

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/23/2012  
FORM APPROVED  
OMB NO. 0938-0391

*Acceptable  
date 4/4/12*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/09/2012
NAME OF PROVIDER OR SUPPLIER  RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 156 SS=D	<p>An Abbreviated Survey was conducted 03/06/12 through 03/09/12 investigating KY#00017935. KY#00017935 was substantiated with deficient practice identified.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the</p>	F 156	<p>I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or findings, nor have we identified mitigating factors.</p> <p><b>F-156</b></p> <p>It is the practice of this facility to inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident</p>	

RECEIVED  
MAR 30 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE 3/29/12

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/23/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/09/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  RICHMOND PLACE REHABILITATION AND HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	<p>Continued From page 1</p> <p>facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart l of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These</p>	F 156	<p>conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State plan developed under §1919 (e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information and any amendments to it, must be acknowledged in writing.</p> <p>The facility will continue to inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>It is the practice of this facility to furnish a written description of legal rights which includes: A description of the manner of protecting</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/23/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/09/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  RICHMOND PLACE REHABILITATION AND HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	<p>Continued From page 2</p> <p>requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the medical record it was determined the facility failed to inform the responsible party of the date when the residents Medicare benefits would be expiring for one (1) of seven (7) sampled residents (Resident #1). Resident #1's responsible party stated she was unaware of the date when Medicare benefits would expire until 07/07/11 when the facility called and stated the resident's Medicare benefits would be expiring on 07/09/11.</p> <p>The findings include:  Review of the Resident #1's medical record</p>	F 156	<p>personal funds, under paragraph © of this section; a description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924© which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>The facility continues to post names, addresses and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/23/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/09/2012
NAME OF PROVIDER OR SUPPLIER  RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	<p>Continued From page 3</p> <p>revealed the facility admiltted the resident, on 03/28/11 with diagnoses which included Difficulty In Walking, Fracture of Vertebrae, Joint Replacement, Muscle Weakness, Chronic Heart Failure, Right Intertrochanteric Fracture, and Atrial Fibrillation. Continued review of Resident #1's medical record revealed there was no documented evidence the facility communicated to the resident or resident's family when Resident #1's Medicare benefits would be exhausted.</p> <p>Interview with Resident #1's responsible party, on 03/05/12 at 8:09 AM, revealed she was called by someone at the facility on 07/07/11 and told Resident #1's Medicare benefits would expire on 07/09/11; and, she would need to pick the resident up on that day. She stated it was too little time to try and prepare for the resident's arrival so she was unable to pick the resident up until 07/10/11. She further stated she was given no oral or written notification of the expiration of Medicare benefits prior to this date.</p> <p>Interview with the Social Services Director, on 03/08/12 at 2:30 PM, revealed the plan for Resident #1 was he/she would be discharged home with his/her responsible party. She further acknowledge there was no documentation of this plan or preparations for Resident #1's discharge due to the exhaustion of Medicare benefits in the medical record.</p> <p>Interview with the Administrator, on 03/09/12 at 4:59 PM, revealed Resident #1 was given a verbal notification and the facility was only required to give a 48 hour notice before discharging the resident due to Medicare benefits expiring. He further stated the law was Medicare</p>	F 156	<p>property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility continues to comply with the requirements specified in subpart1 of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility will continue to inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p>	

It is the practice of this facility to prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

**F-156 Notice of rights rules services and charges.**

- 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?**

Resident #1 was discharged from the facility to home on 7/10/11 upon exhaustion of 100 days of Medicare benefits.

- 2. How will the facility identify other residents having the potential to be**

**affected by the same  
deficient practice?**

An audit of all current residents will be completed by 4/3/12 by the administrator and business office manager to identify residents that require notification of ending Medicare and/ or Managed Care benefits. The administrator will verify that these residents and/or their responsible party will be notified orally and in writing of their Medicare and/or Managed Care non-coverage and appeal notices.

**3. What systemic changes  
will be made to ensure  
that the deficient practice  
will not recur?**

The Interdisciplinary Team (IDT) which consists of the Administrator, Director of Nursing, Assistant Director of

Nursing, Unit Coordinators, Minimum Data Set Coordinators, Admissions Coordinator, Business Office Manager, Social Worker, Lifestyles Director and Therapy Manager were re-educated regarding notification of rights, rules, services, and charges by the Administrator by 4/03/12. The Business Office Manager will be responsible for identification and tracking of resident benefit notifications, along with the Administrator.

A tracking tool for resident benefit notifications was developed, on 3/29/12, by the business office manager to be used as an ongoing audit tool to assist with compliance. This audit tool will be maintained by the business office manager and reviewed at the weekly utilization review

meeting by the Administrator  
and/ or MDS coordinator.

**4. How will the facility  
monitor its performance  
to make sure that  
solutions are sustained?**

Audits of the Medicare and/  
or Managed Care Non-  
Coverage and appeal Notices  
will be reviewed weekly in the  
utilization review meeting by  
the administrator and / or  
MDS coordinator for four  
weeks and then bi-monthly  
for two months. The results  
will be noted and reviewed in  
the monthly Quality  
Assurance meeting. Any issues  
or trends identified will be  
addressed by the Quality  
Assurance Committee as they  
arise and the plan will be  
revised as needed to ensure  
continued compliance. The

Quality Assurance Committee  
consists of the Quality  
Assurance Coordinator,  
Medical Director,  
Administrator, Director of  
Nursing, Social Services  
Director, Staff Development,  
Dietary Manager,  
Housekeeping Manager,  
Maintenance Manager, and  
Activities Director.

5. **The date that the  
corrective action will be  
completed;**

F156 was corrected by 4/4/12.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/23/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/09/2012
NAME OF PROVIDER OR SUPPLIER  RICHMOND PLACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 4 pays for the first 100 days of Skilled Services and there were no options for appeal after the one-hundredth day.	F 156	I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or findings, nor have we identified mitigating factors.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to develop a Comprehensive Care Plan within seven (7) days after the completion of the comprehensive assessment, for one (1) of seven (7) sampled residents (Resident #7). Review of the medical record revealed Resident #7 was admitted on 01/30/12 and his/her initial.	F 280		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/23/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/09/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  RICHMOND PLACE REHABILITATION AND HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	<p>Continued From page 5 comprehensive assessment was completed on 02/06/12.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Care Planning - Interdisciplinary Team", dated 12/08, revealed a comprehensive care plan for each resident is developed within seven (7) days of completion of the resident's Minimum Data Set Assessment (MDS).</p> <p>Interview with the Director of Nursing (DON), on 03/09/12 at 5:45 PM, revealed the facility's policy was to complete a comprehensive Plan of Care within seven (7) days of the completion of the comprehensive assessment for each resident.</p> <p>Review of Resident #7's medical record revealed the facility admitted Resident #7, on 01/30/12, with diagnoses which included Right Femoral Neck Fracture, Right Hip Hemiarthroplasty, Dementia, Glaucoma, Psychotic Behaviors, Constipation and Deep Vein Thrombosis Prophylaxis. Review of Resident #7's Minimum Data Set (MDS) Assessment revealed the Admission MDS assessment was completed for Resident #7 on 02/06/12.</p> <p>Review of the record revealed the facility initiated an Interim Plan of Care on 01/30/12 for falls, comfort/pain, behaviors, orthopedic complications, skin integrity and communication. Additional updates, on 03/06/12, to the Interim Plan of Care included risk for fluid imbalance/weight loss and alteration in bowel function at risk for constipation. However, there was no evidence a full Comprehensive Care Plan</p>	F 280	<p>The MDS Coordinator completed the comprehensive care plan for Resident # 7 on 3/7/12 and it was placed on the chart on 3/7/12.</p> <p><b>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</b></p> <p>All residents have the potential to be affected by this deficient practice. To identify any other residents at risk the MDS Coordinators completed an audit on 3/8/12 of all active residents to verify that each resident had a comprehensive care plan completed within seven (7) days of the comprehensive assessment. Any identified issues were addressed and corrected by 4/3/12.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/23/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/09/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  RICHMOND PLACE REHABILITATION AND HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509
---	--

(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)	(X6) COMPLETION DATE
F 280	<p>Continued From page 6 was developed for Resident #7.</p> <p>Interview with the MDS Coordinator, on 03/07/12 at 4:18 PM, revealed there was no Comprehensive Care Plan developed and the Comprehensive Care Plan should have been developed within twenty-one (21) days of the resident's admission.</p>	F 280	<p><b>3. What systemic changes will be made to ensure that the deficient practice will not recur?</b></p> <p>The Administrator and corporate RIA consultant re-educated the Interdisciplinary Team (IDT) consisting of the Director of Nursing, Assistant Director of Nursing, Unit Coordinators, MDS Coordinators, Social Service Directors, Lifestyles Director, and Dietary Manager on the care plan process including completion of comprehensive care plan within seven (7) days of completing the comprehensive assessment and revision of the care plan based on resident's history, current condition, and assessments. This re-education was completed by 4/3/12.</p>	

A comprehensive care plan review meeting will be conducted weekly with the IDT following completion of each MDS assessment to develop, review, and revise the resident's comprehensive plan of care based on results of the assessment.

**4. How will the facility monitor its performance to make sure that solutions are sustained?**

The RN MDS Coordinator will review two (2) records per week for four (4) weeks and then four (4) records per month following comprehensive care plan review by the Interdisciplinary Team to verify a comprehensive plan of care is developed, reviewed and revised based on the

comprehensive assessment. The RN MDS Coordinator will also verify that each resident and/or family be included in the care plan process and receive written notification of the care plan conference.

Results of the audit will be reported to the Administrator and Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Quality Assurance Coordinator, MDS Coordinators, Social Services Director, Staff Development Nurse, Lifestyles Director, Housekeeping Manager, Maintenance Manager, and Dietary Manager monthly for three (3) months to verify compliance and further recommendations as needed.

5. **The date that the  
corrective action will be  
completed;**

F280 was completed by  
4/4/12.