STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555153	A. BUILDING _____ B. WING _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESKATON CARE CENTER FAIR OAKS	11300 FAIR OAKS BLVD. FAIR OAKS, CA 95628

(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 The following reflects the findings of the California Department of Public Health during an Re-certification survey. Representing the Department of Public Health: HFEN 2589 / 31640 HFEN 2659 / 32476 HFEN 2660 / 32481 HFEN 2753 / 33456 HFEN 1958 / 29917 The facility census was 143, the sample size was 24 residents.	F 000	Eskaton Care Center Fair Oaks, without admitting fault submits the following plan of correction in accordance with the regulatory requirements found in Title 42, Code of Federal Regulation (CFR).	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility's clinical record review, the facility failed to follow the physicians orders for dressing change for one Random Resident's (RR C) PICC line (Peripherally Inserted Central Catheter), a small plastic tube inserted in a residents major vein in the arm or leg to allow administration of fluids or medications. This failure had the potential to place the resident at a high risk for infection. Findings: The facility admitted RR C on 01/09/14 with multiple diagnoses including hypertension, bacteruria (presence of bacteria in urine), and	F 281	A. The Peripheral Central Venous Catheter Dressing for RR C was changed on 6/3/2014. B. All residents/patients with intravenous catheters were assessed for compliance with standard of practice. No other residents/patients were noted out of compliance. C. All available licensed nurses staff were immediately re-educated on the policies and the standard of practices related to the care and maintenance of venous access devices. Nursing documentation to include the date of the last dressing change within the text of at least one nurse's note daily. Central line dressing changes are now assigned to a shift. Residents/patients residing in the	7-4-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/27/14

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

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F 281	Continued From page 1 urinary tract infection. RR C had the PICC line inserted on 5/16/14 and had a dressing that covered the insertion site. The dressing needed to be changed in 24 hours and as per facility's policy and procedure. The dressing was not changed on 5/17/14, 5/23/14/ or 5/30/14 as per facility's policy and procedure which read to change the dressing every 7 days. During an initial tour of the facility on 6/2/14 at 9:15 a.m., RR C was visited in the room and and she was observed to have a worn, off white gauze dressing on her upper left arm. The resident was asked when the dressing on her PICC line was changed and she stated that she was not sure if the dressing had been changed since the PICC line was inserted. During an interview with the Director of Nursing on 6/4/14 at 12 p.m., she confirmed, "The dressing should have been changed seven days after the PICC was inserted on 5/23/14 and again on 5/30/14, but was not changed." During an interview with the Licensed Vocational Nurse 4 on 6/5/14 at 11:56 a.m., he was asked for the reason of why the PICC line dressing change was not done as per facility's policy and procedure. He stated,..."The issue was a miscommunication between all the nurses." Review of the facility's policy and procedure titled "IV Site Care and Maintenance Dressing Change for Vascular Access Devices," dated 04/08, indicated that the dressing must be changed, "...To prevent local and systemic infection related to the IV site. It further added that ...2. Transparent membrane dressings (no gauze over site) are changed every 7 days and prn and that...	F 281	bed closest to the door (A bed) will be changed during the AM shift and the bed closest to the window will be changed during the PM shift. D. QAPI tool has been completed to conduct an audit at least 3 times per week to verify documentation of the last dressing change in the nurse's notes. Facility will also cross check with the IV medication administration flow sheet and view each resident with a venous access device. Audit tool will be forwarded to the director of nursing and/or designee upon completion. DON (designee) to monitor for compliance and identify trends or patterns. Reports will be forwarded to the Quality Assurance Performance Improvement Committee monthly x 6 months. E. Corrective In-service training was initiated on 6/4/2014 and remains ongoing.	

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F 281	Continued From page 2 5. Initial dressing will be changed PRN if saturated, and 24-48 hours post insertion of...PICC."	F 281		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow safe food handling practices, as evidenced by: 1. storing of outdated foods in the refrigerator, 2. thawing of nutritional supplements was not done according to the manufacturer's storage guideline, 3. storing opened and undated foods in the dry food storage, 4. storing a pair of unclean tongs (cooking utensil) with the clean utensils. These failures had the potential to cause foodborne illnesses in the residents. Findings: 1. During a Kitchen Tour with the dietary supervisor assistant (DSA) on 6/2/14, at 8:10	F 371	A. The butter milk, cheese, Farina, marshmallows and shakes were immediately discarded. The tongs were immediately removed and washed. An inspection for any additional expired food was conducted. B. No specific residents were identified or affected by the deficient practice. C. All food items that are not in compliance with the manufacturer's expiration date or the Refrigerator / Freezer Storage Chart will be discarded. Frozen supplements will be removed from the freezer as needed and stamped with an expiration date not to exceed 14 days. The DSA will inspect the "used by date" and/or the "expiration date" on all perishable and opened / undated dry food items during the DSA's weekly inspections. The areas noted to be deficient were included in the "Supervisor's kitchen walk through checklist" and will be conducted two times per week. D. In addition, the DSA will inspect the utensils and racks in the food	7-4-14

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F 371	Continued From page 3 a.m., the following items were found inside the walk-in refrigerator: a) A carton of buttermilk with a Best by Date of 5/18/14, but with no expiration date. b) A package of processed cheese food with a Packaging Date of 2/26/14, but with no expiration date. During a concurrent interview with the DSA on 6/2/14, at 8:10 a.m., he was unable to provide the expiration dates for the buttermilk and the process cheese food. During an interview with the dietary supervisor (DS) on 6/2/14, at 12:35 p.m., she stated for the food storage, the kitchen staff went by the manufacturer's expiration dates. If there was no expiration date, the staff would use the "Refrigerator/Freezer Storage Chart" as a guide to establish food items' shelf life. A review of the "Refrigerator/Freezer Storage Chart", dated 4/5/2010, indicated the shelf life for the: a) Refrigerated buttermilk was 1-2 weeks, which indicated the buttermilk in the walk in refrigerator had passed its shelf life for 16 days. b) Opened, refrigerated cheese was 3-4 weeks, which indicated the process cheese food in the walk in refrigerator had passed its shelf life for almost 10 weeks. 2. During the Kitchen Tour with the DSA on 6/2/14, at 8:20 a.m., a large quantity of thawed, undated, single serving cartons of Ready Care shakes (a nutritional supplement) were found inside the reach-in refrigerator.	F 371	preparation area for cleanliness as indicated on the supervisor's checklist. E. An in-service was conducted on 6/24/14 on the above items. The supervisor's checklist has been modified to include the additional items found to be deficient. The Dietary Consultant will conduct monthly inspections on proper dating, cleanliness and expired foods monthly for 3 months and quarterly thereafter. The QAPI committee has accepted this as a performance Improvement Project and will review the promised corrections monthly for next quarter. To ensure compliance.	

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F 371	Continued From page 4 During a interview with the DSA on 6/2/14, at 8:20 a.m., he stated since the facility used so much of those shakes, it would not be necessary to date and label the single serving cartons once they were taken out of the freezer for thawing. An inspection of the manufacturer's storage guideline for the Ready Care shakes indicated, "Storage and Handling: Store Frozen. Thaw under refrigeration (40 degrees F or below). After thawing, keep refrigerated. Use within 14 days after thawing." 3. During a tour of the dry food storage with the DS on 6/2/14, at 12:35 p.m., the following food items were found opened, unlabeled, and undated: a) A package of Farina Hot Wheat Cereal. b) A package of Miniature Marshmallows. During a interview with the DS on 6/2/14, at 12:35 p.m., she acknowledged that foods need to be dated upon opening. A review of the facility policy titled, "Food Storage" revised 5/19/14, indicated, "...3. Dry storage foods...Opened packages of dry food which are to be stored will be dated upon opening...4. Refrigerated storage...Opened containers will be dated and labeled. Use manufacturers guidelines for expiration dates...6. Frozen supplements placed in the refrigerator for thawing will be dated and used within the refrigerated shelf life determined by the manufacturer. The current supplements are Ready Care and can be held under refrigeration no longer than 14 days..." 4. During the Kitchen Tour with the DSA on	F 371		

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F 371	Continued From page 5 6/2/14, at 8:30 a.m., a pair of tongs with multiple yellow, crusty substances, was found hanging among the clean utensils, on a bar across from the walk-in refrigerator . During a interview with the DSA on 6/2/14, at 8:30 a.m., he stated that tong should not be with the clean utensils, and it needed to be washed.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	A. The disposable bladder catheter irrigation kit was disposed of immediately by the nurse when brought to her attention by the surveyor. B. All resident rooms were checked to ensure that no other disposable items were at bedside without appropriate labels or dates. No other items were found. C. All available nursing staff was immediately reeducated on the purpose and intent of disposable equipment and its proper disposal immediately after use. Training session was also inclusive of disposable items such as the enteral irrigation kit which must be replaced after 24 hours. (Second inservice was provided on June 19, 2014.) D. QAPI checklist tool developed indicating most common disposable equipment items supplied by central supply. Random infection control rounds	7-4-14

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F 441	Continued From page 6 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and document review, the facility failed to implement the infection control program when a used bladder irrigation kit with open container of used normal saline (solution used to irrigate the catheter) was left on the residents bed side table. This failure had the potential to expose the resident to transmission of disease and infection. Findings: Random Resident B was admitted on 05/23/14 with multiple diagnoses including chronic stage III kidney disease. During the initial tour of the facility on 6/2/14 at 8:45 a.m., an open bladder catheter irrigation kit, with an opened 118 cc (cubic centimeter) container, two unopened 118 cc containers, and a graduated cylinder with a 60 cc syringe were observed at the residents bed side table. During an interview with the License Nurse 5 on 6/2/14 at 8:45 a.m. she was asked regarding the opened irrigation kit. She responded, "Not sure who opened and used the kit."	F 441	will be conducted at least twice per week to monitor for extended use of disposable equipment and appropriate labeling and/or dating of equipment that does not require immediate disposal after use. Audit tool will be forwarded to the director of nursing and/or designee upon completion. DON (designee) to monitor for compliance and identify trends or patterns. Reports will be forward to the Quality Assurance and Performance Improvement Committee monthly x 6 months. E. Corrective in-service training was initiated on 6/4/2014 and will remain ongoing.	

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F 441	Continued From page 7 During an interview with the Director of Staff Development on 6/2/14 at 4:20 p.m., she confirmed that bladder irrigation kits are for single use only and must be discarded after each use. A review of the "Nursing Clinical Skills manual," 8th Edition, 2012, revealed... sterile irrigation set with catheter tip syringe (new set for each irrigation).	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain accurate clinical records for 1 of 24 sampled residents (11) and Random Resident (RR-A), when: 1) the nursing staff did not update and/or renew the doctor's orders accurately, which resulted in two conflicting orders; 2) the nursing staff did not document the pain medication administration.	F 514	Identified Issue 1 A. The Coumadin order for resident 11 was clarified to delete the special instruction to "Check PT/INR results on Monday and Thursdays" B. All physician orders for residents/patients receiving Warfarin (Coumadin) therapy were printed and checked to ensure that the lab order is separate from the medication order. No other Coumadin orders were found to have the same discrepancy. C. Memo issued to nursing staff to reinforce the separation or the laboratory studies from the medication orders and posted at each nurse's station. Unit secretaries, who also enter physician orders, also instructed to separate lab orders from the medication order. D. Unit Manager to verify monthly the orders for laboratory studies	7-4-14

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F 514	Continued From page 8 These failures had the potential to cause inadequate and inaccurate care to the residents. Findings: Resident 11 was readmitted to the facility on 5/3/12 with diagnoses that included atrial fibrillation (rapid irregular heart beats of the upper heart chambers which can form blood clots) and ischemic stroke (brain damage caused by a blood clot that lodges in a brain blood vessel, blocking blood flow to part of the brain), which were treated with warfarin (a medication to prevent the formation of blood clots). Resident 11 had two physician's orders: 1) One order dated 2/6/14, was to check Resident 11's Prothrombin Time (PT or PT/INR, a measurement of the blood's tendency to clot, in the measure of warfarin dosage) every Monday. 2) The other order dated 5/13/14 was for Resident 11 to receive warfarin 2.5 mg [milligrams] at bedtime. Special Instructions: ***CHECK PT/INR RESULTS ON MONDAY AND THURSDAYS*** During an interview with the Director of Nursing (DON) on 6/3/14 at 7:20 a.m., she stated when the coumadin (also known as warfarin) order was renewed, the computer automatically generated a "standing order" of "check PT/INR every Mondays and Thursdays". The nurse who inputted the coumadin order into the computer should have removed the standing order. During an interview with Licensed Nurse (LN) 3 on 6/4/14 at 1 p.m., she stated Resident 11's PT/INR had been stable, and therefore, the doctor changed the PT/INR order from every	F 514	for Coumadin use are separate from the medication administration orders for all residents/patients receiving anticoagulant therapy. Validation reports to be forwarded monthly to the director of nursing x 6 months E. Corrective in-service training was initiated on 6/19/2014. Identified Issue 2 A. The nurse administering the narcotic failed to complete the final step of for the medication administration process as required by the software program (Matrix®). This failure allowed for another nurse to sign for "own" administration of the medication. B. Matrix was contacted to explain how documentation error occurred. Administration is now able to request an Administration compliance report to monitor "Prep/Not Administered and Confirmed by Different User." This report will identify any nurse who fails to complete the final step for the administration process. No other residents were identified to have had the same issue for 06/04/2014. C. All available licensed nurses were reeducated on the importance of completion of all	

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F 514	Continued From page 9 Monday and Thursday to every Monday only. However, the nurse who updated the coumadin order had forgotten to remove the previous special instruction of checking PT/INR every Mondays and Thursdays. During an interview with the D wing unit manager (UM) 3 on 6/4/14 at 2 p.m., she stated the nurse who updated the coumadin order had forgotten to remove the previous special instruction of checking PT/INR every Mondays and Thursdays. She stated she also had missed the special PT/INR instruction during her monthly recapitulations of the doctor's orders. During an interview with the physician on 6/4/14 at 5:10 p.m., he stated Resident 11's PT/INR had been stable, therefore, his PT/INR only needed to be checked once a week. A review of the Resident Progress Notes dated 1/23/14 at 14:22 p.m., indicated the doctor ordered to change the PT/INR order to every Monday only. Further review of the Resident Progress Notes showed nursing staff had been notifying the doctors about the Monday PT/INR results from February 2014 to the end of May 2014. A review of the Anticoagulant Administration History indicated the facility had been checking Resident 11's PT/INR every Monday from February 2014 to May 2014. A review of the facility's computer documentation procedure titled "Physician Orders" undated, indicated, "...Reactivation an Order: Expired and discontinued orders can be reactivated. Reactivated orders are created like new orders,	F 514	steps for the process of medication administration. Request has been made to Matrix to enhance program to improve the notification process of incomplete tasks. D. Compliance report will be requested from the software program daily Monday – Friday by the Director of Nursing or designee to monitor this component of the medication administration process x 3 months. Individual training and reeducation will be provided for nurses who fail to complete each step of the medication administration process. Nurse with infractions of more than three occurrences will be address through progressive disciplinary process. E. Corrective in-service training was initiated on 6/19/2014 and remains ongoing.	

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F 514	Continued From page 10 but have all order information copied from the original, except for the start date (default to the current day) and end date (matches the original order's duration, for example 14 more days or open ended). Reactivated orders do need new order signatures for all physician orders..." 2) On 6/4/14, the facility's B Wing Medication Cart was inspected, and the Controlled Drug Record for RR-A, showed that at 6 a.m. on 6/3/14, two Hydrocodone (Norco) tablets were removed from the cart by the night shift nurse. When the electronic Medications Administration History (e-MAH) was inspected to determine if the medication was given, documentation failed to show that it was administered at 6 a.m. The e-MAH, instead showed that the Norco tablets were charted as administered by the day shift nurse, over 7 hours later at, 1:15 p.m. During an interview with the night shift nurse (LN 2) on 6/4/14, she declared administering the Norco tablets 6 a.m. But, due to the tasks needed to complete a medication pass in the computer, it failed to record the actual time the medication was administered. There was no written evidence, anywhere in the record, that Norco tablets were given at 6 a.m. The Facility's policy and procedures titled, Medication Administration Controlled Substances, dated 10/07, states in part that, "When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record when removing dose from controlled storage: Date and time of administration. The Policy further indicates that the nurse should, "Administer the controlled	F 514		

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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) COMPLETION DATE
F 514	Continued From page 11 medication and document dose administration on the MAR [Medication Administration Record]."	F 514		
F 517 SS=C	483.75(m)(1) WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have detailed written plans and procedures to meet emergencies and disasters when: 1) The Emergency Water Supply Policy did not specify the locations of all the emergency water storage. 2) Staff was unaware of the use of a food grade water hose for potable (safe for drinking) water during emergency. 3) The Disaster Menu did not include a vegetarian diet. These failures had the potential to cause facility staff to not be prepared in case of an emergency or disaster. Findings: 1) A review of the Dietary disaster-emergency plans on 6/3/14, at 12 p.m., indicated water in the Blue Barrels was included for potable water use. The plan did not specify the locations of the Blue Barrels.	F 517	A. An inservice was given on 6/27/14 with an emphasis on the location of all emergency water, and how to access the water using the emergency "food grade" hoses. B. No residents were affected by the deficient practice. C. Both non-food grade hoses were removed from the emergency supplies and replaced with "Food Grade" hoses. The location of all emergency water and the use of a food grade hose is written and placed in the "Disaster policy and procedure manual". To address the Vegetarian Diet, the menu can be found in the Emergency Food Disaster manual. An inservice on accessing and preparing the vegetarian food from the provided Menu were covered in the in-service on 6/27/14. D. The facility will monitor the effectiveness of the in-services by conducting a written "Disaster Preparedness" quiz each month for the first quarter and again at 6 months. This project will be accepted by the QAPI team as a Performance improvement	7-4-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555153	A. BUILDING _____ B. WING _____	06/05/2014

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F 517	Continued From page 12 During an interview with the dietary supervisor (DS) on 6/3/14, at 1 p.m., she was unable to locate the Blue Barrels. During a concurrent interview with a floor technician (FT) on 6/3/14, at 1 p.m., he was unable to locate one of the three Blue Barrels. During an interview with the director of environment service (DES) on 6/3/14, at 1:10 p.m., he acknowledged the Emergency Water Plan needed to specify the locations of the Blue Barrels. A review of the facility's disaster menu titled "Emergency Solution: MEALS for ALL" dated 1/2014, indicated, "...In-Service Topic Outline...Trained nutrition staff may not be available during emergency, so plan must be known by other departments...Water is a critical factor during an emergency and a plan for water storage and use is available...Behavioral Objectives: 1. Know location of...water storage..." 2) Further review of the Dietary disaster-emergency plans on 6/3/14 at 12 p.m., indicated water in the hot water tanks was included for potable water use. The plan did not mention the use of food grade water hose for emergency water. During an observation on 6/4/14 at 5:00 p.m., two non food grade water hoses were found inside the facility emergency kit. During a concurrent interview with the DES and maintenance assistant (MA) on 6/4/14 at 5:00	F 517	Project and the effectiveness will be reported to the QA committee for evaluation. E. Inservice dates will be June 27th 2014 and any follow up inservices will be prior to July 5th, 2014.	

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F 517	Continued From page 13 p.m., they verified the two non food grade water hoses were to be used for conveying potable water from the hot water tanks during emergency. They stated they were not aware of the need for food grade water hoses for emergency water and did not know if the facility had any food grade water hoses. They also stated the facility did not have policy relating to using food grade water hose for emergency water. Relevant Citations from the Federal Food Code 2013 5-304.14 Tank, Pump, and Hoses, Dedication. (A) Except as specified in (B) of this section, a water tank, pump, and hoses used for conveying DRINKING WATER shall be used for no other purpose. (B) Water tanks, pumps, and hoses APPROVED for liquid FOODS may be used for conveying DRINKING WATER if they are cleaned and SANITIZED before they are used to convey water. 5-104.12 Alternative Water Supply. Water from an approved source can be contaminated if inappropriately conveyed. Improperly constructed and maintained water mains, pumps, hoses, connections, and other appurtenances, as well as transport vehicles and containers, may result in contamination of safe water and render it hazardous to human health. Materials 5-201.11 Approved. Plumbing systems and hoses conveying water must be made of approved materials and be smooth, durable, nonabsorbent, and corrosion-resistant. If not, the system may constitute a health hazard because unsuitable	F 517		

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F 517	Continued From page 14 surfaces may harbor disease organisms or it may be constructed of materials that may, themselves, contaminate the water supply. 5-302.16 Hose, Construction and Identification. Hoses used to fill potable water tanks should be dedicated for that one task and should be identified for that use only to prevent contaminating the water. Hoses must be made of a material that will not leach detrimental substances into the water. 3) A review of the facility's disaster menu titled "Emergency Solution: Meals for all" dated 1/2014, indicated no vegetarian diet. During an interview with the registered dietitian (RD) on 6/4/14, at 9:15 a.m., she stated a vegetarian menu was in another binder. Further review of the disaster menu indicated no cross-referencing of any vegetarian menu in another binder.	F 517		