

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365899	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/15/2025
NAME OF PROVIDER OR SUPPLIER  Oak Creek Terrace Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2316 Springmill Road Kettering, OH 45440	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, medical record review, and staff interviews, the facility failed to ensure physician orders were followed during a dressing change of a pressure ulcer. This affected one (#29) of the two residents reviewed for pressure ulcers during the annual survey. The facility identified two residents (#27 and #29) with pressure ulcers. The facility census was 62.</p> <p>Findings included:</p> <p>Review of the medical record for Resident #29 revealed an admission date of 09/15/22. Medical diagnoses included fracture of the left femur, heart failure, hypertension, renal insufficiency, neurogenic bladder, malnutrition, and respiratory failure.</p> <p>Review of a physician order for Resident #29 dated 04/16/25, revealed the resident was ordered to have her sacrum pressure ulcer cleansed with normal saline, have Silvadene applied, then a barrier cream applied, and covered with an abdominal (ABD) pad placed over the wound twice daily.</p> <p>Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 was severely cognitively impaired. The resident was dependent on staff for transfers and toileting via Hoyer mechanical lift and required substantial/moderate assistance for other activities of daily living (ADLs).</p> <p>During an observation of a pressure ulcer dressing change for Resident #29 with Licensed Practical Nurse (LPN) #50 and Wound Nurse Practitioner (WNP) #102 on 05/14/25 at 6:56 A.M. revealed WNP #102 turned the resident to her left side. LPN #50 applied gloves and pulled down the resident's incontinent brief. LPN #50 took a washcloth and wiped off the old medication and then applied Silvadene with the same gloved hands. LPN #50 washed her hands in the bathroom, applied new gloves and applied barrier cream and covered with an ABD pad on the resident's sacrum wound.</p> <p>Interview with the LPN #102 on 05/14/25 at 7:03 A.M., verified she didn't cleanse Resident #29's pressure wound with normal saline per physician orders. LPN #102 verified she didn't follow the physician orders when doing Resident #29's pressure ulcer dressing change.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, staff interview and policy review, the facility failed to ensure a fall with major injury was thoroughly investigated. This affected one (#29) resident of the five residents reviewed for accidents. The facility census was 62.</p> <p>Findings included:</p> <p>Review of the medical record for Resident #29 revealed an admission date of 09/15/22. Medical diagnoses included fracture of the left femur, heart failure, hypertension, renal insufficiency, neurogenic bladder, malnutrition, and respiratory failure.</p> <p>Review of a Fall Assessment for Resident #29 dated 02/03/25, revealed the resident was at a medium risk for falls.</p> <p>Review of the Plan of Care for Resident #29 dated 02/19/25 revealed the resident was at risk for falls related to age, history of falls, and physical debility. Interventions included to ensure basic needs are met, offer food and fluids, monitor bowel and bladder function, monitor for a comfortable environment, monitor for change in medical status, low blood pressure, shortness of breath changes, change in function status related to acute or chronic medical conditions, side effects to medications and follow the fall protocol if an incident occurs.</p> <p>Review of an Occurrence Note dated 04/04/25 at 1:30 A.M., revealed Resident #29 had an unwitnessed fall. The nurse went into the room and found the resident lying on her right side on the floor next to the bed. The resident reported I was trying to get the baby. The resident was assessed with an abrasion to the right side of the head, right knee, and right toes. The intervention was to lay down fall mats. The physician and the family were notified. The resident was sent to the hospital.</p> <p>Review of the facility investigation dated 04/04/25 revealed a nurse went into Resident #29's room and found the resident lying on her right side on the floor next to the bed. The resident reported she was trying to get the baby. An assessment revealed abrasions to the right side of the head, right knee, right toes and the vital signs were within normal limits. The physician and the family were notified. The resident was oriented to person, the call light was not on, the resident was a Hoyer lift for all transfers, confused, and incontinent. The resident was sent to the hospital. A new intervention was to lay down fall mats on the floor. The Root Cause Analysis (RCA) was noted the resident got up on her own and fell. The investigation file contained no witness statements.</p> <p>Review of the hospital records for Resident #29 dated 04/04/25, revealed the resident was diagnosed with a closed fracture of distal end of left femur following a fall.</p> <p>Review of Interdisciplinary Team (IDT) documentation for Resident #29 dated 04/04/25, revealed the team agreed to the fall mats for an appropriate intervention and despite the interventions the resident remains at risk for falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 was severely cognitively impaired. The resident was dependent on staff for transfers and toileting via Hoyer mechanical lift and required substantial/moderate assistance for other activities of daily living (ADLs).</p> <p>Interview with the Administrator and the Director of Nursing (DON) on 05/14/25 at 7:18 A.M. revealed they and the IDT met as a group and talked about Resident #29's fall. The Administrator noted the group talked about the new interventions and if they were appropriate, and the fall itself. The Administrator stated they talked to the staff but there was nothing in writing and there wasn't anything in writing about the interventions in place at the time of the fall, anything in writing concerning the last time someone saw the resident and what she was doing at the time and nothing documented when the resident was last toileted.</p> <p>Review of the policy entitled Fall Management dated 01/01/21 revealed each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls. When any resident experiences a fall, the facility will do the following: Assess the resident, complete a post-fall assessment, notify the physician and family, review the resident's care plan and update as indicated, document all assessments and actions and obtain witness statements in the case of injury.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on medical record review, observation, staff interview and policy review, the facility failed to ensure the placement of a gastrostomy tube (G-tube), failed to ensure a resident was positioned at 30 - 45 degree angle, failed to ensure the syringe for administering medications via the G-tube was dated, and failed to ensure medications being administered through the G-tube were properly diluted prior to administering them. This affected one (#41) of the two residents identified by the facility as having a G-tube. The facility census was 62.</p> <p>Findings included:</p> <p>Review of the medical record for Resident #41 revealed an admission date of 06/19/24. Diagnoses included dementia, dysphagia, diabetes mellitus, cellulite of the left lower limb, peripheral vascular disease, renal insufficiency, and benign prostatic hyperplasia.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #41 was moderately cognitively impaired and had a G-tube for nutrition.</p> <p>Review of a physician order for Resident #41 dated 08/01/24 revealed an order to crush medications.</p> <p>Review of a physician order for Resident #41 dated and on 01/21/25 revealed the resident was ordered to receive Aspirin 81 milligram (mg) once a day.</p> <p>Review of a physician order for Resident #41 dated 02/24/25, revealed the resident was ordered to receive enteral feed Jevity 1.2 bolus four times a day,</p> <p>Observation during a medication administration on 05/14/25 at 7:40 A.M., revealed Licensed Practical Nurse (LPN) #101 crushed the aspirin at the medication cart and placed it in a medication cup without any water for diluting then carried the aspirin the container of Jevity into the resident's room. LPN #101 positioned Resident #41 at 90 degrees in his chair. LPN #101 retrieved an undated syringe lying on a towel in the resident's bathroom, connected it to the resident's G-tube and administered 30 milliliters of water through the G-tube. LPN #101 then placed the crushed aspirin in the syringe followed by water. LPN #101 then administered the bolus of Jevity through the G tube and flushed the tube. LPN #101 did not verify G-tube placement prior to administering the water, aspirin, and the bolus of Jevity</p> <p>Interview with the LPN #101 on 05/14/25 at 7:50 A.M., indicated she didn't know the policy for G-tubes. LPN #101 verified she didn't check placement of the G-tube prior to administering the water, medication and the bolus of Jevity. LPN #101 confirmed the syringe wasn't dated; the resident was positioned at a 90-degree angle in his chair instead of a 30-45 degree angle and didn't dilute the aspirin with water before placing it in the syringe.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the policy entitled G-tube Administering Medications dated 01/25/20 revealed the purpose is to safely and accurately administer medications through an enteral tube. To assist with patency of the G-tube, flushes may be administered per physician order.</p> <p>Staff will follow the following procedure: Prepare the medications for administration, verify the tube placement by slowly aspirating the residual stomach contents, (no more than 150 mls), return the contents to stomach, crush medications and dissolve in water or other appropriate liquid or empty capsule contents into water or other appropriate liquid, after administering the compatible medication mixture, a flush of 15 -30 ml of water should be administered before administering the remaining non- compatible medications, remove the plunger from the syringe and connect the syringe to the clamped tubing, unclamp tubing and flush the tube with 15 - 30 ml of water prior to medication administration, pour medication in syringe, unclamp tubing and allow medication to flow down tube via gravity or give gentle boosts with the plunger if the medication will not flow well by gravity, flush the tube with 15 - 30 ml of water after all medication is administered then make resident comfortable and ensure call light is within reach.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, staff interviews and policy review, the facility failed to ensure food and utensils were stored in a safe and sanitary manner. This had the potential to affect 61 out of the 62 residents as the facility identified one resident (#41) with a diet of nothing by mouth (NPO) and received no food from the kitchen. The facility census was 62.</p> <p>Findings include:</p> <p>Observation of the kitchen on 05/14/25 at 12:11 P.M. with Dietary Manager (DM)#06, revealed frozen bags of pot roast were being stored in water in the preparation (prep) sink. Interview at the same time with DM #06, verified they were thawing the pot roast and that cold water should be running while food is thawing in the sink.</p> <p>Continued observation of the kitchen on 05/14/25 at 12:13 P.M. with DM #06, revealed a stack of Styrofoam cups stored on a cart in the dining room. Next to the stack of cups was a bucket of sanitizer solution and a spray bottle labeled Buckeye Eco Heavy Duty Cleaner stored on the shelf above. Interview at the same time with DM #06, verified the findings. DM #06 stated the Styrofoam cups were not supposed to be stored on the cart and chemicals were to be on a storage shelf in the kitchen.</p> <p>Continued observation of the kitchen on 05/14/25 at 4:53 P.M. with DM #06, revealed a stack of wet cups stored on the tray line. Interview at the same time with DM #06, verified the wet cups were being stored on the line. DM #06 stated cups were supposed to air dry on a rack near the three-compartment sink after being cleaned and sanitized.</p> <p>Review of the undated facility policy titled General Food Preparation and Handling revealed food thawing in a sink should be submerged under cold water that is running fast enough to agitate and float off loose ice particles.</p> <p>Review of the undated facility policy titled Policy for Storing Chemicals revealed that chemicals will be stored on a lower shelf away from food or items which may come in contact with food and/or service.</p> <p>Review of the undated facility policy titled Policy for Air Drying Equipment and Utensils revealed after cleaning and sanitizing, utensils, they are to be air dried until dry before being stacked or used for service.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review and staff interview, the facility failed to ensure residents' medical records were complete and accurately documented when a resident sustained a fall with a major injury and was documented in a resident's medical record. This affected one (#29) of the five residents reviewed for accidents during the annual survey. The facility census was 62.</p> <p>Findings included:</p> <p>Review of the medical record for Resident #29 revealed an admission date of 09/15/22. Medical diagnoses included fracture of the left femur, heart failure, hypertension, renal insufficiency, neurogenic bladder, malnutrition, and respiratory failure.</p> <p>Review of a Fall Assessment for Resident #29 dated 02/03/25, revealed the resident was at a medium risk for falls.</p> <p>Review of the Plan of Care for Resident #29 dated 02/19/25 revealed the resident was at risk for falls related to age, history of falls, and physical debility. Interventions included to ensure basic needs are met, offer food and fluids, monitor bowel and bladder function, monitor for a comfortable environment, monitor for change in medical status, low blood pressure, shortness of breath changes, change in function status related to acute or chronic medical conditions, side effects to medications and follow the fall protocol if an incident occurs.</p> <p>Review of an Occurrence Note dated 04/04/25 at 1:30 A.M., revealed Resident #29 had an unwitnessed fall. The nurse went into the room and found the resident lying on her right side on the floor next to the bed. The resident reported I was trying to get the baby. The resident was assessed with an abrasion to the right side of the head, right knee, and right toes. The intervention was to lay down fall mats. The physician and the family were notified. The resident was sent to the hospital.</p> <p>Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 was severely cognitively impaired. The resident was dependent on staff for transfers and toileting via Hoyer mechanical lift and required substantial/moderate assistance for other activities of daily living (ADLs).</p> <p>Review of the hospital records for Resident #29 dated 04/04/25, revealed the resident was diagnosed with a closed fracture of distal end of left femur following a fall.</p> <p>Review of the notes in the Electronic Medical record (EMR) for Resident #29 from 04/04/25 through 05/14/25, revealed no documented notes about the resident having an unwitnessed fall on 04/04/25 and sustaining a fracture of the left femur.</p> <p>Interview with the Director of Nursing (DON) on 05/14/25 at 7:18 A.M. confirmed there wasn't a note in the chart about Resident #29 sustaining a fractured femur after an unwitnessed fall on 04/04/25.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, medical record review, and staff interviews, the facility failed to ensure infection control practices were followed during a dressing change for a pressure ulcer. This affected one (#29) of the two residents reviewed for pressure ulcers during the annual survey. The facility identified two residents (#27 and #29) with pressure ulcers. The facility also failed to ensure their Water Management Plan (WMP) was followed. This had the potential to affect 62 residents who resided in the facility. The facility census was 62.</p> <p>Findings included:</p> <p>1) Review of the medical record for Resident #29 revealed an admission date of 09/15/22. Medical diagnoses included fracture of the left femur, heart failure, hypertension, renal insufficiency, neurogenic bladder, malnutrition, and respiratory failure.</p> <p>Review of a physician order for Resident #29 dated 04/16/25, revealed the resident was ordered to have her sacrum pressure ulcer cleansed with normal saline, have Silvadene applied, then a barrier cream applied, and covered with an abdominal (ABD) pad placed over the wound twice daily.</p> <p>Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 was severely cognitively impaired. The resident was dependent on staff for transfers and toileting via Hoyer mechanical lift and required substantial/moderate assistance for other activities of daily living (ADLs).</p> <p>During an observation of a pressure ulcer dressing change for Resident #29 with Licensed Practical Nurse (LPN) #50 and Wound Nurse Practitioner (WNP) #102 on 05/14/25 at 6:56 A.M. revealed WNP #102 turned the resident to her left side. LPN #50 applied gloves and pulled down the resident's incontinent brief. LPN #50 took a washcloth and wiped off the old medication and then applied Silvadene with the same gloved hands. LPN #50 washed her hands in the bathroom, applied new gloves and applied barrier cream and covered with an ABD pad on the resident's sacrum wound.</p> <p>Interview with the LPN #102 on 05/14/25 at 7:03 A.M. revealed she thought she had changed her gloves in between dirty to clean, but after the Surveyor explained the observation, she admitted she didn't leave the bedside twice to wash her hands and apply new gloves. LPN #102 verified she should have washed hands between going from dirty to clean wound care.</p> <p>2) Review of the facility's WMP with Maintenance Staff #89 on 05/14/25 at 2:30 P.M., revealed the water temperatures and free chlorine levels would be completed monthly for the incoming water main and cold water system.</p> <p>Review of the facility's policy titled Legionnaires Disease last reviewed 2021, with Maintenance Staff #89 on 05/14/25 at 2:30 P.M., revealed the facility should implement mechanical, operational, and chemical control measures that originate from the risk assessment.</p> <p>Interview on 05/14/14 at 2:37 P.M. with Maintenance Staff #89, verified that the facility has not completed monthly cold water temperatures or free chlorine levels.</p>		