



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

October 22, 2010

Ms. Kathy Labbe, Administrator
Valley Terrace
2820 Christian Street
White River Junction, VT 05001

Dear Ms. Labbe:

Enclosed is a copy of your acceptable plans of correction for the complaint and licensing survey conducted on **September 9, 2010**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

A handwritten signature in cursive script that reads "Pamela M. Cota RN".

Pamela M. Cota, RN
Licensing Chief

PC:jl

Enclosure: As noted above.



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2010
NAME OF PROVIDER OR SUPPLIER VALLEY TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2820 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001		
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A 001	VI Initial Comments An unannounced onsite complaint and licensing survey was conducted by the Division of Licensing and Protection from 9/7/2010 through 9/9/2010.	A 001		RECEIVED Division of OCT 18 10 Licensing and Protection
A 607 SS=E	VI Resident Care and Services 6.7 Care Plans The licensee, the resident and/or the resident's legal representative shall work together to develop and maintain a written resident care plan for those residents who require or receive care. The care plan shall describe the assessed needs and choices of the resident and shall support the resident's dignity, privacy, choice, individuality, and independence. The licensee shall review the plan at least annually, and whenever the resident's condition or circumstances warrant a review, including whenever a resident's decision, behavior or action places the resident or others at risk of harm or the resident is incapable of engaging in a negotiated risk agreement. This Statute is not met as evidenced by: Based on record review and interview, the Licensee did not assure the development and / or maintenance of a plan of care describing the care and services required by 4 of 10 reviewed residents (Resident #1, Resident #3, Resident #5 and Resident #10). Findings include: 1. Per record review on 9/7/2010, Resident #1, most recently assessed by the RN (Registered Nurse) on 7/24/2009 had suffered a significant health decline followed by a hospitalization in February 2010 requiring additional staff assistance with mobility, toileting, ambulation, and positioning. There was no indication on the	A 607	Care Plans 1. The care plans that were cited as deficient have been updated and reflect the resident's care needs. 2. Care plans will be reviewed by the nurse manager. Health Service Director to make sure care plans are updated and reflect specific care needs. 3. (A) Vice President of Residential Care from Home office will be doing QIA on charts every 6 months.	9/13/10 9/16/10 9/16/10

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kathy Hall, Executive Director TITLE _____ (X6) DATE 10-12-2010
STATE FORM 6899 XCI4ff If continuation sheet 1 of 4

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A 607	Continued From page 1 care plan that the resident required individualized assistance in these areas. During interview on 9/7/2010 at 4:20 PM, the Executive Director confirmed that the current care plan did not fully reflect the needs of this resident. 2. Per record review on 9/8/2010, Resident #3 receives a long-term blood thinner (Coumadin) on a daily basis, is catheterized and returned from a hospitalization on 9/1/2010 with a new diagnosis of Methicillin Resistant Staph Aureus (MRSA) for which treatment continues to the date of this survey. The most recent annual assessment dated 9/7/2010 identifies Resident #3 as at risk for falls (prior annual assessments also indicated fall risk). The written plan of care for this resident did not identify this resident as a fall risk, describing measures to assist the resident to maintain independence and well-being, nor did it instruct staff regarding the additional risks associated with the resident's Coumadin use and potential falls. Additionally, staff was not alerted to the fact that the resident was being treated for a communicable condition. During interview on 9/9/2010 at 9:35 AM, a staff nurse confirmed that the care plan contains no fall risk alert, no indication that the resident is receiving a blood thinner which may increase the risk of injury in the event of a fall, nor is there an alert to staff that the resident has / is being treated for a contagious condition. 3. Per record review on 9/8/2010, Resident #5 had no plan of care developed to instruct staff in daily care needs. During interview on the afternoon of 9/8/2010, the Executive Director confirmed that there was no plan of care available for Resident #5. 4. Per record review on 9/9/2010, Resident #10	A 607	3. (b) Health Services Director will ensure direct-care staff are informed of individualized care plan needs (e.g. fistula, MRSA) of all residents via written and oral communication A607 - 10/18/2010 - POC accepted as written. - C. Lareway, RN	9/23/10

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A 607	Continued From page 2 had no plan of care directing staff regarding a fistula access port for dialysis treatment. During interview on 9/9/2010 at 11:35 AM, a staff nurse confirmed that Resident #10 receives dialysis treatment 3 times per week via a fistula port and that the plan of care does not indicate the presence of the fistula nor does it instruct in the care and precautions to assure continued patency of the fistula.	A 607		
A 955 SS=D	XI Physical Plant 11.2 At a minimum, resident units shall include the following: 11.2.d Kitchens shall consist of food preparation and storage area that includes, at a minimum, a refrigerator with freezer, cabinets, counter space, sink with hot and cold running water, a stove or microwave that can be removed or disconnected, and electrical outlets. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to assure that 2 resident-occupied units (Resident #11 and Resident #12) contained kitchen areas for food storage and preparation. Findings include: 1. Per observation during the environmental tour on 9/7/2010, the residential units of Resident #11 and Resident #12 did not contain a food storage and preparation area. During interview on the morning of 9/8/2010, the Executive Director confirmed that there were no kitchens / meal preparation areas in these two recently converted units with current occupants, stating that a variance to this requirement had been recieved during the time that these units were part of the memory care unit. She confirmed that no	A 955	<u>Physical Plant</u> The facility is now more aware of what constitutes the need for a variance. A variance for those rooms was requested from Cindy Laraway. on Sept. 8, 2010 via email. There has been no response as of today, 10.12.2010. 10-20-2010 A955 - POC accepted as written. C. Laraway, RN	Variance sent out 9/8/10 waiting on response from state.

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A 955	Continued From page 3 variance had been requested for the changed use of these units nor for the additional 5 units also removed from use as memory care units to standard licensed units.	A 955		

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R104 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.1 Admission</p> <p>5.2.a Prior to or at the time of admission, each resident, and the resident's legal representative if any, shall be provided with a written admission agreement which describes the daily, weekly, or monthly rate to be charged, a description of the services that are covered in the rate, and all other applicable financial issues, including an explanation of the home's policy regarding discharge or transfer when a resident's financial status changes from privately paying to paying with SSI or ACCS benefits. This admission agreement shall specify at least how the following services will be provided, and what additional charges there will be, if any: all personal care services; nursing services; medication management; laundry; transportation; toiletries; and any additional services provided under ACCS or a Medicaid Waiver program. If applicable, the agreement must specify the amount and purpose of any deposit. This agreement must also specify the resident's transfer and discharge rights, including provisions for refunds, and must include a description of the home's personal needs allowance policy.</p> <p>(1) In addition to general resident agreement requirements, agreements for all ACCS participants shall include: the ACCS services, the specific room and board rate, the amount of personal needs allowance and the provider's agreement to accept room and board and Medicaid as sole payment.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	R104	<p>Admission, Residency Agreement</p> <p>It is Valley Terrace's policy to have all resident's sign a residency agreement upon admission. We now have a check-off list to assure that happens.</p> <p>R104 - 10/18/2010 - POC accepted as written. — C. Lavery, RN</p>	9/30/2010

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kathy Ball, Executive Director TITLE _____ (X6) DATE 10-12-2010

STATE FORM 6899 XCI411 If continuation sheet 1 of 10

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R104	Continued From page 1 Based on record review and interview, the facility failed to provide 1 of 10 residents (Resident #5) and / or the resident's legal representative with an admission agreement. Findings include: 1. Per record review on 9/8/2010, Resident #5 had no current signed admission agreement detailing services which are provided, the cost of services, and resident rights / responsibilities available for review. During interview on 9/8/2010 at 11:12 AM, the Executive Director confirmed that there was no current admission agreement available for Resident #5.	R104		
R135 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 Assessment 5.7.b If a resident requires nursing overview or nursing care, the resident shall be assessed by a licensed nurse within fourteen days of admission to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency. This REQUIREMENT is not met as evidenced by: Based on record review and interview, 1 of 10 residents reviewed (Resident #5) was not assessed at the commencement of nursing services. Finding include: 1. Per record review on 9/8/2010, Resident #5 was admitted for a short stay and required medication administration and nursing oversight. During interview later this day, the Executive Director confirmed that there was no current assessment available in the record of this	R135	5.5. <u>Assessment</u> Resident #5's assessment has been completed. It is now Valley Terrace's policy to admit Respite residents just as we do long-term residents. All paperwork will be the same. R135 - 10/18/2010 - POC accepted as written. - C. Laraway, RW	9/13/2010 9/13/2010

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R135	Continued From page 2 resident.	R135		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home did not assure that 1 applicable resident (Resident #1) was reassessed following a significant change in physical status. Findings include: 1. Per record review on 9/8/2010, Resident #1 had been most recently assessed by the RN (Registered Nurse) on 7/24/2009 as independent in bed mobility, requiring 1 assist to transfer, able to walk with supervision and could independently dress with 1 staff assist. On 2/25/2010, Resident #1 was hospitalized for a significant injury, which negatively impacted his / her ability to perform activities of daily living (ADLs) including toileting, dressing, ambulating, and bed mobility. Resident #1 had also been admitted to the Hospice Program due to overall health and ADL (Activities of Daily Living) decline after the completion of the 7/24/2009 assessment and before the 2/2010 hospitalization. During interview on the afternoon of 9/8/2010, the Executive Director confirmed that the resident assessment did not accurately reflect the abilities and needs of the resident.	R136	5.7 <u>Assessment</u> (a) Resident #1 assessment cannot be updated since this resident has passed away. (b) Health Services Director and nurse Manager will review assessments, particularly after hospitalizations and significant changes to be sure the assessment is accurate. (c) Vice President of Residential Services will do Quality Assurance every six months. R136 - 10/18/2010 - POC accepted as written. - C. Laraway, RN	9/20/10 9/20/10

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R147	Continued From page 3	R147		
R147 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.9.c (4)</p> <p>Maintain a current list for review by staff and physician of all residents' medications. The list shall include: resident's name; medications; date medication ordered; dosage and frequency of administration; and likely side effects to monitor;</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the RN did not assure the accuracy of ordered medications for 1 of 10 applicable residents (Resident # 6). Findings include:</p> <p>Per record review on 9/9/2010, the Medication Administration Record (MAR) for Resident #6 stated "Systane eye drops right eye" on a daily basis. The MAR indicated that this medication had been administered daily, in an unknown quantity 9/1/2010 through 9/8/2010. A physician order dated 2/18/2010 indicated that Resident #6 would receive "Systane 1-2 drops each eye TID (3 times daily) PRN (as needed)". The most recent physician order in the record dated 8/5/2010 did not indicate Systane eye drops as a required treatment. During interview on 9/9/2010 at 11:00 AM, a staff nurse confirmed that the order for Systane eye drops was being administered on a scheduled basis to the right eye, but the number of drops administered was unclear, and that the order required clarification to determine the exact dose, desired frequency, or discontinuation of this medication.</p>	R147	<p><u>Medication Administration Record and M.D. orders</u></p> <p>(a) order clarified 9/10/10</p> <p>(b) MIO orders are currently reviewed by 2 licensed persons and the Health Services Director. 9/10/10</p> <p>(c) Staff education regarding M.D. orders and indications pursuant to 5.9.c(4) 9/23/10</p> <p>(d) Quality Assurance on medication records will be done monthly as we transition to the next month of Medication Administration Records. 10/11/10</p> <p>R147 - 10/18/2010 - POC accepted as written. — C. Laraway, RN</p>	

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R179 R179 SS=D	Continued From page 4 V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home did not ensure that 2 of 5 applicable employees had received 12 hours of required yearly training. Findings include: 1. Per record review on 9/8/2010, 2 of 5 employee education files did not contain the required 12 hours of annual training. During interview at 11:58 AM, the Executive Director	R179 R179	5.11 <u>Staff Services</u> Valley Terrace's policy is to provide the twelve hours of mandatory training pursuant to 5.11 b. A tickler file has been created to assure all staff members receive this mandatory training. R179 - 10/18/2010 - POE accepted as written. - C. Laraway, RN	9/13/10 10/11/10

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R179	Continued From page 5 confirmed that although all required mandatory topics related to training had occurred, 2 employee records did not indicate the completion of 12 hours of ongoing education.	R179	5.12.b(4) It is Valley Terrace's policy to do criminal record and adult abuse registry checks on <u>all</u> staff prior to hiring.	9/13/10
R190 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assure that the results of all criminal record and adult abuse registry checks for all staff were maintained on file. Findings include: 1. Per record review on 9/7/2010, 2 of 5 employees had no evidence of previously acquired abuse registry checks available. Per interview on the afternoon of 9/9/2010, the Executive Director confirmed that these record checks had not been available when requested and stated that these record checks had been obtained following the surveyor request to review.	R190	Valley Terrace has created a checklist to make sure all documentation is done. R190 - 10/18/2010 - POC accepted as written. - C. Laraway, RN	9/17/10
R206 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be	R206	5.18 Valley Terrace's management is now aware of the importance of reporting abuse, neglect, or exploitation cases pursuant to 5.18 within 48 hours. R206 10/18/2010 - POC accepted as written. - C. Laraway, RN	9/10/10

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R206	Continued From page 6 contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the Licensee failed to report a suspected case of abuse / neglect of Resident #2 to Adult Protective Services (APS) within the required 48 hour timeframe. Findings include: 1. Per record review, an internal investigation of potential abuse / neglect on 2/3/2010 was completed by the facility on 2/5/2010, resulting in the termination of 2 employees. During interview on 9/8/2010, the Executive Director confirmed that APS was not notified of the incident within the required 48 hours.	R206		
R234 SS=C	VII. NUTRITION AND FOOD SERVICES 7.1.a.(3) The current week's regular and therapeutic menu shall be posted in a public place for residents and other interested parties. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the home failed to post the current week's menu. Findings include: 1. Per observations on 9/7, 9/8, and 9/9/2010, there was no current menu posted for review by residents and other interested parties. During interview on the afternoon of 9/9/2010, a staff member confirmed that the current week's menu was not posted.	R234	7.1a(3) It is the policy of Valley Terrace to post the menus weekly. To assure this happens the Director of Food Service is now responsible for this task. R234 - 10/18/2010 - Pol accepted as written. - C. Heraway, RN	10/12/10

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R246 SS=D	<p>VII. NUTRITION AND FOOD SERVICES</p> <p>7.2 Food Safety and Sanitation</p> <p>7.2.a Each home must procure food from sources that comply with all laws relating to food and food labeling. Food must be safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling or leaks shall be rejected and kept separate until returned to the supplier.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the home did not assure that dented cans of food are removed from resident food supplies. Findings include:</p> <p>1. Per observation during initial tour of the home on 9/7/2010, 3 cans of soup and 1 gallon can of fruit were dented and stored among foods available for resident consumption. Per the Dietary Manager, at the time of discovery, s/he confirmed that the cans were dented and stated that s/he was unaware of a dented can policy and was not aware that these foods should not be used.</p>	R246	<p>7.2</p> <p>(a) Kitchen staff education done regarding food safety and sanitation.</p> <p>(b) All cans will be inspected by our kitchen staff upon delivery and if any dents, leaks, or swelling are found they shall be rejected and sent back at that time.</p> <p>R246 - 10/18/2010 - POC accepted as written. - C. Laraway, RW</p>	9/15/10
R247 SS=F	<p>VII. NUTRITION AND FOOD SERVICES</p> <p>7.2 Food Safety and Sanitation</p> <p>7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or</p>	R247		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/09/2010
NAME OF PROVIDER OR SUPPLIER VALLEY TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2820 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001		
(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
R247	Continued From page 8 heated prior to service. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to follow it's policy to assure that all foods are stored at proper temperatures. Findings include: 1. Per record review during initial tour on 9/7/2010, the home failed to assure that daily temperature logs were maintained for refrigerators and freezers in the main kitchen per policy. There were no walk in refrigerator temperatures available for the following dates: 8/4, 8/5, 8/7, 8/13, 8/15 through 8/18, 8/19 through 8/20, 8/22 through 8/25, 8/27 through 8/31/2010 and 9/2, 9/3 and 9/6/2010. There were no walk in freezer temperatures available for the following dates: 8/1, 8/4, 8/5, 8/7, 8/13, 8/15 through 8/17, 8/19 through 8/23, 8/25, 8/26, 8/28 through 8/31/2010 and 9/2, 9/3, and 9/6/2010. During interview at that time, the Dietary Manager confirmed that refrigerator and freezer temperatures should be taken daily and that temperatures had not been taken daily during the current and previous month as required.	R247	7.2. Ca) All Kitchen staff educated to the importance of 7.2.b 9/15/10 Cb) Director of Food Service 9/10/10 will monitor all temperature logs to include Refrigerator and Freezers. Cc) Quality Assurance will be done weekly by the 9/10/10 Executive Director. R247 - 10/18/2010 - POC accepted as written. - C. Haraway, RN	
R248 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.c. All work surfaces are cleaned and sanitized after each use. Equipment and utensils are cleaned and sanitized after each use and stored properly. This REQUIREMENT is not met as evidenced by:	R248		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/09/2010
NAME OF PROVIDER OR SUPPLIER VALLEY TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2820 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001		
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R248	Continued From page 9 Based on record review and interview, the home did not ensure that all equipment and utensils were cleaned and sanitized after each use. Findings include: 1. Per record review on 9/7/2010, dishwasher temperatures are to be checked at each meal per facility policy to assure that they reach the minimum manufacturer recommendation of 150 degrees Fahrenheit (F) during the wash cycle and 180 F during the rinse cycle to assure proper dish sanitizing during the cleaning process. There were no breakfast temperatures monitored from 8/17 to 9/7/2010 (a total of 22 missed opportunities); no lunch temperatures monitored from 8/17 to 8/30, from 8/31 to 9/3 and from 9/5 to 9/7/2010 (a total of 25 missed opportunities) and no supper temperatures monitored from 8/17 to 8/21, 8/23, 8/26 to 8/29, 8/31 to 9/1, 9/3, and 9/5 to 9/6/2010 (a total of 17 missed opportunities). During interview on the morning of 9/7/2010, the food service worker assigned to monitor dishwasher wash and rinse temperatures confirmed that temperatures had not been monitored this date and confirmed that s/he was unaware of the required dishwasher temperature requirements. During interview later that day, the Executive director confirmed that temperature monitoring is required for each meal and that this has not been routinely performed.	R248	7.2.C. (a) All kitchen staff educated to the importance of checking dishwasher temperatures after every meal. 9/15/2010 (b) Director of Foodservice will monitor dishwasher temperature log daily. 9/10/10 (c) Quality Assurance will be done weekly by the Executive Director. 9/10/10 R248 - 10/18/2010 - POC accepts as written. - C. Lavery, RN	