

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/10/2015
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NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: June 4, 5, 8, 9, and 10, 2015</p> <p>Facility number: 000178 Provider number: 155280 AIM number: 100273840</p> <p>Census bed type: SNF/NF: 97 Total: 97</p> <p>Census payor type: Medicare: 12 Medicaid: 60 Other: 25 Total: 97</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>We respectfully request a desk review for all tags.</p> <p>Enclosed please find the plan of correction for The Waters of Dillsboro/Ross Manor for Annual Survey date of June 10, 2015. Please review our plan of correction and accept this as a proof of compliance. Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p>	
F 0241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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	<p>dignity and respect in full recognition of his or her individuality.</p> <p>Based on interview and record review, the facility failed to ensure each resident maintained their dignity related to timely toileting for 2 of 3 residents reviewed of the 2 residents who met the criteria for dignity. (Residents #162 and #163)</p> <p>Findings include:</p> <p>1. During a confidential interview on 06/05/2015 at 2:19 P.M., Resident #163 indicated staff leaves [the resident] wet with urine and feces. The resident further indicated he/she has had to wait for 45 minutes for assistance after pressing the call light and had complained to the nurses about the long wait times.</p> <p>During a confidential interview on 06/10/2015 at 9:50 A.M., Resident #163 indicated he/she has had to wait a long time for assistance during the evening shift. The resident further indicated the facility did not have enough help and yesterday, 06/09/2015, he/she had to wait 30 minutes for assistance during the day shift because there was only one CNA (Certified Nursing Assistant) working on the unit. The resident indicated once a week, or more, there was only one CNA working on the unit. This had occurred on both the day and evening shifts.</p>	F 0241	<p>Tag F-41 A:Actions Taken: Residents #162 and #163 are receiving care and assistance in a timely manner and they are content with the staff's response to assist them. B:Others Identified: Residents who require moderate to extensive assistance with ADLs (activities of daily living) have the potential to be affected by this finding. C:Measures Taken: An audit was completed to identify residents who reside in the facility and who require moderate to extensive assistance with ADLs based on their MDS. This group was divided into interviewable and non-interviewable residents. D:How Monitored: The DON/Designee or SSD will interview those residents who are able to be interviewed 3 days weekly to see that they are receiving timely care and assistance. Non-interviewable residents who receive moderate to extensive assistance will be assessed 3 days weekly by a nurse to see that ADLs are being completed timely based on their cleanliness, oral care, nail care and their cleanliness and dryness as related to any incontinent episodes. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Any concerns observed during this monitoring will be addressed as found. The</p>	07/10/2015			

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	<p>Review of the Clinical Record on 06/09/2015 at 11:01 A.M. indicated Resident #163 had diagnoses including, but not limited to, stroke, lack of coordination and muscle weakness. The admission MDS (Minimum Data Set) assessment, dated 05/07/2015, indicated Resident #163 had a BIMS (Brief Interview for Mental Status) score of 15 and was alert and oriented. The assessment further indicated the resident needed extensive assistance of two staff members with toileting.</p> <p>2. During a confidential interview on 06/10/2015 at 8:13 A.M., Resident #162 indicated that on some occasions he/she had to wait up to 45 minutes to get assistance to get off the bedpan. The resident indicated that he/she once "...pee'd the bed ..." and also indicated, "...You feel awful when you do that ...that's just a horrible experience ..."</p> <p>The clinical record for Resident #162 was reviewed on 6/10/2015 at 8:52 A.M. Diagnoses included, but were not limited to, weakness and acute renal failure. Resident #162's most recent quarterly MDS (Minimum Data Set) assessment indicated the resident had a BIMS (Brief Interview for Mental Status) of 15, which</p>		<p>results of the monitoring will be reviewed at the daily CQI meetings. Inservice held with all nursing staff included the text of Federal Guideline F-241 and reviewed with emphasis on the Resident Right related to timely care and meeting of the resident's needs to include toileting and incontinent care. Any staff who fail to comply with the points of the inservice will be further educated and or progressively disciplined. As stated prior, the monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Results of the monitoring will be reviewed daily in the CQI meetings. While any negative findings will have been corrected as found, the QA committee will identify any patterns and an Action Plan will be written by the committee as needed. The administrator will monitor any Action Plan weekly until resolution. After the 4 consecutive weeks of zero negative findings is achieved, for a period of no less than 6 months, the DON/Designee or SSD will monitor at least 10% of the residents monthly to see that compliance is maintained. E:This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.</p>		

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F 0353 SS=E Bldg. 00	<p>indicated he/she was cognitively alert and oriented. The MDS also indicated the resident was always continent of urine and required extensive assistance of two staff persons with toileting.</p> <p>3.1-3(t)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on interview and record review, the facility failed to ensure sufficient staff were available to answer call lights in a timely manner, assist residents with ADLs (activities of daily living)</p>	F 0353	<p>Tag F-353 A:Actions taken: Residents #161, #162 and #163 are satisfied with response time to the call lights for assistance with ADLs. assistance with toileting and showering as well as responding to medication</p>	07/10/2015

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	<p>including showering and toileting and respond to medication requests promptly for 3 of 4 residents interviewed (Residents 161, 162, 163) and 4 of 6 staff interviewed (Staff #1, Staff #2, Staff #3, Staff #4).</p> <p>Findings include:</p> <p>During confidential interviews on 06/05/2015 at 2:19 P.M. and 06/10/2015 at 9:50 A.M., Resident #163 indicated he/she waits a long time for assistance on second shift (2-10 P.M.). Resident #163 also indicated that staff had left [the resident] wet with urine and feces at one time. The resident indicated there was not enough help and that yesterday (06/09/2015) he/she had to wait 30 minutes "...because there was only one girl ...". Resident #163 further indicated that at least once a week, there is only one aide working the floor and that he/she has had to wait 45 minutes for the call light to be answered.</p> <p>During a confidential interview on 06/09/2015 at 2:56 P.M., Staff #2 indicated he/she felt like there was not enough time to get everything done. Staff #2 further indicated the Certified Nursing Assistants (CNA) needed more help and that "they spread themselves really thin".</p>		<p>requests. Staff members #1,#2,#3 and #4 are able to perform their assignment duties timely within their shift. B:Others identified: Residents who reside in the facility have the potential to be affected by this finding. C:Measures taken: Based on MDS documentation, a list of interviewable residents was compiled. Three days weekly on various shifts the DON/Designee or SSD will interview 10 of these residents to see if they are satisfied with timely call light response and timely care including assistance with personal care and/or medication administration. These interviews will continue until 4 consecutive weeks of zero negative findings are achieved. The results of the monitoring (interviews) will be reviewed daily at the CQI meetings. The staff will be interviewed, 2 staff members per shift in the 3 main areas (Dillsboro, Ross, Hope Springs) 3 days weekly to see if they are able to complete their assignments. These interviews will continue until 4 consecutive weeks of zero negative findings are achieved. The results of the monitoring (interviews) will be reviewed daily at the CQI meetings. D:How monitored: The administrator/DON will ask to attend a portion of the Resident Council meetings over the next 6 months for feedback related to their needs being met in</p>		

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	<p>During a confidential interview on 06/09/2015 at 3:13 P.M., Staff #3 indicated that every day he/she feels there is too much to get done. Staff #3 further indicated that, if there are only two aides working, they rarely get all the showers done.</p> <p>During a confidential interview on 06/10/2015 at 8:13 A.M., Resident #162 indicated that sometimes he/she would have to lay there for 45 minutes before being helped off the bedpan. The resident indicated that he/she had "...pee' d in the bed ..." due to having to wait so long for staff to answer the call light and also indicated, "...you feel awful when you do that ...that's a horrible experience ..."</p> <p>During a confidential interview on 6/10/2015 at 8:53 A.M., Staff #1 indicated that the CNAs could always use more help, especially when there was only one aide on Station 2 and one aide on Station 3 and a float. Staff #1 indicated when this happens, "...nothing gets done ..."</p> <p>During a confidential interview on 06/10/2015 at 9:23 A.M., Resident #161 indicated he/she had to wait a long time for the call light to be answered and that sometimes he/she has had to wait a long time for pain medication. The resident</p>		<p>reasonable time by staff. Any concerns will be addressed. The Administrator and DON will review the staffing patterns and make adjustments and changes as indicated. The Administrator and DON will review the staffing patterns and make adjustments as indicated. The Administrator has a plan in place to advertise and attract staff and incentives in place to attract applicants to keep the staffing pool numbers adequate. The results of the monitoring to see if residents feel staff response is timely and also to see if staff feel they can complete their assignments timely will be reviewed at the daily CQI meetings. Any patterns will be identified and addressed by an Action Plan written by the committee. Any Action Plan will be reviewed weekly by the Administrator until resolution. After the 4 consecutive weeks of zero negative findings is achieved, 10 residents and 10 staff members (9 various areas and shifts) will be interviewed monthly for a period of no less than 6 months to ensure ongoing compliance. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.</p>				

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	<p>further indicated this was a problem on all shifts, but especially on the third shift (10 P.M. - 6 A.M.).</p> <p>During a confidential interview on 06/10/2015 at 10:22 A.M., Staff #4 indicated that when there is only one CNA working on the floor, it is hard to get all of the residents up and ready. Staff #4 further indicated that when there is only one CNA, and a resident who requires a Hoyer lift (mechanical lift) needs assistance, he/she asks the nurse for help, but if the nurse is unavailable he/she has to go to another nursing station to ask another CNA for assistance. Staff #4 indicated that there had been times when a resident had an incidence of incontinence, when they normally wouldn't, because he/she had to go to another station for help.</p> <p>The "As Worked" schedule (the staff schedule showing exactly who worked and during what times) was provided by the Staffing Coordinator on 06/09/2015 at 9:34 A.M. The schedule indicated:</p> <p>On the following dates there was only one nurse and one CNA for half or more of the day shift:</p> <p>05/24/2015 on Station 2 05/25/2015 on Station 2</p>			

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	<p>05/29/2015 on Station 2 05/30/2015 on Station 2</p> <p>On the following dates there was only one nurse and one CNA for half or more of the evening shift:</p> <p>05/18/2015 on Station 2 and Station 3 05/20/2015 on Station 3 05/23/2015 on Station 2 and Station 3 05/24/2015 on Station 3 05/28/2015 on Station 2 and Station 3 (One CNA was assigned to each Station with one CNA floating between Station 2 on the first floor and Station 3 on the second floor.) 05/29/2015 on Station 3 05/30/2015 on Station 2</p> <p>On the following dates there was one nurse that floated between Station 1 (the locked Alzheimer's unit) and Station 2, while also having only one CNA, for at least one of these Stations during night shift:</p> <p>05/20/2015 05/21/2015 05/22/2015 05/23/2015 05/25/2015 05/27/2015 05/29/2015 05/30/2015</p>			

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	<p>An untitled, typed document, provided by the DON (Director of Nursing) on 6/10/2015 at 9:42 A.M., indicated there were currently 27 residents on Station 1, 18 residents on Station 2, 24 residents on Station 3, and 26 residents on Ross, with a total of 95 residents.</p> <p>The "Ross Blab" list, the "Hoyer lifts" list, and the "2 person assist" list, provided by the DON on 6/10/2015 at 10:19 A.M., indicated 9 residents from Ross and 13 residents total from Stations 1, 2 and 3, required use of a Hoyer lift. This documentation further indicated that 19 residents required two staff members for assistance with care.</p> <p>Record review on 06/10/2015 at 1:05 P.M. indicated the following:</p> <p>Resident #163's Admission Minimum Data Set (MDS) assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 and was cognitively alert and oriented. The MDS also indicated the resident required extensive assistance of two staff persons with toilet use.</p> <p>Resident #162's MDS assessment indicated the resident had a BIMS of 15 and was cognitively alert and oriented.</p>			

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	<p>The MDS also indicated the resident was always continent of urine and that Resident #162 required extensive assistance of two staff persons with toilet use.</p> <p>Resident #161's MDS assessment indicated the resident had a BIMS of 15 and was cognitively alert and oriented. The MDS also indicated the resident required extensive assistance of two staff persons for bed mobility and transfers.</p> <p>Resident Council minutes were provided by the DON on 06/10/2015 at 3:16 P.M. The minutes, dated 01/09/2015, indicated the residents voiced it was taking longer for staff to answer call lights. The communication form, dated 02/06/2015, indicated that the residents complained about there not being enough aides for the workload they had and that residents felt the nurses should help out more when there were not enough aides. The minutes, dated 03/06/2015, indicated the residents had complained that some residents had not been getting their showers on time and the residents could feel the stress coming from the aides and nurses. The minutes also indicated that one resident had been left alone in the whirlpool when she did not feel comfortable being by herself. A communication form with an attached</p>			

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F 0364 SS=E Bldg. 00	<p>note, dated 05/04/2015, indicated that aides would answer call lights and say they would be back, but wouldn't come back. The note also indicated that staff had been telling residents that they were "...working short ..." and did not have time to do some things when asked by the residents.</p> <p>3.1-17(a)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to serve food and drinks at the proper temperature, related to the milk, juice and mighty shakes served too warm and the ham, sweet potatoes, zucchini, carrots, and squash served too cold. This had the potential to affect 95 resident who receive meals in the facility.</p> <p>Findings include: During an observation on 06/09/2015 at</p>	F 0364	<p>Tag F-364 A:Actions taken: Residents who receive food from the dietary department in the facility receive it at safe, acceptable palatable temperatures as dictated per the facility's policy on acceptable food temp guidelines. This includes resident #137. Further, foods/beverages stored in Nourishment room refrigerators are kept at acceptable temps. Milk is not served on the trays with hot foods. B: Others identified: Residents who receive food/drink for consumption from</p>	07/10/2015

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	<p>11:30 A.M. with the DM (Dietary Manager), a food tray was tested. The food tray consisted of milk, juice, sweet potatoes, vegetable mix of zucchini, carrots, and squash, along with a piece of ham. The DM tested the food and drink items with her thermometer and indicated the following temperatures: milk 55.4 degrees Fahrenheit (F), juice 54.7 degrees F., sweet potatoes 112.3 degrees F., mixed vegetables 98 degrees F., and ham 97.3 degrees F.</p> <p>A dining observation of the Alzheimer Unit was conducted on 06/10/2015 at 7:57 A.M. Mighty Shakes were observed on the residents trays, with the hot foods, in the insulated food transportation cart. The DM was notified and the temperature of the Mighty Shakes was tested. The DM used her thermometer and the first Mighty Shake tested at 54.5 degrees F., the second Mighty Shake had a temperature of 49.1 degrees F. The DM indicated the remaining three Mighty Shakes felt warm to the touch and she was going to replace them with a cold one.</p> <p>During an interview on 06/05/2015 at 11:07 A.M., Resident #137 indicated the food was usually cold and the issue of cold food was previously addressed in a resident council meeting.</p>		<p>the dietary department in the facility have the potential to be affected by this finding. C: Measures taken: The Dietary Manger/Designee will do a test tray and document the temps (last tray served) in each of the dining areas 3 days weekly all 3 meals. Any concerns will be addressed as found. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Further, the Dietary Manager will request to attend the Resident Council meetings for 6 months long enough to get feedback from the residents on satisfaction of food temps. Any concerns will be addressed. D: How monitored: The DON/Designee will monitor to see that temps are being taken and logged in all nourishment room refrigerators 5 days weekly. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Results of the monitoring will be discussed daily at the CQI meetings. The Dietician inserviced the dietary and nursing staff as to the food temps and food storage guidelines as stated in Instructions on Fundamentals of a Safe Food Service and Hazard Analysis and Critical Control points adn Foodborne Illness. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/10/2015
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NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
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	<p>During an interview on 06/08/2015 at 11:47 A.M., the DM indicated she was aware that some of the residents in unit 4 had complained about the eggs being served cold. The facility replaced a Pellet system (food storage and transportation system) two months ago and she was not aware of any more complaints of cold food.</p> <p>During an interview on 06/09/2015 at 11:34 A.M., the DM indicated she could not drink the milk that warm and she would not enjoy her meal, especially the vegetables, being served at the current temperatures. The DM indicated staff on unit 1 had requested the drinks to be placed on the tray inside the warming cart prior to arrival for convenience in serving the residents.</p> <p>During an interview on 06/10/2015 at 8:02 A.M., the DM indicated the Mighty Shakes should not have been placed on the tray prior to serving and could not be served at the temperatures they were reading on the thermometer.</p> <p>Record review of the "Resident Council Minutes", on 06/10/2015 at 3:16 P.M., indicated the following:</p> <p>02/06/2015 - "New Business", Ross</p>		<p>as indicated. All monitoring results will be reviewed daily at the CQI meetings. Any patterns will be identified. As necessary, an Action Plan will be written by the QA committee. The Administrator will review the plan weekly until resolution. After the 4 weeks of zero negative findings is achieved, ongoing monitoring will occur at least monthly for a period of no less than 6 months to ensure ongoing compliance. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.</p>	

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	<p>indicated the food continues to still be cold.</p> <p>02/06/2015 - "New Business", Dillsboro indicated breakfast was cold every morning.</p> <p>03/06/2015 - "New Business", Ross indicated food was cold all the time in the resident's rooms.</p> <p>03/06/2015 - "Nursing" indicated food was cold by the time it enters the resident's rooms.</p> <p>04/03/2015 - "New Business" indicated the resident's were still concerned about the food being cold on the food cart.</p> <p>The current facility policy, dated 2010 and titled, "Instructions on Fundamentals of a Safe Food Service", was provided by the Administrator on 06/09/2015 at 2:24 P.M. The policy indicated, "Right Temperatures ...cold (under 40 degrees F stops bacteria from growing, heat (over 135 degrees F kills most bacteria. Cold foods should be kept chilled, hot foods should be kept hot. Prepared food should never be left standing at room temperature any unnecessary time ..."</p> <p>The current facility policy, dated 2010 and titled, "Hazard Analysis and Critical Control Points (HACCP) and Foodborne Illness", was provided by the Administrator on 06/09/2015 at 2:24 P.M. The policy indicated, "Potentially</p>			

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F 0371 SS=E Bldg. 00	<p>Hazardous Foods ...Potentially hazardous foods have a history of being involved in foodborne illness outbreaks, as well as a natural potential for contamination ...</p> <p>The following have been classified as potentially hazardous foods: Milk and milk products, meat product (pork, beef, lamb) and eggs."</p> <p>3.1-21(a)(2) 3.1-21(i)(2) 3.1-21(i)(3)</p> <p>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</p> <p>Based on observation, interview and record review, the facility failed to store and serve food and drinks under sanitary conditions, related to high refrigerator temperatures, for 2 of 7 refrigerators observed. (3 door refrigerator, Alzheimer unit snack refrigerator)</p> <p>Findings include:</p>	F 0371	<p>Tag F-371</p> <p>A:Action taken: Food is store/served in the facility under sanitary conditions and at proper acceptable temperatures per safe food handling guidelines. This included proper temp being maintained in the 3 door refrigerator in the dietary department as well as Nourishment Room refrigerators. The 3 door refrigerator in the dietary department has had the</p>	07/10/2015

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	<p>1. During the initial kitchen tour on 06/04/2015 at 9:51 A.M. with the Dietary Manager (DM), the 3 door refrigerator had visible condensation on the back inside wall. The temperature log indicated the refrigerator temperature was 36 degrees Fahrenheit.</p> <p>During an interview on 06/04/2015 at 9:52 A.M., the DM indicated there was a work order for the 3 door refrigerator and the new maintenance director had ordered the replacement gasket door seals.</p> <p>During an interview on 06/09/2015 at 12:06 P.M., the Maintenance Director indicated he had observed the rubber gasket hanging loose outside the door of the 3 door refrigerator on 06/03/2015. The new door gaskets seals and rollers were ordered on 06/05/2015.</p> <p>During an observation and interview with the DM on 06/09/2015 at 12:11 P.M., the DM indicated the 3 door refrigerator thermometer on the top shelf read 56 degrees Fahrenheit. The DM tested the temperature of the following items: a half full gallon milk jug had a temperature of 52.3 degrees Fahrenheit and a carton of nutritional orange juice had a temperature of 54.1 degrees Fahrenheit.</p>		<p>gasket replaced. B:Others identified: Residents who receive food/drink for consumption from the dietary department in the facility have the potential to be affected by this finding. C: Measures taken: Inservice for nursing and dietary staff were educated on the policies related to safe food storage as stated in Instructions on Fundamentals of a Safe Food Service. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. D:How monitored: The temps in the refrigerators are documented daily and kept on logs. This included the 3 door dietary refrigerator and the Nourishment Room refrigerators. The dietary staff log the Dietary Manager/Designee will monitor the 3 door refrigerator temps in the dietary department daily ongoing. The DON/Designee will monitor the Nourishment Room refrigerators temp logs 5 days weekly. The monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. The findings will be discussed at the daily CQI meetings. Any refrigerator found to be "too warm" is immediately reported to the maintenance staff so that it can be repaired immediately. Food/beverages found to be not cool enough to be consumed safely will be discarded. This monitoring will be</p>	

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	<p>During an interview on 06/09/2015 at 12:15 P.M., the DM indicated the items in the 3 door refrigerator did not meet safe food temperatures and would not be served.</p> <p>2. During an observation on 06/09/2015 at 2:22 P.M., with the Alzheimer Unit Coordinator, the Alzheimer unit snack refrigerator had a thermometer on the door with a temperature of 52 degrees Fahrenheit. The thermometer was moved to the back of the top shelf. At 2:37 P.M., the temperature was rechecked and the thermometer read 48 degrees Fahrenheit.</p> <p>During an observation on 06/09/2015 at 3:43 P.M., with the DM, the Alzheimer unit snack refrigerator had a thermometer on the top shelf with a temperature of 46 degrees Fahrenheit. The DM tested the temperature of the following items: yogurt had a temperature of 49.3 degrees Fahrenheit and the Boost (nutritional supplement) had a temperature of 59.9 degrees Fahrenheit.</p> <p>During an interview on 06/09/2015 at 3:44 P.M., the DM indicated the items tested in the Alzheimer unit snack refrigerator were not within safe food temperatures and would have to be thrown away.</p>		<p>ongoing. The refrigerator temp monitoring results will be reviewed at the daily CQI meetings. Any refrigerator found not to have been cold enough will have been addressed as found. Any unsafe food will have been discarded. The monitoring of the Noursihment Room refrigerators will continue after the 4 consecutive weeks of zero negative findings is achieved at least weely for a period of not less than 6 months to ensure ongoing compliance. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.</p>	

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NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018			
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F 0431 SS=D Bldg. 00	<p>The current facility policy, dated 2010 and titled, "Food Storage", was provided by the Administrator on 06/09/2015 at 2:24 P.M. The policy indicated, "...Keep potentially hazardous foods out of the temperature danger zone (41 degrees Fahrenheit- 135 degrees Fahrenheit) ...Set refrigerators to the proper temperature. The setting must ensure the internal temperature of the food is 41 degrees Fahrenheit or lower. Place hanging thermometer in the warmest part of the refrigerator. Conduct random temperature checks of food items ..."</p> <p>3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and</p>						

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	<p>cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to properly label insulin pens when opened for 1 of 3 medication rooms observed. This had the potential to affect 2 of 5 residents with undated, open insulin pens. (Residents #13 and #137)</p> <p>Findings include:</p> <p>An observation of the Medication Room in the Ross building was conducted on 06/10/2015 at 9:50 A.M. with LPN (Licensed Practical Nurse) #5. Two insulin pens were not labeled with the dates they were opened for Residents #13 and #137. Resident #13 had a Novolog insulin pen with 40 units remaining that</p>	F 0431	<p>Tag F-431</p> <p>A:Actions Taken: Insulin pens including those for residents #13 and #137 are dated appropriately as per policy. They are discarded after 28 days. B: Others identified: Any residents who receive insulin via an insulin pen have the potential to be affected by this finding. C: Measures taken: The DON/Designee will monitor all med carts 3 days weekly for undated insulin pens/meds/biologicals. Any found opened and not dated (as appropriate) will be discarded. This monitoring wil continue until 4 consecutive weeks of zero negative finds are achieved. Inservice for Nursing staff educated on the policy of Medication Storage and</p>	07/10/2015

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	<p>was received from the pharmacy on 03/16/2015. Resident #137 had a Novolog insulin pen with 75 units remaining that was received from the pharmacy on 04/18/2015.</p> <p>During an interview on 06/10/2015 at 9:52 A.M., LPN #5 indicated the insulin pens should have been labeled with the date they were opened. She further indicated she would be disposing of the two insulin pens immediately.</p> <p>The DON (Director of Nursing) provided the current policy, titled "Medication Storage Policy", on 06/10/2015 at 11:01 A.M. The policy indicated, "Medications and biologicals are stored safety [sic], securely, and properly following the manufacture or supplier recommendations." The policy further indicated Novolog insulin pens expire 28 days after initial use or after removing from the refrigerator, whichever comes first.</p> <p>Review of the Treatment Records for Residents #13 and #137, provided by the DON (Director of Nursing) on 06/10/2015 at 12:54 P.M., indicated Resident #13 had last received Novolog on 06/09/2015 and Resident #137 had last received Novolog on 06/10/2015.</p>		<p>emphasis was placed on insulin pens. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. D: How Monitored: The med cart monitoring will be reviewed daily at the CQI meetings. Any findings will have been addressed as found, but any identified patterns will be identified and an Action Plan will be written as needed to address the pattern. The Administrator will review any such plans weekly until resolution. After the 4 consecutive weeks of zero negative findings is achieved, ongoing random monitoring will continue at least once monthly for a period of no less than 6 months to ensure ongoing compliance. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.</p>	

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	3.1-25(j) 3.1-25(k) 3.1-25(o)				