DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Foulk Living LLC, Nursing Home

DATE SURVEY COMPLETED: February 26, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES
	An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from February 20, 2024, through February 26, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day was 42. The sample totaled 22 residents.	
3201	**Regulations for Skilled and Intermediate Care Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey completed February 26, 2024: cross refer: F623, F644, F689, F712, F761, F804, F812.	**Corrective Action:** R295 is no longer a resident in our facility. E3 (MD) has been educated on the requirement that an H&P must be completed by the MD within 14 days of admission. **Identification of other residents:** All new residents have the potential to be affected. An audit of all new residents admitted over the past 30 days has been completed to ensure an H&P was completed by the physician within 14 days of admission. No other residents were identified as not meeting this requirement. **System changes:** The root cause of this concern was failure of E3 (MD) to complete an H&P on R295 within 14 days of admission. E3(MD) has been educated on the stated regulation.
3201.9.1.2	**History and physical examination prepared by a physician within 14 days of the resident's admission to the nursing facility.**	

Provider's Signature T. Mallon Title DON/Interim E.D Date 3/18/24

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	Based on record review and interview, it was determined that the facility failed to ensure that R295's physician admission history and physical, which was completed on 11/18/22, was completed within 14 days for R295, who was admitted on 11/1/22. Findings include: R295's clinical record revealed: 11/1/22 – R295 was admitted to the facility with diagnoses, including but not limited to, vascular dementia with psychotic disturbances and hypertension. 11/9/22 – R295 seen by E30 (NP) and documented a note titled "History and Physical". 11/18/24 4:24 PM - R295 seen for the first time by R3 (MD) and documented a note titled an "Acute Encounter". This was 17 days after his admission to the facility. 2/22/24 11:15 AM – During an interview, E31 (RN) stated that R295 was admitted to the facility from home. 2/26/24 3:15 PM – Findings were reviewed at the exit conference with E1 (Don, Interim NHA), E2 (ADON) and E4 (Corporate Clinical Specialist).	
	Title 16 Health and Safety	
3201.9.6	**All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long-Term Care residents Protection.**	**Corrective action:** All licensed staff members will be reeducated on the requirement to report incidents with significant injuries within 8 hours of the incident. Identification of other residents:
3201.9.8	**Reportable Incidents are as follows:**	

Provider's Signature [signature] Title D.O.N / Interim E.D Date 3/18/24

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3201.9.8.4 3201.9.8.4.2	**Significant Injuries** **Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours.** Based on record review and interviews, the facility failed to report R8's incident (a fall with injury) that occurred on 5/16/23 at 7:20 AM until 5/17/23 at 4:20 PM, well past the eight hour time frame. Findings include: R8's clinical record revealed: 3/31/17 – R8 was admitted to the facility with diagnoses, including but not limited to, dementia and peripheral vascular disease. 5/16/23 2:22 PM – E8 (LPN) documented a Health status Note stating, "...it was about 7:20 AM went to resident's room to assist CNA with hoyer transfer...While sitting resident down to her wheelchair, she slid out of sling falling to the floor hitting back of head...Obtained order to send resident to [hospital] ER (emergency room) for evaluation". 5/16/23 8:59 AM - C1's ED (emergency department) Physician record documented, "...96 year old female...who presents today after fall...was dropped out of sling...". 5/17/23 4:20 PM – E1 (DON, Interim NHA) reported R8's incident to Delaware Health and Social Services, Division of Health Care Quality. This reportable incident (injury with transfer to an acute facility) was reported thirty -three hours after it occurred, well outside the eight hour time frame.	All Residents have the potential to be affected by the alleged deficient practice. An audit of all incidents with significant injuries for the past 30 days has been completed to ensure that the State notification was completed within the 8-hour timeframe. System changes: The root cause of this concern was failure to notify the State of an incident involving significant injuries. All license staff have been educated on the need to report incidents with significant injuries within 8 hours of the incident. Success evaluation: A 100% audit was completed on all incidents with significant injuries for the past 30 days to ensure that the State was notified within the 8-hour timeframe. Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. The results of the audits will be reviewed by the Quality Assurance Team.

Provider's Signature [signature] Title D.O.N / Interim ED Date 3/18/24

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	2/26/24 3:15 PM – Findings were reviewed at the exit conference with E1 (DON, Interim NHA), E2 (ADON) and E4 (Corporate Clinical Specialist).	

Provider's Signature _____ Title D.O.N / Interim CEO Date 3/18/24

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	085060	A. BUILDING _____ B. WING _____	C 02/26/2024

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FOULK LIVING	1212 FOULK ROAD WILMINGTON, DE 19803

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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from February 20, 2024 through February 26, 2024. The facility census was 42 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unnanounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from February 20, 2024 through February 26, 2024. The deficinecies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day was 42. The survey sample was 19 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistand Director of Nursing; CNA - Certified Nursing Assistant; DON - Director of Nursing; EMR - Electronic Medical Record; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator;	F 000		

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

Electronically Signed | 03/18/2024

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 000	Continued From page 1 SW - Social Worker. Adipose tissue - body fat Bilateral - both left and right; hoyer- a mechanical device utilized to lift and transfer residents; Lacerations - a deep cut or tear in skin or flesh; Lateral - relating to the side; MDS - Minimum Data Set; Medial - situated in the middle; ORIF - open reduction and internal fixation - a type of surgery used to stabilize and heal a broken bone; Tibia - Fibula - the two long bones located in the lower leg.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		4/1/24

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F 623	Continued From page 2 discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual	F 623		

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F 623	Continued From page 3 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R42) out of one resident reviewed for hospitalization, the facility failed to notify the resident and the resident's	F 623	Corrective Action: Corrective actions have been ensured by the Director of Nursing. R42 is a resident	

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F 623	Continued From page 4 representative in writing, of R42's transfer to the hospital, including the reason for the transfer. Findings include: Review of R42's clinical record revealed: 1/11/24 - R42 was admitted to the facility. 1/16/24 - R42 was transferred to the hospital because of a decline in physical and mental condition. R42 was admitted to the hospital and was discharged back to the facility on 1/19/24. 2/22/24 2:20 PM - During an interview, E23 stated that she provided a verbal communication to R42's representative of R42's hospital transfer, including the reason for the transfer. E23 stated that a written communication was not provided. 2/26/24 3:15 PM - Finding was reviewed at the exit conference with E1 (DON, Interim NHA), E2 (ADON), and E4 (Clinical Specialist).	F 623	in the facility. The Director of Nursing/Designee has completed staff training to prevent a recurrence of this concern. Identification of other Residents: All Residents have the potential to be affected. To prevent other residents from being affected, all nursing and social services staff members have been trained on the requirement to provide notice of the bed hold policy including a written copy to the resident/POA at time of discharge/transfer. A 100% audit of all discharges and transfers in the last 30 days has been completed to determine resident/POA notification of the Bed Hold policy. System Changes: The Root Cause of the concern was the failure to provide a bed-hold notice to R42/POA at time of hospitalization. The facility policy "Bed-Holds and Returns" was reviewed and found to meet professional standards. The facility system for daily clinical review meetings has been updated to include a review of all transfers and discharges to ensure that the resident/POA has been notified of the Bed Hold policy. The Director of Nursing or Designee will complete education for all nursing and social services staff regarding the requirement to provide resident/POA notification of the Bed Hold policy. The nursing management team will provide oversight to ensure ongoing compliance.	

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F 623	Continued From page 5	F 623	Success Evaluation: A 100% audit of all discharges and transfers in the last 30 days has been completed to determine Resident/POA notification of the Bed Hold policy. Subsequent audits of all discharges in the previous 7 days will be completed by the Director of Nursing or Designee to ensure that Resident/POA was notified of the Bed Hold policy in writing; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's	F 644		4/1/24

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F 644	Continued From page 6 assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R3) out of one reviewed for PASARR, the facility failed to refer R3 for a PASARR level II evaluation when R3 was diagnosed with delusional disorder in June 2023. Findings include: R3's clinical record revealed: 12/29/21 - R3's Preadmission Screening and Resident Review (PASARR) documented, " ...No Level II required ... There is no evidence of a PASRR (sic) condition of an intellectual/developmental disability or serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted." 6/15/23 - R3 was admitted to the facility with diagnoses, including but not limited to, dementia, heart disease and delusional disorder. 6/16/23 - R3's care plan documented, " ...I have impaired cognitive function or impaired thought processes r/t (related to) dementia and delusional d/o (disorder)." 12/15/23 - R3's Minimum Data Set (MDS) assessment Section I Active diagnoses	F 644	Corrective action: Corrective actions have been ensured by the Director of Nursing. R3 remains a resident at our community. An updated PASSAR has been submitted to Maximus. The Director of Nursing/Designee has completed staff education to prevent a recurrence of this concern, including the Social Services Director/Admission Director, the MDS coordinator, as well as the IDT team. Identification of Other Residents: All residents have the potential to be affected. In order to prevent other residents from being affected, all staff members involved in the PASARR process have been educated. A 100% audit was completed on all current residents□ PASARR levels. There were no further level 2 PASARRs identified. System Changes: The root cause of this concern was the failure of the IDT team to identify a resident in need of a level 2 PASARR. The Admissions Director will obtain a copy	

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F 644	Continued From page 7 documented "I5950 Psychotic Disorder (other than schizophrenia)". 2/21/24 3:52 PM - During an interview, E23 (Social Worker) stated that she "relies on Nursing or the MDS/ RNAC to notify her if there is a new diagnosis that requires a new PASARR evaluation." Once notified, she completes the online PASARR application requesting an evaluation. 2/21/24 4:02 PM - Surveyor requested and was provided all known copies of R3's PASARRs by the facility. The facility was only able to produce the PASARR evaluation dated 12/29/21. 2/26/24 3:15 PM - Findings were reviewed at the exit conference with E1 (DON, Interim NHA), E2 (ADON) and E4 (Corporate Clinical Specialist).	F 644	of the resident□s PASARR prior to admission. Any Level 2 assessments will be identified, and the IDT team will be notified. All new admissions are reviewed during the daily clinical meeting for any diagnoses that would warrant the need for a Level 2 PASSAR. PASARR levels on all new admissions will be discussed and any recommendations made will be implemented. Success Evaluation: A 100% audit was completed on all current residents□ PASARR levels. Subsequent audits will have a goal of 100% compliance. Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		4/1/24

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F 684	Continued From page 8 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R1) out of six residents reviewed for accident hazards and falls, the facility failed to ensure R1's received immediate medical attention following a bus accident that caused a fall from the wheelchair. Findings included: Cross refer F689 The facility policy titled Individual Safety Responsibilities: Authorized Driver Last revised 6/15/07 documented: "12. Traffic Accident: In the event of a traffic accident: ..Help anyone who is injured, call an ambulance if necessary..." R1's record revealed: 9/8/21 - R1 was admitted to the facility with diagnoses including, but not limited to, cancer and difficulty in walking. 5/31/23 - A significant change MDS assessment documented that R1 was cognitively intact with a "BIMS of 15." 6/28/23 - The facility's incident report and investigation revealed that "after attending a social outing, R1 was being driven back to the facility when the transport van driver tapped the brake causing R1's wheelchair to propel forward and R1 to slide out of the wheelchair onto the	F 684	Corrective Action: Corrective actions have been ensured by the Director of Nursing. The Director of Nursing has completed education with all team members who transport residents to prevent a recurrence of this concern. Education included the directive that 911 should be called immediately for any instances whereby a resident requires immediate medical attention. Identification of Other Residents: All Residents have the potential to be affected. In order to prevent other residents from being affected, all staff members involved with van transport have been educated that emergency help should be requested immediately following an accident to ensure that the resident receives the necessary medical attention. System Changes: The Root Cause of the concern was a failure of the van driver to call 911 for emergency help at the time of the accident. The van driver is no longer	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOULK LIVING	1212 FOULK ROAD WILMINGTON, DE 19803

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F 684	Continued From page 9 van's floor. While resident was on the floor of the transportation van E19 (Housekeeping Manager) who was in the front passenger seat stated he saw that E18 (van driver, former employee) was in a panic, E19 asked E18 to stay with the resident while he drove back to the facility 1.3 miles away very slowly. E19 called the facility's receptionist and informed her they were in an accident and they would need help once they got to the facility." 6/28/23 3:00 PM - R1's facility progress note documented, "At around 10:20 (AM) received a call from the receptionist that 'a resident fell in the van outside'. Rushed to the assisted living entrance and the transportation van pulled up and noticed [R1] lying on the foot bed of the van supine in front of her wheelchair. [R1] verbalized that she slid from the wheelchair during the van transport and that her legs hurt. Denies any LOC (loss of consciousness), or head injury. [R1] was awake and oriented to person, place, time and situation. Laceration noted laterally on bilateral shins. Scant amount of blood noted, no active bleeding noted. Nurse Practitioner [E30] in the building made aware, ordered to ok to send [R1] to the hospital. Emergency Service called and [R1] picked up by... fire company EMS (Emergency Medical Service). [R1's family member]... made aware of the incident and verbalized that she would meet [R1] at the hospital." 2/26/24 10:23 AM - During an interview with E1 (DON, interim NHA), with E2 (ADON) and E4 (Corporate Clinical Specialist) present, "On 6/28/23, we received a call from the front desk asking if nurses could come to the parking lot STAT. We went outside and I [E1] saw [R1] sitting	F 684	employed at the facility. Education included the directive that 911 should be called immediately for any instances whereby a resident requires immediate medical attention. Education will be conducted annually for all those who transport residents and at time of hire for new team members responsible for transporting residents. Success Evaluation: The Director of Nursing/Designee will ensure education is provided to all team members involved with van transport to ensure they are aware to call for emergency help immediately following an accident. Re-education will be completed on an annual basis and with all new hires. The education will be audited and will be reviewed by the Quality Assurance Team at the Quarterly Quality Assurance meeting.	

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F 684	Continued From page 10 in the van on the floor, the wheelchair was behind [R1] and [R1] was half lying and half sitting, and both legs were crooked and bleeding. I immediately called 911 and we tried to stop the bleeding. R1 was asked if she was in any pain and R1 denied pain. R1 did say that the van floor was hard on her back. I noticed that the wheelchair was stuck In the van and that R1 was not strapped in. I immediately asked the driver [E18] if he strapped [R1] in, he said that he did not and that he didn't know why he did not. I called her daughter... We did vital signs which were normal and wrapped her legs to stop the bleeding. The fire company was here quickly - they got here before the paramedics". Review of the incident report and facility investigation lacked evidence as to why the van driver did not call for emergency help at the time of the accident and instead drove back to the facility where emergency services were called. 2/26/24 3:15 PM - Findings were reviewed at the exit conference with E1, E2 and E4.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)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, it was	F 689	Past noncompliance: no plan of	

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F 689	Continued From page 11 determined that for one (R1) out of six residents reviewed for accident hazards and falls, the facility failed to ensure R1's environment was free from accident hazards as possible. On 6/28/23, while being driven back to the facility in a borrowed transport van from another facility, an accident occurred which resulted in R1 sustaining multiple fractures. The unsafe facility transport caused R1 harm. Based on review of the facility's evidence to correct the non-compliance and the facility's substantial compliance at the time of the current survey, the deficiency was determined to be past non-compliance as of 7/5/23. Findings included: R1's record revealed: 9/8/21 - R1 was admitted to the facility with diagnoses including, but not limited to, cancer and difficulty in walking. 5/31/23 - A significant change MDS assessment documented that R1 was cognitively intact with a "BIMS of 15." 6/28/23 - The facility's incident report and investigation revealed that after attending a social outing, R1 was being driven back to the facility when the transport van driver tapped the brake causing R1's wheelchair to propel forward and R1 to slide out of the wheelchair onto the van's floor. R1 was returned to the facility where 911 was called and fire company EMS (Emergency Medical Services) transported R1 to the hospital. 6/28/23 11:08 AM - Per C1's (hospital Forensic Nurse Examiner) notes, R1 arrived at the hospital after a "motor vehicle collision with complaints of right and left leg pain." Reportedly R1 stated, "I	F 689	correction required. Corrective Action: Corrective action has been ensured by the Director of Nursing. The plant transport employees were educated on the safety and proper use of wheelchair securement in transport vehicles in accordance with the facility policy "Loading and Unloading Non-Ambulatory Wheelchair Passenger Policy". Identification of other Residents: All Residents have the potential to be affected by the deficient practice. Facility transport personnel were educated on the Loading and Unloading Non-Ambulatory Wheelchair Passenger Policy (operating the wheelchair lift, positioning the wheelchair in the vehicle, attaching the two rear securement straps, attaching the two front securement straps, attaching the lap belt, attaching the shoulder belt); to ensure the safe transfer of every resident on/off all vehicles through the proper use of device/lift, and the safety of all residents during the transport process. System Changes: The Root Cause was determined to be related to driver's [E18] negligence by breaching his duty of care to the resident	

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F 689	Continued From page 12 fell out of my wheelchair when the bus stopped short." 6/28/23 1:17 PM - The hospital record documented, "[R1] was on a transportation van when it came to a sudden stop causing [R1] to fall out of [R1's] wheelchair striking [R1's] head and bilateral lower extremities". The record documented findings of a "frontal contusion and abrasion no active bleeding left lower extremity medial aspect of calf large laceration with exposed adipose tissue measuring approximately 15 cm by 10 cm. [R1's] right lower extremity with 2 linear lacerations to the lateral aspect of [R1's] lower leg approximately 10 cm in length bleeding noted dressing applied...[R1] is complaining of significant pain to [R1's] left lower extremity with any movement." 6/28/23 3:00 PM - R1's facility progress note documented, "At around 10:20 (AM) received a call from the receptionist that 'a resident fell in the van outside'. Rushed to the assisted living entrance and the transportation van pulled up and noticed [R1] lying on the foot bed of the van supine in front of her wheelchair. [R1] verbalized that she slid from the wheelchair during the van transport and that her legs hurt. Denies any LOC (loss of consciousness), or head injury. [R1] was awake and oriented to person, place, time and situation. Laceration noted laterally on bilateral shins. Scant amount of blood noted, no active bleeding noted. Nurse Practitioner [E30] in the building made aware, ordered to ok to send [R1] to the hospital. Emergency Service called and [R1] picked up by... fire company EMS (Emergency Medical Service). [R1's family member]... made aware of the incident and verbalized that she would meet [R1] at the	F 689	by not applying a restraint device when it was ordinary, prudent and reasonable. This action resulted in the resident sliding out of the wheelchair when the transportation van slowed down. The system changes that were instituted included termination of the van driver, educating all drivers with best practices for loading and unloading non-ambulatory wheelchair passengers to ensure all residents are safely transported. Specifically, all drivers returned demonstrated the process of operating the wheelchair lift, positioning the wheelchair in the vehicle, attaching the two rear securement straps, attaching the two front securement straps, attaching the lap belt, attaching the shoulder belt. Before each trip, the driver must utilize the wheelchair securement checklist to ensure residents are secured in the transport vehicle. Success Evaluation: 100% of all employees responsible for transporting our resident were educated on the Loading and Unloading Non-Ambulatory Wheelchair Passenger Policy (operating the wheelchair lift, positioning the wheelchair in the vehicle, attaching the two rear securement straps, attaching the two front securement straps, attaching the lap belt, attaching the shoulder belt). Education included return demonstration. The plan is for education to be ongoing and conducted annually	

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F 689	Continued From page 13 hospital." 6/28/23 11:34 PM - Per the hospital record, R1 was transferred to another hospital after the previous facility noted bilateral open tibia-fibula fractures that occurred earlier that day when R1 was being transported in a wheelchair and not strapped in causing [R1] to fall out of the wheelchair. The hospital record documented a "need for surgical repair." 6/28/23 - The facility's documented immediate actions in response to R1's transport accident included the following: - canceled all other appointments and resident transport for the day; - suspension of the driver [E18] because the preliminary investigation indicated that [E18] did not follow safety protocol...; - observation of the van and wheelchair immediately after the incident revealed that the shoulder strap was not fastened; - training initiated and completed by the plant manager [E21] on proper and safe medical transport; and - initiation of an investigation of the incident. 6/28/23 - The facility's in-service training documentation included the following: - Loading and Unloading Non-Ambulatory Wheelchair Passenger Policy (operating the wheelchair lift, positioning the wheelchair in the vehicle, attaching the two rear securement straps, attaching the two front securement straps, attaching the lap belt, attaching the shoulder belt); - Wheelchair Securement Checklist; and - Training (must include and frequency). The in-service training was completed on the same day, 6/28/23, of R1's accident.	F 689	and with all newly hired employees responsible for transporting residents. Education compliance will be reviewed by the Quality Assurance team during the QAPI meetings.	

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F 689	Continued From page 14 6/29/23 - The hospital records documented that R1 was"... going to the operating room for ORIF bilateral periprosthetic proximal tibia fractures today." 7/5/23 - R1 was readmitted to the facility from the hospital. 7/5/23 - The facility's documented plan of correction as a result of the investigation was: - "the van driver [E18] was terminated; - root cause analysis - was determined to be related to driver's [E18] negligence by breaching his duty of care to the resident by not applying a restraint device when it was ordinary, prudent and reasonable. This action resulted in the resident sliding out of the wheelchair when the transportation van slowed down; - care plan changes - residents care plan was updated to include safe resident transport. Interventions for this goal was to have resident properly fastened in the wheelchair transportation vehicle; - systemic changes - trained drivers with best practices for loading and unloading non-ambulatory wheelchair passengers to safety. Specifically, all drivers returned demonstration of attaching the shoulder belt. Before each transport the driver must utilize wheelchair securement checklist to ensure residents are secured in transport vehicle." 2/26/24 10:23 AM - During an interview with E1 (DON, interim NHA), with E2 (ADON) and E4 (Corporate Clinical Specialist) present, "On 6/28/23, we received a call from the front desk asking if nurses could come to the parking lot STAT. We went outside and I [E1] saw [R1] sitting	F 689		

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F 689	Continued From page 15 in the van on the floor, the wheelchair was behind [R1] and [R1] was half lying and half sitting, and both legs were crooked and bleeding. I immediately called 911 and we tried to stop the bleeding. R1 was asked if she was in any pain and R1 denied pain. R1 did say that the van floor was hard on her back. I noticed that the wheelchair was stuck In the van and that R1 was not strapped in. I immediately asked the driver [E18] if he strapped [R1] in, he said that he did not and that he didn't know why he did not. I called her daughter... We did vital signs which were normal and wrapped her legs to stop the bleeding. The fire company was here quickly - they got here before the paramedics". 2/26/24 2:53 PM - During a follow-up interview with E1, with E2 and E4 present, the plan of correction was initiated on 6/28/23 and completed on 7/5/23. 2/26/24 at 2:55 PM - Based on the Surveyor's review of the facility's thorough investigation, documented response, completion of audits from 7/7/23 to 11/24/23, staff interviews and no further transportation incidents, R1's accident was determined to be past non-compliance harm. 2/26/24 3:15 PM - Findings were reviewed at the exit conference with E1, E2 and E4.	F 689		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.	F 712		4/1/24

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F 712	Continued From page 16 §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R195) out of one resident reviewed for physician services, the facility failed to ensure that R195 was seen for the required physician visits. Findings include: Review of R195's clinical record revealed: 4/30/2019 - R195 was admitted to the facility. Review of the electronic medical record (EMR), revealed the following alternating physician/ nurse practitioner visits were made to R195 from June 2022 thru February 3, 2023: 6/3/22 - E3 (MD) 8/3/22 - E30 (NP) 9/21/22 - E30 12/7/22 - E30 2/3/23 - E30. E3 did not visit the R195 in October 2022, which	F 712	Corrective Action: Corrective actions have been ensured by the Director of Nursing. R195 is no longer a resident in this facility. The Director of Nursing/Designee has completed education with the Medical Director to prevent a recurrence of this concern. Identification of other residents: All residents have the potential to be affected by this concern. In order to prevent other residents from being affected the Medical Director has been educated on the regulation. A 100% audit was completed on all current residents to ensure that they were seen by a physician at a minimum of every 30 days for the first 90 days, then every 60 days thereafter. The audit revealed that all residents currently in the facility have been seen by	

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F 712	Continued From page 17 was the month R195 should have received a required physician visit. 2/26/24 3:15 PM - Finding was reviewed at the exit conference with E1 (DON, Interim NHA), E2 (ADON), and E4 (Clinical Specialist).	F 712	a physician at the required frequency. System changes: The root cause of this concern was the failure of a physician to see R195 every 60 days. The contracted company that provides physician services was contacted and an electronic tracking system for physician visits has been implemented. Success Evaluation: The Director of Nursing/designee completed an audit of all current resident's physician visits to ensure all residents are seen by the physician per regulation guidelines. Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		4/1/24

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F 761	Continued From page 18 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that for one (R36) out of twenty-six medication administration observations, the facility failed to provide accurate labeling to facilitate consideration of precautions and safe administration. For (R36), the medication label was not updated with the new order. Findings include: 2/23/24 8:31 AM - During an observation with E17 (LPN) for medication administration, the medication packet label for quetiapine Seroquel a medication used to treat certain mental/mood disorders was noted to read as quetiapine 25 MG tablet - give 1 tablet by mouth 3 times a day. However, the order and MAR (medication	F 761	Corrective Action: Corrective actions have been ensured by the Director of Nursing. R17 is a resident in the facility. The medication Drug Label for Resident R17 has been updated by the Pharmacy and is now accurate per the current Physician order. The Physician was notified that the previous label was incorrect, and that this has now been corrected. Identification of Other Residents:	

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F 761	Continued From page 19 administration record) documented that the order was updated to be given two times a day beginning 1/29/24. During the observation E17 was interviewed and it was revealed the label should have been updated to reflect the change. E17 did confirm the new versus old order. 2/26/24 - During an interview E16 (LPN) revealed that when there is a medication change, the nurse who receives the communication would have been responsible for placing an "FYI label" on the medication packet. Then when it's time for a new blister pack, the medication will come from the pharmacy with a changed label. The change would also be documented in a "communication log book" and the change would be communicated to each shift and for multiple days "until everyone knows about it". 2/26/24 3:15 PM - Findings were reviewed at the exit conference with E1 (DON, Interim NHA), E2 ADON, and E4 (Clinical Specialist).	F 761	All Residents have the potential to be affected. In order to prevent other residents from being affected, all nursing and staff members were educated on the requirements regarding updating medication labeling. A 100% audit of all medication carts was completed to ensure accurate medication labels were present for all current residents. No new concerns regarding medication labeling were noted as a result of this audit. System Changes: The Root Cause of the concern was a failure to adhere to the "Labeling of Medication Containers" policy and to ensure that the medication label was accurate based on the current physician order. The facility policy for "Labeling of Medication Containers" was reviewed and found to meet professional standards. The facility system for daily clinical review meeting has been updated to include a review of all change in medication dosages or administration parameters to ensure that an updated medication label has been obtained from the pharmacy and while waiting for it to be delivered place an "Order changed see MAR" label directly on the medication. The Director of Nursing or Designee will complete education for all nursing and staff members on the requirements regarding medication labeling. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation:	

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F 761	Continued From page 20	F 761	An initial 100% audit of all medication carts for medication storage in order to ensure accurate medication labels for all current residents has been completed. Subsequent Audits of a random sample of a minimum of 10% of resident medication storage will be completed by the Director of Nursing or Designee to ensure accurate medication labels for all residents; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was	F 804	Corrective Action:	4/1/24

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	085060	A. BUILDING _____ B. WING _____	C 02/26/2024

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FOULK LIVING	1212 FOULK ROAD WILMINGTON, DE 19803

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F 804	Continued From page 21 determined that for one (R18) out of one reviewed for food, the facility failed to maintain appetizing food temperatures for food trays that are delivered to third floor residents in their rooms. Findings include: R18's clinical record revealed: 3/24/23 - R18 was admitted to the facility. 2/7/24 - E3 (MD) updated R18's diet order to regular diet, regular texture and regular/thin liquid consistency. 2/21/24 3:28 PM - During an interview, R18 stated that she takes all her meals in her room and her, "food is delivered cold all the time". 2/23/24 11:30 AM - The Surveyor went to the kitchen to request a test lunch tray for the hot entrée. 2/23/24 12:07 PM - The Surveyor observed food being plated for the third floor food truck. 2/23/24 12:35 PM - The third floor food truck arrived on the third floor. 2/23/24 12:36 PM- The Surveyor and E25 (Food Service Director) observed the CNAs delivering food trays to the residents in the dining room. 2/23/24 12:52 PM - The Surveyor and E25 observed food tray being delivered to room 317. 2/23/24 12:55 PM - The Surveyor and E25 observed food tray being delivered to room 306. 2/23/24 12:59 PM - The Surveyor and E25	F 804	Corrective actions have been ensured by the Director of Nursing and the Food and Beverage Director. It is the policy of Foulk Living to ensure that food has nutritive value, appearance, and is palatable and at the preferred temperature. R18 remains a resident in our facility. Identification of Other Residents: All Residents have the potential to be affected. In order to prevent other residents from being affected, the Food and Beverage director or designee will ensure that the food trays are delivered to those residents who eat in their rooms prior to distributing the food trays to the residents in the dining room to ensure that food is palatable and at the preferred temperature. System Changes: The Root Cause of the concern was a failure to maintain appetizing food temperatures for a food tray that was delivered to R18 in their room. The facility system for delivering trays to resident rooms was updated. The food trays will be delivered to those residents who eat in their room prior to distributing food trays to those residents in the dining room. The Food and Beverage Director or Designee will provide oversight to ensure ongoing compliance. Success Evaluation: An audit of the food delivery system will be completed by the Unit Manager/Supervisor/Designee to ensure that the trays are delivered first to those	

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F 804	Continued From page 22 observed food tray being delivered to R18's room. 2/23/24 12:59 PM - E25 obtained food temperatures for the test tray. The salmon tested at 121 degrees F (Fahrenheit), the rice at 118 degrees F, the soup at 123 degrees F and the vegetables at 127 degrees F. 2/23/24 1:00 PM - The Surveyor tasted the food tray. The food was presented in a very appetizing manner; however the salmon, rice and veggies was were very unpalatable as they were cool. The soup was also cool to taste and therefore, not enjoyable. 2/26/24 3:15 PM - Findings were reviewed at the exit conference with E1 (DON, Interim NHA), E2 (ADON) and E4 (Corporate Clinical Specialist).	F 804	residents who eat in their room. This audit will have a goal of 100% compliance. Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team at the Quality Assurance meeting.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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. §483.60(i)(2) - Store, prepare, distribute and	F 812		4/1/24

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F 812	Continued From page 23 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of other documentation, it was determined that the facility failed to ensure food was stored in a sanitary manner; failed to ensure the dishwasher operated at the correct temperature level to sanitize the residents' dishes; failed to maintain dishwasher temperature logs; failed to ensure food stored in a container was maintained in a clean and sanitary manner and failed to ensure the kitchen area was maintained in a sanitary condition, and failed to maintain refrigerator temperature logs. Findings include: Review of the facility policy for Preventing Foodborne Illness, last updated 2017 indicated, "Food and nutrition employees will follow appropriate hygiene and sanitary procedures to prevent the spread of food borne illness...Employee's must wash their hands...Functioning of the refrigeration and food temperatures will be monitored." 1. During the follow up tour conducted on 2/20/24 at 11:30 AM the following was observed: -Empty soap dispenser at the hand washing sink in the food preparation area with slow drain and pooling water. -Wall adjacent to the hand washing sink in the food preparation area visible black substance on wall and wall and siding separating. -E25 (FSD) and E27 (cook) observed without beard restraints. -E26 (cook) wearing hair unsecured and on collar. -Flour handle inside bin, not on holder	F 812	Corrective Action: Corrective action has been ensured by the Administrator and Director of Food and Beverage. Education was conducted for all employees who handle food. Education included maintaining temperature logs, handwashing techniques, the handling/storage of food to prevent foodborne illness, monitoring/documenting dishwasher temperature to ensure sanitization of utensils/dishes, the requirement to wear beard restraints and to secure hair off collar. The dishwasher was repaired and can reach temperatures required for heat sanitization (165 degrees). Repairs have been scheduled to cover the exposed wall to ensure closure of gap(s). Repairs have been scheduled with the plumber to alleviate the pooling of water in the handwashing sink in the food preparation area. The black substance adjacent to the hand washing sink in the food preparation area was professionally removed by ServePro. All dietary employees are wearing beard restraints. All dietary employees are securing their hair with hair nets. The flour handle has been removed from the bin. All employees were educated on keeping the handle in the holder.	

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F 812	Continued From page 24 immediately confirmed by E28 (dietary staff) -February 2024 Production refrigerator near kitchen line temperature log last dated as completed on 2/8/24. 2. During a second follow up tour conducted 2/21/24 at 9:33 AM the following was observed: -E25 (FSD), E29 (dishwasher) and E27 (cook) observed without beard restraints. -E26 (cook) observed wearing hair unsecured and on collar. 3. During observation of the function of the facility's dish machine on 2/21/24 at 9:41 AM - 10:09 AM the facility dish machine failed to reach temperatures required for heat sanitization of 165 degrees. E25 confirmed that the facility used a high temperature process dish sanitization. E25 then reported that the dish machine function display screen "has been malfunctioning off and on and that the facility did not have a maximum registering thermometer to run through the dish washing cycle." During repeated dish washing cycles the following was observed: - 9:51 AM - 9:54 AM Wash cycle 133 degree's and rinse cycle 115 degree's. second wash 135 45 seconds. -9:55 AM -9:56 AM Wash cycle 126 degree's, rinse cycle 118 degrees with display screen reading"warning too low", wash cycle 126 degree warning too low, rinse cycle 113. -9:57 AM - 9:58 AM Wash cycle 131 degree's, rinse cycle 133 degree's. -9:59 AM - 10:01 AM Wash cycle 141 -139 degree fluctuation. -10:02 AM - 10:03 AM Wash cycle 149 -150 degree's, rinse cycle 155 - 157 degree's. -10:04 AM - 10:06 AM Wash cycle 156-159 degree fluctuation.	F 812	Identification of Other Residents: All Residents have the potential to be affected. The Food and Beverage Director/Designee will ensure that education will be ongoing with current and newly hired staff to ensure that the kitchen is maintained in a sanitary manner through compliance with all food safety requirements. System Changes: The root cause of the concern was the failure of the dietary staff to ensure the following: that food was stored in a sanitary manner, that the dishwasher was being operated at the correct temperature level to sanitize the residents' dishes, that dishwasher/refrigerator temperature logs were maintained, that food was stored in a clean and sanitary manner, that the kitchen area was maintained in a sanitary condition (see above for specifics). The facility process for kitchen sanitation rounds was updated to include weekly rounds with the dietician and the Food and Beverage Director to ensure that the kitchen is being properly maintained and the above concerns have all been corrected. The facility policy for Preventing Foodborne Illness – Employee Hygiene and Sanitary Practice and Handwashing/Hand Hygiene were reviewed and found to meet professional standards. The Food and Beverage Director or Designee will complete	

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F 812	Continued From page 25 -10:09 AM - E25 stated that "When this happens repeatedly we sanitize again using chemicals. I'm going to call and try to get someone out". Observations from both follow up kitchen visits were discussed and E25 confirmed the findings. 2/21/24 11:07 AM - Review of maintenance records revealed service calls and completion of repairs to the facility's dish machine on the following dates: 10/2/23 ,11/7/23,11/16/23, 11/17/23 and 1/21/24. 2/21/24 11:30 AM - Review of dish machine temperature logs revealed the following: -December 2023 lacked evidence of log entries from 12/4/23 - 12/20/23, then 12/22/23-12/31/23. A hand handwritten note on the log indicated, "Display Malfunctioning" in the spaces without entries. -January 2024 lacked evidence of log entries on 1/4, 1/11, 1/12, 1/14 -1/21 and 1/23-1/31. -February 2024 lacked evidence of log entries from 2/1 - 2/15, 2/17 and 2/18. 2/21/24 1:51 PM - Kitchen tour findings were reviewed with E1 (DON) who reported maintenance workers have been contacted regarding dish washing machine repairs. 2/22/24 - A maintenance repair person repaired the facility dishwashing machine. The report documented "Not hitting temperature, and rinse motor running constantly...replaced the main control board as it was faulty. Machine is now hitting temperature...". 2/26/24 3:15 PM Findings were reviewed at the exit conference with E1 (DON, Interim NHA), E2 ADON, and E4 (Clinical Specialist).	F 812	education for all dietary staff regarding appropriate standards for kitchen sanitation and hand hygiene, including ensuring that the kitchen handwashing sink is in working order in accordance with proper sanitary standards and all other areas of the kitchen (storage and equipment) are maintained in good repair. The Food and Beverage Director or Designee will provide oversight to ensure ongoing compliance. Success Evaluation: An audit to ensure compliance with kitchen sanitation and employee hygiene standards was completed by the Food and Beverage Director/Designee. An additional audit was completed to include the kitchen handwashing sink is in working order and good repair without any sanitation concerns. An ongoing audit will also be conducted by the Food and Beverage Director/designee to ensure all sanitation concerns are maintained. Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team at the Quality Assurance meeting.	

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