STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST CAROLINA REHAB AND WELLNESS	2575 W 5TH STREET GREENVILLE, NC 27834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 03/25/2019 through 03/28/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #LQUD11.	E 000		
F 623 SS=B	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 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	F 623		4/24/19

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

Electronically Signed | 04/20/2019

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F 623	Continued From page 1	F 623		

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 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

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F 623	Continued From page 2 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 staff interviews the facility failed to provide written notice of discharge to the resident or the resident's representative for a facility-initiated discharge for 3 of 3 residents reviewed for a facility-initiated discharge (Resident #39, # 72, and #77). The findings included: 1. Resident #39 was admitted to the facility on 8/2/96 with diagnoses that included seizure disorder and hypertension.	F 623	1. Going forward - all residents who are discharged to another facility (hospital, another nursing facility, etc) will be sent a letter of discharge. 2. All residents that are discharged from the facility to another facility will be sent a letter of discharge to the residents' responsible party. 3. The admissions director and business office manager were inserviced regarding the process of sending out a discharge	

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F 623	Continued From page 3 Review of a nurse's note dated 11/27/18 revealed Resident #39 was sent to the hospital for intravenous antibiotics. A review of the medical record revealed no written no of discharge was provided to the resident representative for the resident's hospital transfer on 11/27/18. Review of a nurse's note dated 11/29/18 revealed Resident #39 was readmitted to the facility from the hospital on 11/29/18. During an interview on 3/27/19 at 12:42 with Nurse #4 she stated when Resident #39 was sent to the hospital the paperwork sent included the face sheet, the list of diagnoses, code status, medication administration record and a transfer form. Nurse #4 stated no other paperwork was included when Resident #39 was sent to the hospital. No written notice of discharge was provided by Nurse #4. During an interview on 3/27/19 at 2:41 pm the Admissions Coordinator stated she did not send written notice of discharge to the resident or the resident's representative for the resident's hospital transfer on 11/27/18. During an interview on 3/27/19 at 2:47 pm with the Social Services Coordinator stated she did not send written notice of discharge to the resident or the resident's representative for the resident's hospital transfer on 11/27/18. During an interview with the Administrator on 3/27/19 at 3:17 PM he indicated he was not aware of the requirement to provide written notification to the resident or the responsible party	F 623	letter to all residents that have been discharged from the facility to another facility. 4. An audit will be performed by the Administrator or their designee to ensure that those residents who have been discharged from this facility to another facility had a discharge notice sent to their responsible party. This audit will be performed on discharged residents for the next 3 months. 5. The results of these audits will be brought to the facility Quarterly Assurance & Assessment Committee meetings to ensure that those residents that were discharged from this facility to another facility were mailed a discharge notice and to look for any possible trends.	

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F 623	Continued From page 4	F 623		

for emergent hospital transfers. He stated he notified the Ombudsman of all discharges, including hospital transfers.

2. Resident #72 was admitted to the facility on 11/8/16 with diagnoses that included dementia, hypertension, and heart disease.

Review of a nurse's note dated 2/26/19 revealed Resident #72 was sent to the hospital for evaluation of trembling.

A review of the medical record revealed no written notice of discharge was provided to the resident representative for the resident's hospital transfer on 2/26/19.

Review of a nurse's note dated 2/26/19 revealed Resident #72 was readmitted to the facility from the hospital on 2/28/19.

During an interview on 3/27/19 at 12:42 with Nurse #4 she stated when Resident #72 was sent to the hospital the paperwork sent included the face sheet, the list of diagnoses, code status, medication administration record and a transfer form. Nurse #4 stated no other paperwork was included when Resident #39 was sent to the hospital. No written notice of discharge was provided by Nurse #4.

During an interview on 3/27/19 at 2:41 pm the Admissions Coordinator stated she did not send written notice of discharge to the resident or the resident's representative for the resident's hospital transfer on 2/26/19.

During an interview on 3/27/19 at 2:47 pm with the Social Services Coordinator stated she did

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F 623	Continued From page 5	F 623		

not send written notice of discharge to the resident or the resident's representative for the resident's hospital transfer on 2/26/19.

During an interview with the Administrator on 3/27/19 at 3:17 PM he indicated he was not aware of the requirement to provide written notification to the resident or the responsible party for emergent hospital transfers. He stated he notified the Ombudsman of all discharges, including hospital transfers.

3. Resident #77 was admitted to the facility on 10/19/16 was discharged to the hospital on 1/21/19. Resident #77's diagnoses included acute respiratory failure, tracheostomy and diabetes.

A review of the hospital discharge summary revealed Resident #77 was admitted to the hospital on 1/21/19 and was discharged on 1/24/19.

A review of the quarterly Minimum Data Set dated 12/9/18 revealed Resident #77 was moderately cognitively impaired and totally dependent for all activities of daily living.

On 3/27/19 at 12:42 PM during an interview Nurse #4 reported the information sent with the resident when transferred to the hospital included the resident's face sheet, diagnosis sheet, code status, medication administration record, transfer form and a transfer sheet. She stated they do not send any information for the resident or family or a bed hold policy.
Nurse #4 added they call the responsible party in the process of the resident leaving the facility.

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F 623	Continued From page 6 During an interview on 3/27/19 at 2:41 PM the Admission Director she was the staff member who was contacted by the case manager (from the hospital) when one of the facility's residents was hospitalized. She said she was not the person responsible for notifying the family if a resident was sent to the hospital. On 3/27/19 at 2:47 PM the Social Worker stated the Administrator was the person who contacted the Ombudsman for residents who were hospitalized. On 3/27/19 at 3:17 PM the Administrator stated he was not sending written notification to residents or their responsible party for transfers to the hospital. He stated the residents or family were told verbally.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for hospice status and psychological therapy for 2 of 19 residents reviewed for MDS accuracy. (Resident #129 and Resident #22) Findings included: 1. Review of an order dated 9/17/18 revealed Resident #129 was ordered to be evaluated and admitted to hospice.	F 641	1. A. The MDS that did not list that resident #129 was receiving hospice services accurately was corrected. B. The MDS that did not list that resident #22 was receiving psychological services accurately was corrected. 2. A. An initial audit was performed by the MDS Coordinator to ensure that the MDS's of the other residents in the facility who are receiving hospice services were	4/24/19

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F 641	Continued From page 7 Review of a hospice patient information report dated 11/19/18 revealed Resident #129's effective hospice date was 9/17/18. Resident #129 was admitted to the facility on 11/21/18. The resident's active diagnoses included Parkinson's disease, dementia, and glaucoma. Review of Resident #129's admission note dated 11/21/18 revealed he was admitted to the facility under the services of hospice. Review of a discharge minimum data set assessment dated 11/26/18 revealed Resident #129 was coded in section O0100 question K as not having received hospice care as a resident. During an interview on 3/27/19 at 9:46 AM Nurse #2 stated she remembered Resident #129. She further stated he was on hospice care during his stay in the facility. During an interview on 3/27/19 at 2:21 PM MDS Nurse #1 stated Resident #129 was on hospice care during his stay. She concluded the minimum data set assessment dated 11/26/19 was incorrect and should have reflected Resident #129's hospice status. During an interview on 3/28/19 at 8:20 AM the Director of Nursing stated it was her expectation minimum data set assessments accurately reflected the status of the resident. 2. Resident #22 was admitted to the facility on 1/7/11 with diagnoses that included: dementia, heart failure and hyperlipidemia.	F 641	coded correctly. B. An initial audit was performed by the MDS Coordinator to ensure that the MDS's of the other residents in the facility who are receiving psychological services were coded correctly. 3. A. The MDS staff were inserviced on making sure that hospices services were coded accurately on those residents receiving hospice services. B. The MDS staff were inserviced on making sure that psychological services were coded accurately on those residents receiving psychological services. 4. A. An audit will be performed by the MDS Coordinator or their designee to ensure that the MDS is accurately showing hospice services being received for all those residents under the care of hospice. This audit will be performed 1x/week x 4 weeks and then 1x/month for 3 months. B. An audit will be performed by the MDS Coordinator or their designee to ensure that the MDS is accurately showing psychological services being received for all those residents receiving psychological services. This audit will be performed 1x/week x 4 weeks and then 1x/month for 3 months. 5. A. The results of these audits will be brought to the facility Quality Assurance & Assessment Committee meetings to	

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F 641	Continued From page 8 Review of a progress note dated 8/8/18 revealed Resident #22 received psychological therapy on 8/8/18. Review of Resident #22's minimum data set assessment (MDS) dated 8/12/18 revealed the resident was assessed in section O, question O0300E as not receiving psychological therapy services during the 7 day look back period of the assessment. During an interview on 3/27/19 at 4:57 PM the MDS Nurse #1 stated Resident #22 received psychological therapy services and question O0300E on the 8/12/18 minimum data set assessment was coded incorrectly. An interview was conducted on 3/28/19 at 11:00 AM with the Administrator who stated it is her expectation that MDS assessments are coded accurately to reflect therapy services received.	F 641	ensure that hospice care is being coded accurately on the MDS for those residents who are receiving hospice care and to look for any possible trends. B. The results of these audits will be brought to the facility Quality Assurance & Assessment Committee meetings to ensure that psychological services are being coded accurately on the MDS for those residents who are receiving psychological services and to look for any possible trends.	
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 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	F 761		4/24/19

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F 761	Continued From page 9 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 observations, staff interviews record review and manufacturer's information the facility failed to keep unattended medications locked in a medication storage room for 1 of 2 medication storage rooms observed and failed to maintain the manufacturer's temperature storage parameters for the flu vaccine, pneumococcal vaccine, Tuberculin Multidose vials, Humalog Kwikpen (a type of insulin), insulin multidose vials, Promethazine (a medication to treat nausea) suppositories, Veltassa (a medication to treat high blood potassium) packets and Lactinex (a probiotic supplement) packets in 1 (200 hall) of 2 medication rooms. Findings included: 1. During observation on 3/26/19 at 4:00 PM the 200 hall nurse's station medication room was observed to be open. The 200 hall medication room was located at the nurse's station. Nurse #1 walked away from the nurse ' s station. The door to the medication room remained open and was unattended. Nurse #1 went down the 200 hall and returned to the nurse ' s station at 4:02 PM.	F 761	1. A. The doors to the 200 Hall medication room was equipped with an automatic door closure to ensure that when the door closes it will latch. B. The medication refrigerator in the 200 Hall medication room was taken outside and was defrosted and deep cleaned to ensure that it was in proper working order. The medications that were in this refrigerator were part of the emergency backup kit that the facility keeps and those medications were sent back to the pharmacy. 2. A. The other medication storage room within the facility was already equipped with an automatic door closure device to ensure that the door closes and latches. B. The other refrigerators in the medication storage rooms within the facility were also defrosted and deep cleaned to ensure that they were all in proper working order. A new refrigeration temperature monitor sheet was developed	

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F 761	Continued From page 10 During observation on 3/26/19 at 4:20 PM Nurse #1 was observed to exit the 200 hall nursing station and not fully close the 200 hall medication room door leaving it unlocked and unattended. At 4:20 PM a nurse aide and housekeeping staff was observed to walk by the unlocked 200 hall medication room. At 4:21 PM a housekeeping staff member walked by the unlocked 200 hall medication room. At 4:22 PM the housekeeping director was observed to walk by the unlocked medication room. At 4:23 PM a resident walked by the unlocked medication room as well as a dietary cook. At 4:24 PM returned to the 200 hall nurse's station. During an interview on 3/26/19 at 4:24 PM Nurse #2 stated if staff are not right at the nurse's station then the 200 hall medication room door was to be pulled closed and locked. She further stated the door was unlocked and unattended and Nurse #1 should have locked the door prior to leaving the nurse's station. During an interview on 3/26/19 at 4:33 PM Nurse #1 stated unattended medications were supposed to be locked. She further stated when staff leave the nurse's station they would close the 200 hall medication room. She further stated she pulled the door behind her and did not know it did not completely close and was still open. During an interview on 3/26/19 at 4:52 PM the Director of Nursing stated when nurses leave the nurse's station the staff are to close the door to locked unattended medication. She further stated it was her expectation that unattended medications be locked, and Nurse #1 should have fully closed the door whenever she left the nurse's station.	F 761	and placed in each medication storage room and it explains what to do if the temperature is too high or too low. 3. A. Nursing staff were inserviced about the importance of ensuring that the medication storage rooms doors were being shut and latched. B. The nurses/med aides in the facility were inserviced about the new refrigerator temperature monitor sheets and what to do if the temperatures are reading either too hot or too cold and how to adjust the temperature of the refrigerators. 4. A. An audit will be performed by the Administrator or their designee to ensure that the medication storage rooms doors are shut and latched. This audit will be performed 1x/week for 4 weeks and then 1x/month x 3 months. B. An audit will be performed by the Administrator or their designee to ensure that the refrigerators in the medication storage rooms are keeping an appropriate temperature. This audit will be performed 5x/week x 4 weeks and then 1x/week x 3 months. 5. A. The results of these audits will be brought to the facility Quality Assurance & Assessment Committee meetings to ensure that the mediation storage room doors are being shut and latched and to look for any possible trends. B. The results of these audits will be	

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F 761	Continued From page 11 2. Review of the manufacturer's storage parameters are as follows: 1. Influenza vaccine. The packaging insert indicated to store between 36-46 degrees Fahrenheit (F). 2. Pneumococcal vaccine polyvalent. The packaging insert indicated to store between 36-46 degrees F. 3. Tuberculin Multidose vial. The packaging insert indicated to store between 35-46 degrees F. 4. Humalog Kwikpen. The manufacturer's storage parameters indicated to store between 36-46 degrees F. 5. Novolog insulin multidose vial. The manufacturer's storage parameters indicated to store between 36-46 degrees F. 6. Levemir insulin multidose vial. The manufacturer's storage parameters indicated to store between 36-46 degrees F. 7. Novolin N insulin multidose vial. The manufacturer's storage parameters indicated to store between 36-46 degrees F. 8. Novolin 70/30 multidose vial. The manufacturer's storage parameters indicated to store between 36-46 degrees F. 9. Promethazine suppositories. The manufacturer's storage parameters indicated to store between 36-46 degrees F. 10. Veltassa packets. The manufacturer's storage parameters indicated to store between 36-46 degrees F. 11. Lactinex packets. The manufacturer's storage parameters indicated to store between 36-46 degrees F. The refrigerator on 200-hall was observed with the Director of Nursing on 3/27/19 at 3:41 PM to contain the above referenced medications and	F 761	brought to the facility Quality Assurance & Assessment Committee meetings to ensure that the refrigerators in the medication storage rooms are keeping an appropriate temperature and to look for any possible trends.	

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	345377	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 761	Continued From page 12	F 761		

biologicals. The temperature reading of the thermometer in the refrigerator was observed to be at 32 degrees F. This temperature was also observed by the Director of Nursing.

On 3/27/19 at 3:45 PM a review of the facilities medication refrigerator temperature log for hall 200 showed the following recordings:

1. 2/11/19 - 34 degrees F
2. 2/22/19 - 34 degrees F
3. 2/23/19 - 34 degrees F
4. 2/25/19 - 34 degrees F
5. 2/27/19 - 35 degrees F
6. 3/26/19 - 32 degrees F

On 3/27/19 at 4:37 PM interview with the Director of Maintenance revealed that he had received no report that the medication refrigerator on hall 200 had been out of range.

On 3/28/19 at 7:56 AM interview with nurse #3 revealed that she had recorded the temperature for hall 200 medication refrigerator on 2/11/19, 2/22/19, 2/23/19 and 3/26/19. She indicated that she did not recall what time she had checked the temperatures. She stated she sometimes checked temperatures when she came on to her shift at 11:00 PM and other times she checked it after midnight. She indicated she had not reported the temperature readings to anyone. She further indicated that she had not been aware that she was to take any action with regards to the refrigerator temperatures other than just writing them down.

On 3/28/19 at 9:11 AM an interview with the Director of Nursing revealed that the nurse checking the medication refrigerator temperature should have made sure that the temperature was

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F 761	Continued From page 13 within the correct range, attempted to adjust it if it was not, rechecked it and if it still fell outside the correct range notified maintenance so they could address the issue.	F 761		
F 812 SS=E	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 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard potentially hazardous opened food items stored in 1 of 1 refrigerator by their expiration date and failed to prevent the growth of pink mold on the interior of the ice machine for 1 of 1 kitchen ice machine. The findings included: 1. An observation of the kitchen's reach-in refrigerator on 3/25/19 at 9:25 AM revealed 2	F 812	1. A. The sandwich meat that was noted to be out of the use by date was immediately thrown away. B. The ice machine was deep cleaned to ensure that there were no signs of pink mold on or in the machine. 2. A. An audit was performed to ensure that there were no other foods items that	4/24/19

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F 812	Continued From page 14 zipper closure plastic bags of ham and 1 zipper closure plastic bag of roast beef. One of the packages of ham had a hand written label which listed a use by date of 3/14/19 and the 2nd package of ham had a hand written label with a use by date of 3/20/19. The package of roast beef had a hand written label with a use by date of 3/18/19. During an interview with Dietary Manager #1 on 3/28/19 at 9:27 AM she reported she had discarded the outdated food items and the items should have been discarded by the use by dates on the bags. 2. An observation of the ice maker on 3/25/19 at 9:45 AM revealed the area around the right side of the ice chute where the ice exited into the ice storage bin had pick mold growing on it. During the observation with the dietary manager on 3/25/19 at 9:45 AM she stated she was not sure of the date the ice maker was last cleaned. She said the kitchen staff were responsible for keeping the ice maker clean and that it was on a cleaning schedule. During an interview with Dietary Manager #1 on 3/28/19 at 9:27 AM she stated the ice machine was not on a specific cleaning schedule but she was going to put the ice maker on the cleaning schedule.	F 812	were outside of their use by date. B. No other remedy was necessary since cleaning the ice machine took care of the original issue and this is the only ice machine within the dietary department. 3. A. Dietary Staff members were inserviced on a foods' use by date and what do to when food was past a use by date - they were informed that they food in questions was to be thrown away and to also let the dietary manager know that that the item could be reordered if necessary. B. Dietary staff members were inserviced on how to properly clean the ice machine and how often to do so. 4. A. An audit will be performed by the Dietary Manager or their designee to ensure that food being stored is within the use by date. This audit will be performed 3x/week x 4 weeks and then 1x/week x 3 months. B. An audit will be performed by the Dietary Manager or their designee to ensure that the ice machine is clean and free of signs of mold. This audit will be performed 1x/week x 4 weeks and then 1x/month x 3 months. 5. A. The results of these audits will be brought to the facility Quality Assurance and Assessment Committee to ensure that all food being stored in the dietary department is within the use by date and	

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F 812	Continued From page 15	F 812	to look for any possible trends. B. The results of these audits will be brought to the facility Quality Assurance and Assessment Committee to ensure the ice machine in the dietary department is clean and free of any signs of mold and to look for any possible trends.	