POC Approved
December 13, 2021
Debbie Freeman, RN

Debra Freeman

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FORM APPROVED

Alabama Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D6206	A. BUILDING: _____ B. WING _____	11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERANDA SUITES, THE	165 LANDING LANE DADEVILLE, AL 36853

(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) COMPLETE DATE
A 000	Initial Comments On November 3, 2021, an unannounced licensure survey and complaint investigation was conducted for this 30 bed Assisted Living Facility (ALF) with a census of 22. There was one (1) complaint investigated during this survey. Intake ID: 20211018016 was unsubstantiated. Deficiencies were cited during this survey for failure to operate in accordance with the Rules of the Alabama State Board of Health (SBOH), Alabama Department of Public Health (ADPH), Chapter 420-5-4, Alabama Administrative Code, for Assisted Living Facilities. The deficiencies cited pose a risk or potential risk of harm to the residents and requires a plan of correction.	A 000		
A 401	420-5-4-.04 (1) (2) Personnel. Personnel. (1) An assisted living facility shall ensure personnel are employed and on duty to meet the care and safety needs of all residents 24 hours a day, 7 days a week. (a) An assisted living facility shall be staffed at all times by at least one individual who has a current certification in cardiopulmonary resuscitation (CPR). (b) An assisted living facility must be staffed to ensure the safe evacuation of all residents in the event of a fire or emergency. (2) Employee Schedule. An assisted living facility shall post a schedule of employees indicating names and days and hours scheduled	A 401		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jan Henry

TITLE: administrator

(X6) DATE: 12-6-2021

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A 401	Continued From page 1 to work. This schedule shall be retained in the facility for 6 months after use. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility was not staffed at all times with at least one (1) individual who was currently certified in cardiopulmonary resuscitation (CPR). Findings: On November 2, 2021, the surveyor reviewed the employee work schedules (October 2021 and November 2021) and employee files with Employee Identifier (EI)#1, Administrator. A review of the documents revealed the facility was not always staffed with at least one (1) individual certified in CPR on second shift (3 PM - 11 PM). EI#1 informed the surveyor one of the second shift Resident Aide's (EI#7), was attending a CPR renewal class today. At the conclusion of the survey, EI#1 provided the surveyor with supporting evidence the CPR course had been successfully completed by EI#7 on November 2, 2021, which would, adequately cover second shift.	A 401	1] A 401 420-5-4-.04 (1) (2) Personnel 2] The corrective action taken in response was to immediately send Emp#7 to a CPR class performed at the Alexander City Fire dept. wherein she returned with her certification. 3] An additional employee who is in training to assist in floor duties has also been qualified and both of their certifications are on file in their employee file. 4] To try and avoid this issue in the future, the Administrator will work toward setting up schedules for incoming prospective employees to be certified prior to any shift assignment, other than training, and try and establish a computer notification alert to give a 90 day advanced notice of forthcoming CPR requirements. 5] All things regulatory will wind up on the Administrator's desk regardless and it will ultimately be her that manages the final administration.	Immediate 11/02/2021 Immediate Under constant review Perpetual
A 402	420-5-4-.04 (3) Personnel. (3) Employee Screening. (a) Prior to any resident contact, such as but not limited to assistance with activities of daily living, newly employed personnel shall have a physical examination certifying that the employee is free of signs and symptoms of infectious skin lesions and diseases that are capable of	A 402		

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A 402	Continued From page 2 transmission to residents through normal staff to resident contact. Employees who develop signs or symptoms of infectious skin lesions or diseases that would be capable of transmission to residents through normal staff to resident contact shall not be permitted to have resident contact until free from such signs and symptoms. (b) Not more than 30 days prior to any resident contact, newly employed personnel shall be properly evaluated for tuberculosis. (c) Vaccines. Assisted living facilities shall immunize employees in accordance with current recommended Centers for Disease Control and Prevention (CDC) guidelines (www.cdc.gov/vaccines). Any particular vaccination requirement may be waived or delayed by the State Health Officer in the event of a vaccine shortage. (d) An assisted living facility shall not hire an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure all employees were properly screened prior to working at the facility. Findings: On November 2, 2021, the surveyor reviewed the employee files with EI#1, Administrator. A review of EI#8's file revealed EI#8 was hired as a resident aide on May 21, 2020. However, the tuberculosis (TB) skin test was administered on	A 402		

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A 402	Continued From page 3 October 25, 2019, which was greater than 30 days prior to hire. EI#1 told the surveyor she (EI#1) thought this was incorrect and would follow up with the provider.	A 402	1] A 402 420-5-4-.04 (3) Personnel 2] After consultation with employee #8, and about her physician, it was determined *by her doctor* that because employee #8 was a re-hire and because she had previously had the TB test originally done within the past 12 months, that from the doctor's perspective, to re-test for TB at this point would have apparently been redundant, therefore the original test was deemed by her doctor as acceptable but **does not fall within the ADPH 30 day guideline**.	11/3/2021
A 403	420-5-4-.04 (4) Personnel. (4) Personnel Records. An assisted living facility shall maintain a personnel record for each employee. This record shall contain: (a) An application for employment which contains information regarding the employee's education, training, and experience. (b) Verification of current certification or licensure, if applicable. (c) Record of required physical examinations and vaccinations. (d) Verification the facility has not hired an individual whose name is on the Alabama Department of Public Health Nurse Aide Abuse Registry. (e) Date of hire. (f) Date of initial resident contact. (g) Date employment ceased. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain personnel files with all the required information.	A 403	3] A check of other employees files are being conducted to insure that no other employee falls into this timing issue. 4] Efforts are underway to create a newer more electronic oversight system 5] Unless she otherwise redirects someone else to oversee this, the Administrator will be responsible for this implementation and oversight.	ongoing Ongoing Perpetual

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A 403	Continued From page 4 Findings: The surveyor reviewed employee files with EI#1, Administrator, on November 2, 2021. The following resident aides did not have the date of initial resident contact documented in their personnel record; EI#7, EI#8, and EI#9.	A 403	1] A 403 420-5-4-.04 (4) Personnel 2] Files for identified employees have been reviewed and corrected as needed. 3] Currently, all employee files are being reviewed for all necessary date, certifications and training completed. 4] A review of processes is underway to research ways to electronically monitor files and compliance	11/03/2021 Ongoing
A 405	420-5-4-.04 (6) Personnel. (6) Training. (a) All staff who have contact with residents, including the administrator, shall have initial training prior to resident contact and refresher training annually and as necessary. Documentation of all staff training to include attendance records and any required post-test or evaluations shall be maintained in the facility. In addition to any information otherwise required by the facility's policies and procedures, the facility shall ensure that prior to resident contact, all staff members receive training on the subject matter listed below: 1. State law and rules on assisted living facilities. 2. Facility policies and procedures. 3. Resident rights. 4. Current certification from the American Heart Association or the American Red Cross in cardiopulmonary resuscitation (CPR) within 90 days of hire. 5. Identifying and reporting abuse, neglect, and exploitation.	A 405	5] In concert, all things regulatory are always under the direct auspices of the Administrator or her designate should she select one.	Perpetual

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A 405	Continued From page 5 6. Basic first aid. 7. Advance directives. 8. Protecting resident confidentiality. 9. Resident fire and environment safety. 10. Special needs of the elderly, mentally ill, and mentally retarded. 11. Safety and nutritional needs of the elderly. 12. Identifying signs and symptoms of dementia. (b) Cardiopulmonary Resuscitation. An assisted living facility shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in CPR. All employees of an assisted living facility who have contact with residents must be certified in CPR from the American Heart Association or the American Red Cross. New employees must obtain certification in CPR within 90 days of hire. An assisted living facility equipped with an automated external defibrillator (AED) shall be staffed at all times by at least one individual who has a current certification from the American Heart Association or the American Red Cross in AED utilization. Substitute training approved by the Department for use by emergency medical services personnel (EMSP) may be utilized in lieu of those courses or certifications offered by the American Heart Association or American Red Cross in CPR or AED utilization.	A 405		

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A 405	Continued From page 6 (c) If the facility admits or retains residents with special needs such as diabetes, hospice, or oxygen therapy, the facility shall provide staff with the appropriate training. (d) Continuing Education. All staff must receive annual continuing education sufficient to remain knowledgeable of the training specified above. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure all staff were certified in Cardiopulmonary Resuscitation (CPR) within 90 days of hire. Findings: The surveyor reviewed the employee files with EI#1, Administrator, on November 2, 2021, and found the following employees had worked at the facility greater than 90 days and currently were not certified in CPR: EI#7's date of hire was May 22, 2021, and was not certified until November 2, 2021. EI#9's date of hire was April 29, 2021, and certification was still pending. EI#1 told the surveyor it was an oversight on her (EI#1) part.	A 405	1] A 405 420-5-4-.04 (6) Personnel 2] Immediate corrective action taken by the Administrator was to have the remaining three, new employees certified in CPR. 3] As stated previously in this report, all employee's files are being reviewed in order to assess and evaluate their compliance. 4] The new planned for change of command to hopefully take place in January of 2022 will be able to take their youth, their electronic savvy and parlay that into a potentially more effective method of record keeping. 5] The Buck stops with the Administrator and whether or not she elects to maintain strict electronic records or whether or not to have paper backup, will be her decision.	11/3/2021 January 2022 projected Perpetual
A 611	420-5-4-.06 (4) (a) (b) Care of Residents. (4) Personal Care and Services. The	A 611		

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A 611	Continued From page 7 facility shall provide care and services consistent with community standards. (a) Portions of residents' records necessary for staff to provide care, including the plans of care and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. (b) Plan of Care. There shall be a written plan of care developed for each resident prior to or at the time of admission. The plan of care shall be based on the initial medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be reviewed and updated based on the annual examination, and all other physician examinations, diagnoses, and recommendations of the resident's treating physician, and the resident's monthly assessments. The plan of care shall be developed and updated in cooperation with the resident and, if appropriate, the sponsor. All entries on the plan of care shall be accurately dated. 1. The plan shall at all times reflect the current condition of the resident and document the personal care and services required from the facility by the resident. In addition to other items that may be required by the facility's own policies and procedures, the plan of care shall contain the following: 2. A listing of the resident's individual needs or problems that require intervention by the facility. 3. A listing of interventions provided by the facility to address the resident's identified	A 611		

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A 611	Continued From page 8 needs or problems. 4. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care for each resident receiving care from an outside provider. 5. Activities of Daily Living. Residents of assisted living facilities shall be assisted and encouraged to maintain a clean, well-kept personal appearance. Each facility shall provide all needed assistance with activities of daily living to each resident. (i) Bathing. Residents shall be offered a bath or partial bath or shall be assisted with a bath or partial bath daily, and more often when necessary or requested. (ii) Oral Hygiene. Residents shall be assisted with oral hygiene to keep mouth, teeth, or dentures clean. Measures shall be used to prevent dry, cracked lips. (iii) Hair. Resident's hair shall be kept clean, neat, and well groomed. (iv) Manicure. Fingernails and toenails shall be kept clean and trimmed. (v) Shaving. Men shall be assisted with shaving or shaved as necessary to keep them clean and well groomed. (vi) Personal Safety. Residents shall be provided assistance with personal safety. 6. As changes in medication and	A 611		

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A 611	Continued From page 9 personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to develop written plans of care that adequately addressed residents' care needs with appropriate interventions. In addition, the plans of care were not accessible to the direct care staff at all times. THIS IS A REPEAT DEFICIENCY FROM THE PREVIOUS SURVEY(S) CONDUCTED ON AUGUST 1, 2019, APRIL 19, 2017, AND JULY 3, 2014. Findings: Resident Identifier (RI)#3 RI#3 was admitted to the facility on March 14 2018, with diagnoses which included, Parkinson's disease, chronic atrial fibrillation (a-fib), hypertension, osteoarthritis left hip, chronic kidney disease stage 2, cerebral vascular accident (CVA), and urinary tract infections (UTI). RI#3 had been treated for three (3) UTI in recent months, with two (2) of those UTI requiring hospitalizations (June and August 2021). Refer to deficiency 621 for additional information. EI#2, RA, informed the surveyor the urine was cultured and the bacteria isolated was escherichia coli (E-coli). The care plan did not include interventions that would help prevent similar infections in the future. On June 15, 2021, RI#3	A 611	1] A 611 420-5-4-.06 (4) (a) (b) Care of Residents 2] Resident R#3 has been advised of how and why she has had multiple UTI issues. R#3 and her family arranged for her to have hip surgery which enhances her ability to properly care for herself. The Veranda does have written Plans of Care filled out by the resident's doctor as well as Care Plans prepared by the Administrator, and in conjunction with resident's families, further stating the expected outcome from our limited health care oversight. 3] Utilizing the doctor's Plan of Care, coupled with the internal Care Plan produced by Staff and upon arrival to The Veranda, Staff will use every caution to insure that we follow the doctor's Plan of Care as closely as possible and add any intervention oversight as can be determined by staff to as closely as possible maintain the instructions within that doctor's Plan of Care 4] Follow-up with her health care provider is currently under review. A weight loss issue was traced to an intentional effort by the staff at Rehab to drop her weight in an effort to reduce hip pain. Efforts are underway to try and acquire any documentation relative to reasoning and for continued oversight. 5] It is the Administrator or her designate's responsibility to oversee and impliment doctor's Plan's of Care and try and insure through internal Care Plan's that instructions are followed.	Throughout November 2021 Upon admission Ongoing and perpetual Under review Perpetual

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A 611	Continued From page 10 was hospitalized for a UTI and a-fib. RI#3 returned to the facility on June 28, 2021, and was found to have an 11 pound weight loss (145 lbs to 134 lbs). Based on the October 2021 weight log RI#3 had lost another four (4) pounds (134 to 130). The care plan was not updated with appropriate weight loss interventions. EI#1 informed the surveyor RI#3 was intentionally trying to keep the weight off, however, there was not a statement from RI#3's physician giving approval for the weight loss. RI#4 RI#4 was a new admission to the facility on October 13, 2021. RI#4 had a significant past medical history of chronic obstructive pulmonary disease, (COPD), hypertension, paroxysmal atrial fibrillation, pacemaker, and dementia. RI#4 was scheduled to have Ipratropium Albuterol nebulizer treatments three (3) times a day. The care plan did not address this chronic conditions with appropriate interventions if a COPD exacerbation should occur. During interviews with EI#1, Administrator, and EI#2, Administrative Designee, the surveyor learned the resident aides (RA) did not have access to the facility's document titled, "ADL CARE PLAN - MONTHLY ASSESSMENT." EI#1 told the surveyor these individualized resident care documents were kept in a locked room because they would come up missing. The surveyor reinforced the importance of having these written plans of care accessible for the RA at all times. EI#1 and EI#2 verbalized understanding and agreed to comply by placing them in an area that would be accessible to all care staff 24/7.	A 611	(continued) 1] A 611 420-5-4-.06 (4) (a) (b) Care of Residents 2] Communicating with R#3's Physician requesting supporting documentation relative to resident's weight loss while in Rehab. 3] As soon as documentation is in hand, updates to resident's file will be completed along with Physician's approval of weight loss. 4] Changes to procedure include that after any Dr's visit and or hospitalization, the Administrator will attempt to as quickly as possible request any and all records which could be important to resident's future care. 5] The Administrator of record or their designate will be responsible for this follow-up RI#4 1] RI#4 had a **Doctor's order** on file requiring a specified three (3) times a day treatment protocol for his breathing treatments. There were no PRN orders 2] The resident's Care Plan was formulated to as closely as possible mirror the orders from Resident's Doctor, thus, there were no orders on file allowing for individual employee decision making or interventions relative to treatment frequency or timing. 3] Within 5 days of Surveyor inspection, RI#4 was dismissed to family and subsequently, as we understand it, moved along with his wife into a memory care unit in Auburn. 4] Administrator had made duplicates of Care Plans and made accessible in kitchen area for employee viewing when needed. 5] The Administrator will make oversight of these files a common part of her weekly records review.	Ongoing as speed with which Physician's have time to comply with request vary from practice to practice. Perpetual 11/03/2021 11/08/2021 11/05/2021 Perpetual

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A 621	Continued From page 11	A 621		
A 621	420-5-4-.06 (11) (b) Care of Residents. (b) Retention 1. An assisted living facility shall not allow any resident to return to the assisted living facility from a higher level of care if that resident requires care that exceeds the level of care the facility is licensed to provide or the facility is capable of providing. 2. An assisted living facility shall not retain a resident that has symptoms or behaviors that infringe on the rights or safety of residents currently in the facility. 3. Residents who have unmanageable behaviors or behaviors that may be dangerous to themselves or others shall not be retained in an assisted living facility. 4. An assisted living facility shall not retain a resident who requires medical or skilled nursing care which is expected to exceed 90 days unless: (i) The individual is capable of performing and does perform all tasks related to his or her own care; OR (ii) The individual is incapable of performing some or all tasks related to his or her own care due to limitations of mobility or dexterity BUT the individual has sufficient cognitive ability to direct his or her own care AND the individual is able to direct others and does direct others to provide the physical assistance needed to complete such tasks, AND the facility staff is capable of providing such assistance and does	A 621		

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A 621	Continued From page 12	A 621		

provide such assistance. If the facility chooses to offer this assistance, the facility shall develop and implement a policy and procedure to ensure safe practices by facility staff.

5. If a resident of an assisted living facility is diagnosed with a terminal illness other than dementia and requires hospice care, the resident may be admitted to a properly licensed and certified hospice program. A resident receiving hospice care may remain in the facility beyond 90 days. If the facility is unable or becomes unable to meet the needs of a resident receiving hospice care, or if a resident receiving hospice care requires care beyond what the facility may lawfully provide pursuant to this section, then the facility shall promptly make arrangements to discharge or transfer the resident to a safe and appropriate placement in accordance with the discharge procedures and prearranged plan required by these rules for assisted living facilities.

The facility would in all cases remain responsible for ensuring the appropriate delivery of care and must take all necessary steps to ensure that care needed by a resident is delivered to the resident.

6. All skilled services provided in the facility, such as but not limited to wound care or insertion of a urinary catheter, shall be provided by the staff of properly licensed or certified agencies. Skilled services shall not be delegated to facility staff.

7. Residents that develop acute infectious pulmonary disease, such as active tuberculosis, or other diseases capable of

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A 621	Continued From page 13 transmission to other individuals through normal person-to-person contact shall be immediately transferred to an appropriate level of care until certified by a physician to be free of a contagious condition. 8. No assisted living facility shall be operated in whole or in part in a manner that prevents free and unhindered egress from the facility by any of its residents. 9. An assisted living facility shall not retain any resident who cannot safely reside in the facility unless his or her egress from the facility is restricted. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that when a resident returned from the hospital the resident did not continue to require a level of care they are not licensed to provide. Findings: RI#3 had been treated with oral antibiotics for three (3) urinary tract infections (UTI) since June 2021. On August 20, 2021, RI#3's primary care provider admitted her/him to the local hospital for intravenous (IV) antibiotics. RI#3 returned to the facility on August 23, 2021, with a venous access device (saline lock) in place for intermittent infusion of antibiotics. The physician had written an order for home health to infuse three (3) doses of an antibiotic (ertapenem) used to treat severe infections. EI#2, RA, told the surveyor she (EI#2) received report from the case manager at the time of RI#3's discharge, but she (EI#2) was not informed the saline lock was not going to be	A 621	1] A 621 420-5-4-.06 (11) (b) Care of Residents 2] As stated, RI#3 returned from the hospital with a Saline Lock device as ordered by her physician and RI#3 was fully back into the facility when it became obvious that home health was coming in to provide the infusions as ordered by resident's doctor. 3] While this is the first time we've experienced this, we are reviewing other resident's records to insure no-one else is affected. 4] Protocol's are in place to monitor resident's who are returning from hospital visits and their re-entry to ALF campus to be met with the same diligence as that generally reserved for a new resident. 5] As with all Protocol, it will be the responsibility of the Administrator or their designate.	Ongoing as needed Perpetual

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A 621	Continued From page 14 discontinued. EI#2 said she (EI#2) was not aware the saline lock was present until RI#3 was already back at the facility. EI#2 said the home health nurse administered the IV antibodies on August 24, 25, and 26, 2021, without complications.	A 621		
A 702	420-5-4-.07 (2) Food Service (2) Food Handling Procedures. (a) Dish and Utensils Washing, Disinfection, and Storage. 1. Wash water shall be changed with sufficient frequency to avoid gross contamination, and final rinse water shall be kept clean and clear. 2. Hand washed repeated service and multi-service utensils and dishes, after washing and rinsing, shall be sanitized by either of the following methods: (i) Utensils and dishes shall be completely immersed for a period of not less than 30 seconds in water that is at least 171 degrees Fahrenheit (pouring scalding water over utensils and dishes does not meet this requirement); or (ii) A cold water sanitizer. A sanitizing solution shall be used in accordance with manufacturer's instructions. Utensils and dishes shall be completely immersed for a period of not less than 10 seconds in a clean solution containing not less than 50 ppm, and not more than 200 ppm, of available chlorine bleach, or 30 seconds in 12.5 ppm of iodine or the amount of time set by the manufacturer in a 200 ppm quaternary ammonium solution. Water	A 702		

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temperature must be at least 75 degrees Fahrenheit. Water temperatures and chemical concentrations shall be monitored and documented prior to dishwashing. A record of each test shall be maintained for at least three months.

3. Dishes and utensils shall be allowed to air dry.

4. After washing, rinsing, sanitizing, and air-drying, all repeated use service ware (utensils and dishes) shall be stored in a clean, dry place that is protected from pests, dust, splash, and other contaminants. Utensils shall be handled in such a way as to prevent contamination from hands and clothing.

5. The results from the use of dishwashing machines shall be equivalent to those obtained from the method outlined above, as documented in material provided from the manufacturer and kept on file at the facility.

(b) Ice. Crushed or chipped ice shall be protected from splash, drip, and hand contamination during storage and service. The ice scoop may be stored in the ice bin in a manner to prevent ice from coming into contact with the handle, or it may be stored in an airtight container outside the ice bin.

(c) Protection of Food from Contamination.

1. Food and food ingredients shall be stored, handled, and served so as to be protected from pests, dust, rodents, droplet infection, unsanitary handling, overhead leakage, sewage

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A 702	Continued From page 16 back flow, and any other contamination. Sugar, syrup, and condiment receptacles shall be provided with lids and shall be kept covered when not in use. 2. Medications, biologicals, poisons, detergents, and cleaning supplies shall not be kept in the refrigerator or in other areas used for storage of food. 3. Food shall not be stored on the floor. All food and food ingredients stored on shelving must be placed on shelving that is at least six inches above the floor. 4. Refrigerators shall maintain a maximum temperature of 41 degrees Fahrenheit. Freezers shall be maintained at a maximum temperature of 0 degrees Fahrenheit. Thermometers shall remain in refrigerators and freezers at all times. 5. All leftover foods shall be labeled and dated with a "use by date", so that it may be consumed or discarded by that date, which is no more than 3 days from the date it was prepared. 6. All food products shall be used by the manufacturer's indicated date or discarded. 7. Food shall be prepared either in the licensed facility or another location even when that location is not part of the licensed facility. All food preparation areas used by the facility shall be subject to the same inspections as though part of the licensed facility. The licensed facility is responsible to ensure adequate equipment and measures are used to ensure that food is not contaminated in transport and that foods that are	A 702		

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transported are held and served at the appropriate temperatures at all times.

8. Hot food shall be maintained at a minimum of 135 degrees Fahrenheit and cold foods at a maximum 41 degrees Fahrenheit.

9. Frozen food items (raw and cooked) shall be thawed under refrigeration or under running water prior to preparation. Frozen food may also be thawed as part of the cooking process when indicated by package directions. Raw meats shall be stored below and away from vegetables, fruits, and other foods to prevent contamination (meat juices dripping on other foods).

10. Laundry shall not be brought through the food preparation or service area.

(d) Storage and Service of Milk and Ice Cream.

1. Milk and fluid milk products shall be served only from the original containers in which they were received from the distributor. This shall not apply to cream for coffee, cereals, and milk for milk drinks which may be dispensed from a readily cleanable container approved for such use.

2. Milk and fluid milk products shall be stored in such a manner that bottles or containers, from which the milk or milk product is to be poured or drunk, will not become contaminated from drip or contact with foods. Milk shall be maintained and stored at a maximum temperature of 41 degrees Fahrenheit and shall not be served at a temperature warmer

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A 702	Continued From page 18 than 45 degrees Fahrenheit unless specifically requested to be served at a warmer temperature by a resident. 3. Contaminating substances shall not be stored with or over open containers of ice cream. Ice cream dippers, spatulas, and other serving utensils shall be cleaned between uses. (e) Kitchen Garbage and Trash Handling. 1. Kitchen garbage and trash shall be placed in suitable containers with tight-fitting lids and properly stored pending removal. Kitchen garbage and trash shall not be allowed to accumulate in the kitchen and shall be removed from the premises at frequent intervals. 2. After being emptied, all garbage cans and trash cans shall be washed and dried before reuse. (f) Employees' Cleanliness. 1. Employees engaged in the handling, preparation, and serving of food shall wear clean clothing at all times. Employees shall wear hair restraints, for example, hairnets, headbands, caps, or other adequate means to prevent contamination of food from hair. Employees whose duties include contact with residents shall change clothing or wear a clean covering over clothing before handling, preparing, or serving food. 2. Employees handling food shall wash their hands thoroughly before starting work each day, immediately after contact with any soiled	A 702		

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A 702	Continued From page 19 matter, and before returning to work after each visit to the rest room. 3. Street clothing not worn by the employee shall be stored in lockers, dressing rooms, or closets designated for staff use. (g) Live Fowl or Animals. Live fowl or animals shall not be allowed in the food service area. (h) Smoking and Spitting. Smoking, other use of tobacco products, and spitting within the food service area shall be prohibited for all staff, residents, and visitors. (i) Dining in Kitchen. Dining in the kitchen shall not be permitted in congregate assisted living facilities. (j) Paper for Food Wrapping. Only new paper, foil, or plastic wrap shall be used for wrapping of foods. (k) Laundering of clothing shall not be permitted in food preparation or service areas. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the dishes were properly sanitized by using the correct temperate of water in the dishwasher. THIS IS A REPEAT DEFICIENCY FROM THE PREVIOUS SURVEY CONDUCTED ON AUGUST 1, 2019. Findings:	A 702		

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A 702	Continued From page 20 The surveyor toured the kitchen with EI#5, Cook, on the afternoon of November 2, 2021. The surveyor asked EI#5 how the dishes were sanitized. EI#5 said the dishwasher used high temperatures to sanitize the dishes. However, the rinse temperatures recorded on the log for the month of October and November 2021 were inadequate. The temperatures were measured and recorded in Celsius (C) but did not reach the required 171 degrees Fahrenheit (77.2 degrees C). The next morning EI#2, Administrator Designee, informed the surveyor she (EI#2) had adjusted the booster water heater and the temperature was now hot enough to sanitize the dishes. On November 3, 2021, the surveyor and EI#2 observed the rinse temperature to reach 191 degrees Fahrenheit.	A 702	1] A 702 420-5-4-.07 (2) Food Service 2] EI#2 (Administrator Designate) reprogrammed the dish washer to read in Fahrenheit rather than Celsius all the while increasing the temperature to not only the required 171, from the 169 degrees that it was reading during the survey, but to 191 degrees F. 3] The cooks have both been re-energized to understand the dish washing controls and how to adjust them or when to ask for assistance so that someone else could do it for them. 4] The head cook has been instructed to provide daily readings for both the dish washer and refrigerator. 5] The Administrator or her designate will need to start auditing the temperature records on a weekly basis and sign off on it's accuracy.	corrected at time of survey ongoing and Perputual
A 703	420-5-4-.07 (3) Food Service. (3) Dietary Service. (a) Number of Meals. No fewer than three meals shall be provided each 24 hours. Food service shall be provided in a resident's room during temporary illness if necessary. The diet shall be well-balanced, palatable, properly prepared, and sufficient in quantity and quality to meet the nutritional needs of the residents in accordance with Dietary Reference Intakes of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. The food must be adapted in type and preparation to the habits, preferences, and physical abilities of the residents. (b) Timing of Meals. A time schedule for serving meals to residents and personnel shall be	A 703		

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established. Meals shall be served approximately five hours apart with no more than 14 hours between the evening meal and breakfast. The time schedule of meals shall be posted with the menu. The facility shall make evening snacks available after service of the evening meal. The facility shall provide fluids throughout the day and shall make between-meal nourishment (snacks) available.

(c) Menu. The menu shall be planned and written at least 1 week in advance. The current week's menu shall be posted in the food service area and shall be kept on file for the following 2 weeks. For any resident with a physician's order for a therapeutic diet, the facility shall have a copy of the diet and the facility shall document the adjustment of its menu to accommodate the resident's needs.

(d) Alternate food selections or substitutes shall be made available to all residents.

(e) A facility shall not obtain food from charitable organizations. A facility shall not avoid serving a meal by sending or transporting residents to missions, soup kitchens, or other charitable facilities for meals.

(f) The amount of food on hand shall be sufficient to serve three meals per day to all residents for 3 days. Non-perishable food and potable water shall be maintained in the facility in sufficient quantity to serve three meals per day to all residents for 3 days.

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A 703	Continued From page 22 This Rule is not met as evidenced by: Based on observation and interview the facility failed to post the time schedule of meals with the menu. Findings: During the initial tour of the facility on November 2, 2021 at 7:28 AM, the surveyor did not see the meal times posted for breakfast, lunch, or dinner. The surveyor brought this to the attention of EI#1. EI#1 explained the posting was inadvertently taken down while decorating for the fall holidays. EI#1 immediately retrieved the framed meal times schedule and placed in the dining room.	A 703	1] A 703 420-5-4-.07 (3) Food Service 2] Meal times are posted as a part of all menu's and which were posted and prevelent, however, the actual framed posting of meal times was missing. 3] The time postings were replaced at time of survey and will be monitored to isnure their presence 4] An alternate posting is being currently considered. 5] The Administrator in concert with the senior cook will be responsible.	Corrected immediately by Bus. Mgr. Perpetual
A 804	420-5-4-.08 (4) Physical Facilities. (4) Food Service Facilities. (a) Floors. Floors in food service areas shall be of such construction as to be easily cleaned, sound, smooth, non-absorbent, without cracks or crevices, and shall be provided with approved and conveniently located facilities for the disposal of floor wash water. (b) Walls and Ceilings. Walls and ceilings of food service areas shall be of tight and substantial construction, and smoothly finished. The walls and ceilings shall be without horizontal ledges and shall be washable up to the highest level reached by splash and spray. Roofs and walls shall be maintained free of leaks. All openings to the exterior shall be provided with doors or windows which prevent the entrance of rain or dust during inclement weather.	A 804		

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A 804	Continued From page 23 (c) Screens or Outside Openings. Openings to the outside shall be effectively screened, or suitable provisions made equal to screening (such as fly fans). Screen doors shall be equipped with self-closing devices. (d) Lighting. The kitchen, dishwashing area and the dining room shall have adequate light. (e) Ventilation. Vent/exhaust hoods, vented to the outdoors, shall be provided over cooking surfaces to aid in removing cooking odors. Existing recirculating vent hoods in Family facilities may remain in use when filters are cleaned or replaced regularly to prevent excess grease accumulation. Group assisted living facilities with residential stoves may use a residential hood sized for the stove. Commercial exhaust hoods shall be installed when commercial cooking equipment is used. Congregate facilities shall use a commercial exhaust hood system. (f) Employee Toilet Facilities. Toilet rooms, if provided, shall not open directly into any room or space in which food is prepared, stored, displayed, or served, nor into any room in which utensils are washed or stored. Toilet rooms shall include a lavatory and shall be well lighted and ventilated. (g) Hand Washing Facilities. Each Group and Congregate assisted living facility shall provide a hand washing lavatory in the kitchens which shall be equipped with a soap dispenser and a supply of soap, disposable towels, and hot and cold running water through a mixing valve or combination faucet. The use of a	A 804		

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common towel and common bar soap is prohibited. Hands shall not be washed in sinks where food is prepared. Existing Group and Congregate facilities that enlarge or renovate kitchens shall install a hand wash sink.

(h) Refrigeration Facilities. Adequate refrigeration facilities, automatic in operation for the storage of perishable foods shall be provided. Refrigeration shall be maintained at 41 degrees Fahrenheit or less. All refrigerators shall be provided with thermometers. All refrigerators shall be kept clean.

(i) Equipment and Utensil Construction. Equipment and utensils, except single service utensils, shall be so constructed as to be easily cleaned and shall be kept in good repair. No cadmium plated, lead, or readily corrodible utensils or equipment shall be used.

(j) Separation of Kitchen from Resident Rooms and Sleeping Quarters. Any room used for sleeping quarters shall be separated from the food service area by a solid wall with no direct openings. Sleeping accommodations shall not be permitted within the food service area.

(k) Clean Rooms. Floors, walls, and ceilings of rooms in the food service area shall be clean and free of an accumulation of rubbish, dust, grease, dirt, etc.

(l) Clean Equipment. Equipment in the food service area shall be clean and free of dust, grease, dirt, etc.

(m) Clean Counters, Tables, Tablecloths, and Napkins. Tables and counters, which are

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A 804	Continued From page 25 used for food service, shall be kept clean. Tablecloths and cloth napkins shall be laundered after each use. (n) Location and Space Requirements. Food service facilities shall be located in a specifically designated area and shall include the following rooms and space: kitchen, dishwashing, food storage, and dining room. (o) Equipment. Minimum equipment in the kitchen shall include the following: 1. Range. In a Family or Group assisted living facility, a residential use range is permitted. A Congregate assisted living facility shall have a heavy-duty range suitable for institutional use with double oven, or equivalent. 2. Refrigerator. A Family or Group assisted living facility may use a residential refrigerator. A Congregate assisted living facility shall have a heavy duty refrigerator suitable for institutional use. 3. Fire extinguisher. A five-pound type BC for residential hoods, and K type for commercial hoods. 4. Dishwashing. The dishwashing equipment for Family and Group assisted living facilities shall be either residential type using cold water sanitizers or commercial type with a booster water heater. Dishwashing equipment for all Congregate assisted living facilities shall be commercial type using a booster water heater or an automatic dispensing sanitizing chemical system.	A 804		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 804	Continued From page 26 5. A three-compartment sink with a booster heater or chemical sanitizing system for the third compartment shall be provided in Congregate assisted living facilities. 6. Garbage cans with cover. (p) Food Storage. A well-ventilated, cool food storage room, pantry, or cabinets shall be provided. Adequate shelving, bins, suitable cans, and raised platforms shall be provided and kept clean. Perishable food shall be stored at least six inches above the floor. The storeroom shall be of such construction as to prevent the invasion of rodents and insects, the seepage of dust and water, leakage, or any other source of contamination. (q) Dining Room. A resident dining room, or rooms, shall be provided which is large enough to seat not less than 100 percent of the bed capacity. (r) Water Heating Equipment. Equipment for heating an ample supply of water, under pressure, for all washing purposes shall be provided. Hot water shall be piped to all hand-washing facilities, and to each compartment of all dishwashing and laundry sinks. Water heaters shall be automatic type. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to equip the hand washing lavatory in the kitchen with disposable towels.	A 804		

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	D6206	A. BUILDING: _____ B. WING _____	11/03/2021

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A 804	Continued From page 27 Findings: On November 2, 2021 at 1:45 PM, the surveyor toured the kitchen with EI#5, Cook. The surveyor inspected the hand washing lavatory and noted there was not any paper towels in the vicinity. The surveyor asked EI#5 how she dried her hands and she (EI#5) said she used paper dinner napkins. The surveyor noted the paper dinner napkins were across the kitchen stored in a drawer. EI#5 said they had run out of paper towels. EI#1 explained the paper towels had not been replaced because someone was taking the paper towels out of the kitchen. EI#1 went onto say we have plenty of napkins.	A 804	1] A 804 420-5-4-.08 (4) Physical Facility 2] New Hand Towel dispensers are being purchased for the kitchen, employee rest room and guest rest room. 3] We anticipate the new units will be available for installation soon. 4] With new units in place keeping them stocked will become a continuing duty of the senior floor aide and the senior cook. 5] Ultimate responsibility will always lie in the hands of the Administrator	Ongoing Temp. roll towels will be in place until the new units installed Perpetual
A1101	420-5-4-.11 (1) Fire and Safety (1) General. (a) Fire Safety and Emergency Plan. All assisted living facilities shall maintain a current written fire safety, relocation, and evacuation plan. In facilities which do not have multiple smoke compartments, an evacuation floor plan shall be appropriately posted in a conspicuous place. (b) Fire Drills. Fire drills shall be conducted at least once per month in all facilities at varying times and days and quarterly on each shift of Group and Congregate facilities. All fire drills shall be initiated by the fire alarm system. The drills may be announced in advance to the residents. The drills shall involve the actual evacuation of residents to assembly areas in adjacent smoke compartments or to the exterior as specified in the emergency plan to provide staff and residents with experience in exiting	A1101		

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A1101	Continued From page 28 through all exits required by the currently adopted Life Safety Code. Written observations of the effectiveness of the fire drill plan shall be assessed monthly, filed, and kept for at least three years. (c) Fire Drills During Resident Sleeping Hours. When drills are conducted between 9 PM and 6 AM, a coded announcement shall be permitted to be used instead of the normal audible fire alarm signals. These drills may be conducted without disturbing sleeping residents, by using simulated residents or empty wheelchairs. (d) Roller latches are prohibited on doors separating corridors from adjacent spaces. (e) If alcohol-based hand rub dispensers are used in the facility, the dispensers must be installed in a manner that: 1. Minimizes leaks and spills. 2. Adequately protects against inappropriate access. 3. Complies with the requirements of the currently adopted Life Safety Code. (f) Fire Alarm and Sprinkler System. 1. Fire Alarm System. Where fire alarm systems are required, a corridor smoke detection system shall be installed on each floor, including areas open to the exit access corridor, to comply with NFPA 72, connected to the facility's fire alarm system. In lieu of corridor smoke detection, smoke detectors connected to the building fire	A1101		

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A1101	Continued From page 29 alarm system may be installed in each resident's room, open areas, and at smoke doors (except that corridor smoke detection shall not be deleted when its use is dictated by other requirements). 2. Fire alarm and sprinkler system outages of more than 4 hours require evacuation of the facility or the establishment of a continuous fire watch. The fire watch procedure must be coordinated with the Department and the local Fire Marshal. Outages and fire watch documentation shall be reported to the Department within 12 hours or no later than the next duty day, and shall be corrected expeditiously. 3. The fire alarm system and the sprinkler system shall be inspected by licensed, trained, and qualified personnel at least semiannually for compliance with the respective codes. Inspection and testing reports shall be maintained in the facility for a period of at least 3 years. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to conduct and document fire drills monthly and quarterly on each shift as required. Also, not all monthly fire drills had a written observation of the effectiveness of the fire drill. In addition, the fire alarm system was not inspected at least semiannually for compliance with the respective codes. THIS IS A REPEAT DEFICIENCY FROM THE PREVIOUS SURVEY CONDUCTED ON AUGUST 1, 2019.	A1101		

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A1101	Continued From page 30 Findings: On November 2, 2021, the surveyor reviewed the 2020 and 2021 fire and safety documentation with EI#1, Administrator. EI#1 was unable to produce the following documentation: 2020 First Quarter: February no monthly drill. Second Quarter: No third shift drill. Third Quarter: July and September no monthly drills. Fourth Quarter: December no monthly drill. Semiannual Fire Alarm System: None for the year. 2021 First Quarter: No second shift drill. Third Quarter: September no monthly drill.	A1101	1] A1101 420-5-4-.11 (1) Fire & Safety 2] Missing fire book still being sought. Evidence of drills via Furlong records. **1st Qtr** ~ Third shift silent drill. Documentation, which is strictly internal, disappeared with the entire book for 2020. Silent drills are not patched through Furlongs. **2nd Qtr** ~ **3rd Qtr & 4th Qtr** ~ Based on Furlong's, the third and fourth quarter drills were apparently silent 3rd shift drills and thus not patched through Furlong's. **Fire System Checks** ~ Safeguard - On April 22, 2020, Brendle was paid $800 for something. On May 1, 2020, Safeguard was paid $ 1,000 for something? We are following up with both vendors. 3] A full review is being conducted with incoming buyers along with their new Administrator to establish new guidelines for compliance. 4] The new Administrator, in the process of achieving her license, is being additionally trained in the requirements expected of facility oversight. 5] The new Administrator, along with tentative buyers will promulgate new procedures.	Under Constant Review
A1203	420-5-4-.12 (5) Physical Environment. (5) General Building Requirements - Family, Group, and Congregate. (a) Structural Soundness and Repair. The building shall be structurally sound, free from leaks and excessive moisture, in good repair, and painted with sufficient frequency to be reasonably attractive inside and out. The interior and exterior of the building shall be kept clean and orderly. (b) Temperature to be Maintained. The facility shall maintain a comfortable temperature. A comfortable range is between 71-81 degrees Fahrenheit. (c) Lighting. Each resident's room shall	A1203		

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A1203	Continued From page 31	A1203		

have artificial light adequate for reading and other uses as needed. All entrances, hallways, stairways, inclines, ramps, cellars, attics, storerooms, kitchens, laundries, and service units shall have sufficient artificial lighting to prevent accidents and promote efficiency of service. Night lights shall be provided in all hallways, stairways, and bathrooms.

(d) Screens. All screen doors and operable windows shall be equipped with tight-fitting, full-length insect screens. Screen doors shall be equipped with self-closing devices.

(e) Emergency Lighting.

1. All assisted living facilities shall provide emergency artificial lighting to adequately illuminate halls, corridors, kitchens, dining areas, and stairwells in case of electrical power failure. As a minimum, dry cell battery-operated lighting shall be provided to light such spaces.

2. Emergency lighting must provide illumination in accordance with the currently adopted Life Safety Code for at least 90 minutes.

(f) Floors.

1. All floors shall be level, smooth and free of cracks, and finished so as to be easily kept clean. The basic requirement for floor finishes shall be wall-to-wall with such finishes as paint, stain, sealer, carpet, sheet vinyl, vinyl tile, hard tile, or other appropriate floor finish.

2. Any differences in floor levels shall not prevent a resident from navigating safely

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A1203	Continued From page 32 throughout the facility. (g) Walls and Ceilings. All walls and ceilings shall be of sound construction with an acceptable surface and shall be kept clean and in good repair. (h) Windows. Operable windows shall be so constructed and maintained so that they fit snugly, and are capable of being opened and closed easily. (i) Ceiling Height. Each room occupied by residents shall have a ceiling height of eight feet or more. Existing facilities with ceiling heights less than eight feet shall be acceptable when the height complies with the codes. (j) Handrails. If handrails are installed in halls or corridors, the handrails shall be mounted at 30-36 inches above the floor and returned to the wall at each end. (k) Stairways. Stairways shall be well lighted, kept in good repair, and have handrails. Open space under stairs shall not be used for storage purpose. All walls and doors under stairs shall meet the same fire rating as the stairwell. (l) Doors. 1. In each new assisted living facility, doors of resident bathrooms connected to resident bedrooms shall swing into the bedroom. 2. Bedroom and bathroom doors may be equipped with hardware that will permit a resident to lock himself within the room, provided a master key is readily accessible for the staff at	A1203		

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A1203	Continued From page 33 a central location. 3. Resident bedroom and other exit access doors in each assisted living facility shall be at least three feet wide. Bedroom doors in Family assisted living facilities shall not be less than 32 inches wide. 4. Exterior egress doors except the main entry/exit door, may be equipped with a delayed egress locking system installed in accordance with NFPA 101. Other special locking arrangements are permitted only in specialty care assisted living facilities. 5. Exit doors swinging outward shall swing out over a landing having a minimum length and width equal to the door's width at the same level as the floor level, except existing doors shall not have more than a four inch step down. Exit doors of Family facilities may swing inward. (m) Ventilation. The building shall be well-ventilated at all times to prevent accumulation of objectionable odors. Kitchens, laundries, service rooms, toilets, and bathrooms shall be ventilated by windows, gravity vents, or mechanical means as necessary to prevent offensive odors from entering other parts of the facility. (n) Fire Extinguishers. Fire extinguishers shall be provided for each hall, kitchen, and laundry, of type and capacity appropriate to the need. 1. Each fire extinguisher shall receive an annual inspection with maintenance, and	A1203		

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A1203	Continued From page 34 recharging when necessary, by a fire equipment servicing representative. An annual servicing tag shall be attached to the extinguisher reflecting the name of the servicing company, representative, day, month, and year of maintenance. 2. A visual inspection of each fire extinguisher shall be conducted monthly by designated staff of the facility and documented on the attached extinguisher tag by the designated staff person. (o) Call System. Except in Family facilities, a central electric or electronic call system shall be conveniently provided for each resident, usable in bedrooms and bathrooms. The call system shall be certified to meet the applicable Underwriters Laboratories standard. (p) Manufactured homes/mobile homes are not permitted. (q) Fireplaces and inserts, shall be inspected and cleaned annually, and shall comply with the currently adopted building code. Openings shall be protected with screens, or doors. (r) Exit marking. In Group and Congregate facilities, a sign bearing the word "EXIT" in plain legible block letters shall be placed at each exit. Additional signs shall be placed in corridors and passageways wherever necessary to indicate the direction of exit. Letters of signs shall be at least four inches high. All exit and directional signs shall be kept clearly legible by continuous internal electric illumination and have battery back-up or emergency power.	A1203		

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A1203	Continued From page 35 (s) Heating, Lighting, and other Service Equipment. 1. Central or individual room gas heating systems shall be of the enclosed flame type equipped with automatic flame shut-off control and shall be vented directly to the outside. Heating units of any type shall be located to avoid direct contact with any combustible material and shall be maintained in accordance with manufacturer's recommendation. 2. Open flame and portable heaters are prohibited in assisted living facilities. This does not apply to a fire place with gas logs protected as noted elsewhere in these rules. 3. Lighting shall be restricted to electricity. Electric wiring, motors, and other electrical equipment in all assisted living facilities shall be in accordance with local electrical codes and the NFPA National Electrical Code. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to document the visual inspection of each fire extinguisher on the attached extinguisher tag monthly. Findings: During the initial tour of the facility the morning of November, 2021 at 7:20 AM, the surveyor noted four (4) fire extinguishers had not been inspected since September 27, 2021. Later on at 11:44 AM, the surveyor noted the fire extinguishers had a date and initials added, "10/21 JH." The surveyor discussed this with EI#6, Facility Manager. EI#6	A1203		

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A1203	Continued From page 36 explained he did visually inspect all the fire extinguishers on October 21, 2021, but failed to document the date on the attached tag. EI#6 went onto say he must have gotten interrupted. DEBRA FREEMAN, REGISTERED NURSE	A1203	1] A 1203 420-5-4-.12 (5) Physical Environment 2] Fire Extinguisher checks and documentation will be addressed with the incoming new tentative ownership and Administrator 3] New pending management advised of requirement 4] Changes put into place is to stress that the Administrator will be responsible to insure this monthly task is completed in a timely manner. 5] This task is the perpetual responsibility of the Administrator even if a designate is selected.	Initial completion made on Nov. 3, '21

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