asked, she stated she did not think to put a gait belt on the resident, but also said she did not think a gait belt had been necessary based on a couple of factors. First, she stated the resident became agitated when she attempted to put a gait belt on him/her, and second, due to the resident's improved gait, she did not believe a gait belt had been warranted. The CNA said the resident had been so busy that evening, he/she fell asleep once he/she sat down. An interview on 11/17/16 at 9:45 a.m. and subsequent interviews with the DON, (Director of	F 323		

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F 323	Continued From page 10 Nursing), revealed Resident #1 had been very lethargic when he/she arrived on 10/10/16. She stated initially the resident required transfer assistance of 2 staff and a gait belt, but had not been equipped with a safety alarm because of the resident's lethargic state and because their facility had a locked unit. She stated they do not necessarily resort to alarms if they are adequately staffed. According to the DON, the resident came from their affiliated facility in Knoxville, where he/she had required transfer assistance of 2 staff and had been equipped with a safety alarm because they did not have a locked memory unit. When asked if the change in the resident's activity level would have warranted the use of a safety alarm, the DON said the charge nurse would have been responsible to reassess the resident to see if an alarm would have been warranted. When this surveyor informed the DON that other staff interviews revealed the resident ' s lethargic state diminished and he/she became more active, she stated she had not been informed of the resident's change. Regarding the Fall Risk Assessment that instructed staff to immediately implement a prevention protocol if a resident scored 10 or more, the DON stated they did not have one. When asked what protocol they followed, she stated they do not follow a protocol. She stated they assess every resident on an individual basis. The DON revealed she expected everyone to follow the care plan. An interview on 11/22/16 at 2:40 p.m. with Staff E, LPN, revealed that she worked the overnight shift on the 10/12/16. According to the LPN, she arrived in the memory unit about 3:00 a.m. and saw Staff C coming out the 1st room on the right. She believed Resident #1 resided in that room. As she sat and charted, she said she heard a	F 323		

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F 323	Continued From page 11 loud noise. According to the LPN, she went down the hall where she met Staff C. As they searched rooms, she stated she believed Staff C had been the one to find Resident #1 on the floor. The nurse said she went to get the equipment to do vital signs. She said she returned and attempted to check Resident #1's vital signs. She stated she had been unable to assess the resident because he/she became combative. She stated the resident denied having pain, so they stood him/her near the bed, and she had been able to check his head and arms. As they walked the resident from near the bed to the doorway, he/she lifted both legs and said " put me down " . The LPN said they lowered the resident to his/her knees. She went to get a wheel chair. When she returned, Staff A had been present, so she held the wheel chair while the LPN and Staff C put the resident in it. She stated they wheeled the resident to the dining room table where he/she sat for an hour and a half with the LPN as she charted. According to the LPN, the resident occupied him/herself by playing with her paperwork. Once she finished charting, the LPN said she told Staff C to give Resident #1 Tylenol and call her if he/she complained of pain. She stated Staff C attempted to call her, but she had been rounding up front with Staff D. Consequently, Staff E said she had been unaware that Staff C tried to call. The LPN said In the event of an emergency, Staff C would have had to keep calling until she reached her. The LPN said ideally an intercom would be nice, but believed that their current system worked fine. According to her, the doors are alarmed and they hear it up front. She stated they also carry their cell phones at night. The LPN stated Resident #1 had not complained of pain at any time. She stated another neuro assessment had been due	F 323		

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	165324	A. BUILDING _____ B. WING _____	C 11/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF PLEASANTVILLE, LLC	909 NORTH STATE STREET PLEASANTVILLE, IA 50225

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F 323	Continued From page 12 for the Resident, so she returned to the memory unit about 5:40 or 5:45 a.m. She said Staff C informed her at that time the resident complained of pain and she had given Tylenol. The day shift nurses walked in right after that and she said she reported off to them. An interview on 11/23/16 at 6:55 a.m. with Staff A, CNA, revealed she worked on the memory unit from 10:00 p.m. on 10/11/16 until 6:00 a.m. on 10/12/16. According to the CNA, she had never met the resident, and he/she had been asleep on the couch in the lounge when her shift began. The CNA said between 1:00 a.m. and 2:00 a.m. on 10/12/16, Staff A's co-worker had gone on break, and she had been left alone on the memory unit. During that time, the resident woke up and got up off the couch on his/her own. The CNA said she approached the resident and applied a gait belt as she assisted him/her to the bathroom. According to her, the resident seemed very unsteady. Next, the CNA said she helped to transfer the resident to bed by herself. During shift report, the CNA said she heard the resident had been unsteady, very restless and did not like to stay in one place. According to the CNA, nobody told her how many people were required to transfer the resident. The CNA admitted that a reference sheet related to new admissions could be found in the ADL book, but she had not looked at it before her shift began. She did not think she needed to because typically only residents that require the assistance of one staff are on the memory unit. She agreed that obviously there are exceptions like in that situation. She said typically one person can deal with most of the residents, so they only ask for help when a resident becomes combative. Staff A stated that once she thought about it, she should have checked to see	F 323		

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F 323	Continued From page 13	F 323		

if the resident needed more assistance. She said it gets crazy sometimes, like when she arrived at 10:00 p.m. on the evening of 11/22/16. She stated there had been about 8 residents up walking around, and one of them had tried to get out the door. She stated that sometimes she cannot even get report due to the commotion. Staff A spoke of the early morning hours of 10/12/16 when the nurse, Staff C and she were all in the memory unit because of Resident #1's fall. Staff A stated that Staff D had been up front alone at that point and she would have been spread kind of thin since the 3 of them were in the memory unit. She said that some nights are wonderful, but other nights are horrible because the residents are climbing the walls. Staff A stated she thought at least 2 staff members were needed up front at all times. When asked what she would do if she were alone on the unit during an emergency situation, she stated she would call the nurses ' station up front. According to her, if nobody answered, she would keep trying until she got ahold of someone. She said that had never happened before, but she could see how it would be possible. According to Staff A, the Administrator and DON have changed 3 times in the 3 years she had worked at the facility, and most of the nurses are new again. She stated it seemed like a revolving door, and everyone had a different idea of how things should be done. According to her, because a communication barrier existed, it felt like she had to figure it out on her own once she " hit the floor " .

The Daily Nurse Hall Assignments revealed between 10/1/16 - 11/12/16 on the 10:00 p.m. - 6:00 a.m. shift, only one staff member had been scheduled on the memory unit, one staff member over the rest of the facility and one nurse to

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F 323	Continued From page 14 supervise the entire facility on 10/1/16, 10/2/16, 10/3/16, 10/8/16, 10/9/16, 10/26/16, 10/31/16, 11/12/16.	F 323		
F 371 SS=D	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: Based on observation, and staff interviews, the facility failed to maintain proper sanitation of the kitchen. The facility reported a census of 45 residents. Findings include: An observation on 11/3/16 at 9:00 a.m. during the initial dietary tour revealed unsanitary conditions in multiple areas of the kitchen and pantry as follows: - the window, window frame and window sill above the stainless sink next to the dishwasher had brown residue splattered on the surface and the white caulk around the window frame had black mildew on it. - The white wall behind the dishwasher and the stainless backsplash behind the stainless sink had an excessive accumulation of black and	F 371	Accura Healthcare of Pleasantville does produce food from sources approved or considered satisfactory by Federal, State or local authorities; and Store, prepare, distribute and serve food under sanitary conditions. Window, window frame and sill have been taken out and wall covered, the white wall behind the dishwasher and the stainless back splash has been cleaned and removed and a white back splash has been installed, the floor and plumbing under the stainless and dishwasher sink has been cleaned and the plumbing painted; the white and tan vinyl floor in the pantry cleaned; the can opener and the vertical adjustment mechanism cleaned; the surface of the laminated counter top cleaned; the white wall behind the hand washing sink in the pantry cleaned and painted; the facuet inside the stainless steal hand washing sink in the pantry was cleaned; the stainless steal back splash above the griddle/stove combination cleaned.	12/23/16

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F 371	Continued From page 15 brown residue splattered all over it. - The floor and plumbing under the stainless sink and dishwasher had an excessive accumulation of greasy brown and black residue on the surface. - The white and tan vinyl floor in the pantry room had debris randomly scattered and brown residue splattered on it. - the can opener mounted on the counter top next to the hand washing sink in the pantry had excessive accumulation of greasy black residue on the point that punctures the can, the wheel that spins the can and the vertical adjustable mechanism the can opener slides on. - The surface of the laminated counter top where the can opener had been mounted had brown residue splattered on it. - The white wall behind the hand washing sink in the pantry had an accumulation of a greasy brown residue. - The faucet and the inside of the stainless hand washing sink in the pantry had an excessive accumulation of white chalky mineral deposits on the surfaces. - The stainless griddle and the stainless backsplash above the griddle/stove combination had an excessive accumulation of greasy black and brown residue on it. An interview on 11/16/16 at 10:00 a.m. with the Maintenance Supervisor revealed he had been off of work for a couple months. According to the Supervisor, he noticed the decline in the cleanliness of the kitchen after he returned to work. An interview on 11/22/16 at 2:30 p.m. with the Dietary Manager revealed that the facility did not	F 371	DSM educated dietary staff on 12/23/16 regarding the cleaning schedules. The DSM/designee will do random audits of the cleaning schedule to ensure the cleaning schedule is being done. Any concerns will be taken through the quality assurance meeting and addressed in a timely manner.	

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F 371	Continued From page 16 have a policy on general kitchen cleaning. The Manager submitted a blank a.m. and p.m. cleaning schedule and stated a completed form could not be located.	F 371		