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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155133 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/18/2012 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2100 MIDWAY ST<br>COLUMBUS, IN 47201 |
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| F0000              | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 11, 12, 13, 14, 15, and 18, 2012</p> <p>Facility number: 000058<br/>Provider number: 155133<br/>AIM number: 100283340</p> <p>Survey team:<br/>Cheryl Fielden, RN-TC<br/>Diana Sidell, RN<br/>Jill Ross, RN<br/>Susan Worsham, RN (6/12/12)</p> <p>Census bed type:<br/>SNF/NF: 143<br/>Total: 143</p> <p>Census payor type:<br/>Medicare: 21<br/>Medicaid: 95<br/>Other: 27<br/>Total: 143</p> <p>Sample: 24</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> | F0000         |   |                      |

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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|                          | Quality review completed 6/25/12<br>Cathy Emswiller RN   |                     |  |                            |

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| F0153<br>SS=D      | <p>483.10(b)(2)<br/>RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS</p> <p>The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.</p> <p>Based on interview and record review, the facility failed to ensure residents could access their medical records when requested, in that 3 of 9 residents had requested to view their medical records and were denied. This affected 3 of 9 residents at the group meeting.<br/>(Residents #84, 95, and 142)</p> <p>Findings included:</p> <p>During a resident group meeting on 6/11/2012 at 10:30 a.m., with residents who were identified by the Activity Director as being reliable to interview, Residents #84, 95, and 142 indicated they had requested to look at their medical records about 2 to 3 months ago, and staff would not allow them to see their records.</p> <p>During an interview on 6/18/12 at 4:05</p> | F0153         | <p><b>This plan of correction is the Center's credible allegation of compliance.</b></p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provisions of federal and state law.</p> <p>F 153<br/>The Right to Access/Purchase Copies of Records</p> <p>The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including</p> | 07/16/2012           |

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|  | <p>p.m., the Executive Director indicated that to her knowledge, no residents have asked to see their clinical records.</p> <p>A policy and procedure for "Patient Access to Protected Health Information (PHI)" was provided by the Executive Director on 6/15/12 at 11:55 p.m. The policy indicated, but was not limited to: "Every patient has the right to access his or her protected health information (PHI). The right of access is not absolute, and there may be situations where access is not allowed. Kindred Healthcare responds to requests to access a patient's health information in the strictest time frames specified by either: the Final Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA), state law, or other federal laws...."</p> <p>3.1-4(b)(41)<br/>3.1-4(b)(2)</p> |   | <p>current clinical records within 4 hours (excluding weekends and holidays).</p> <p>I. What corrective action(s) will be accomplished for those residents found to be affected by this alleged deficient practice?</p> <p>The residents # 84, #95 and # 142 were informed of the policy and procedure "Patient Access to Protected Health Information" by the Executive Director on June 29, 2012.</p> <p>II. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken.</p> <p>Residents requesting to review records have the potential to be affected by this alleged deficient practice.</p> <p>The facility staff was re-educated on July 5, 2012 by the Social Service Director / Designee on Resident Rights and on the Policy and Procedure for "Patient Access to Protected Health Information."</p> <p>Activity Director / Designee will review the policy and procedure for "Patient Access to Protected Health Information" with residents during Resident Council on July 9, 2012.</p> |                      |   |

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|  |  |   | <p>III. What measures will be put in place or what systemic changes will be made to ensure that the alleged deficient practice does not recur.</p> <p>Activity Director / Designee will interview residents during the monthly Resident Council regarding any issues with reviewing their medical records when requested and identified issues will be given to Executive Director for follow-up.</p> <p>The Admissions Director/Designee will add a letter upon admission that will inform the resident that they may review their clinical record as they wish.</p> <p>All current resident or responsible parties have been notified via a letter either in person or mailed that they may view their clinical record as they wish.</p> <p>The staff was in serviced on 7-5-2012 about the residents having the right to review their clinical records.</p> <p>IV. How the corrective actions will be monitored to ensure the alleged deficient practice will not recur.</p> <p>The Admissions Coordinator/Designee will monitor this system using a spread sheet listing who received a letter and when.</p> |                      |   |

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|                    |  |               | <p>Issues identified in Resident Council will be reviewed in monthly Performance Improvement Committee and appropriate plans of action initiated until 100% compliance is achieved.</p> <p>Date of Compliance: July 16, 2012</p> |                      |

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| F0157<br>SS=D  | <p>483.10(b)(11)<br/>NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br/>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the family and physician after a resident had seizures and after an episode of lethargy where</p> | F0157   | <p>F 157<br/>Notify of Changes (injury, decline, room, etc..)<br/><br/>The facility must immediately</p>        | 07/16/2012  |  |   |  |

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|  | <p>resident was unable to take his medications. This affected 1 of 21 residents reviewed for family and physician notification in a sample of 24. (Resident #85)</p> <p>Findings included:</p> <p>Resident #85's record was reviewed on 6/12/12 at 11:28 a.m. The record indicated Resident #85 was admitted with diagnoses that included, but were not limited to, epilepsy, dementia with behavior disturbances, and high blood pressure.</p> <p>A significant change minimum data set assessment dated 5/25/12 indicated Resident #85 was moderately impaired - decisions poor; cues/supervision required in cognitive skills for daily decision making, required extensive assist of two or more persons for transfers, did not ambulate, and required assist of one for eating, dressing, and bathing.</p> <p>A care plan with a revised date of 6/5/12 indicated Resident #85 had a seizure disorder related to epilepsy/carnitine deficiency. The interventions included, but were not limited to: "Allow seizure to run it's course. Observe progression noting type of body movement and duration....Notify MD and responsible</p> |   | <p>inform the resident; consult with the physician; and if known, notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental or psychosocial status.</p> <p>I. What corrective action(s) will be accomplished for those residents found to be affected by this alleged deficient practice?</p> <p>Resident # 85's physician was notified on 4/29/2012 of seizure activity.</p> <p>II. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken.</p> <p>Residents with diagnosis of seizure disorder have the potential to be affect by this alleged deficient practice.</p> <p>DNS/designee has reviewed the records of residents with seizure diagnosis to ensure physicians have been notified of any recent seizure activity.</p> <p>The Licensed staff will be re-educated on July 5, 2012 by the SDC on policy and procedure for "Change of Condition" and "Seizures"</p> <p>III. What measures will be put in</p> |   |  |   |  |

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|  | <p>party if a seizure should occur...."</p> <p>Nurse's notes dated 4/25/12 at 5:00 p.m. indicated: "Reported to this nurse that seizures occurred in dining Hall at 4:50 p. Activity lasted 5 min."</p> <p>No documentation could be found in the clinical record that indicated the physician or family had been notified of this seizure.</p> <p>Nurse's notes dated 4/25/12 at 11:30 p.m. indicated: "Res. was returned to Rm. (room) after dinner by CNA. Res. very tired, prepared for bed and went to sleep. Slept heavily throughout rest of evening. Unable to wake him enough to get him to take meds from me. Evening meds [not] given."</p> <p>The Medication Administration Record (MAR) for April, 2012 indicated one of the medications not given on 4/25/12 at 9:00 p.m., was Dilantin; 200 milligrams given twice a day for seizures.</p> <p>No documentation could be found in the clinical record that indicated the physician or family had been notified of the lethargy and inability to take evening medications.</p> <p>Nurse's notes dated 4/26/12 at 10:00 a.m. indicated: "Resident had seizure lasting</p> |   | <p>place or what systemic changes will be made to ensure that the alleged deficient practice does not recur.</p> <p>The Director of Nursing / Designee will utilize Kindred's Review of Process Measures – Notifying Family, Physician and Resident Change of Condition tool 3 times a week for 4 weeks, then weekly times 8 weeks, then monthly for 3 months, and any identified issues will be corrected and addressed with education and/or disciplinary action up to and including termination.</p> <p>The staff are scheduled to be in serviced on educated on Kindred's policy and procedure related to notification of changes on 7/10/2012.</p> <p>IV. How the corrective actions will be monitored to ensure the alleged deficient practice will not recur.<br/>The results of the review of process measures tool will be reviewed in Performance Improvement Committee monthly until compliance is met and then quarterly until 100% compliance is achieved.</p> <p>Date of Compliance: July 16, 2012</p> |                      |   |

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|  | <p>approx[imately] 7 min. Jerking of [upper] extremities noted, resident had scant amt. of blood running out of mouth. This nurse unable to assess mouth d/t (due to) resident yelling "NO". Resident became very sleepy [after] seizure."</p> <p>No documentation could be found in the clinical record that indicated the physician or family had been notified of this seizure.</p> <p>During an interview on 6/18/12 at 4:35 p.m., the Executive Director indicated staff didn't notify the physician.</p> <p>A policy and procedure for "Condition Change of a Resident", with a last review date of 1/20/12, was provided by the Executive Director on 6/18/12 at 10:20 a.m. The policy indicated, but was not limited to: "Resident change of condition is identified for proper treatment implementation. The physician is informed of resident events and/or change in resident's condition...."</p> <p>A policy and procedure for "Seizure", with a last review date of 1/20/12, was provided by the Executive Director on 6/18/12 at 2:30 p.m. The policy indicated, but was not limited to: "A seizure is a hyper-excitation of neurons in the brain leading to a sudden, violent,</p> |   |   |                      |   |

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|                    | <p>involuntary series of muscle contractions that may be paroxysmal and episodic...4. Notify the physician...."</p> <p>3.1-5(a)(2)</p> |               |   |                      |

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| F0226<br>SS=D  | <p>483.13(c)<br/>DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to implement their written policies and procedures related to abuse training in that 2 staff failed to have abuse training upon hire. This affected 2 of 196 employees. (Employee #4 and 5)</p> <p>Findings include:</p> <p>The employee record review was completed on 6/18/12 at 5:15 p.m. This review indicated Employees #4 had a start date of 3/22/2010 and did not have resident rights and abuse training completed.</p> <p>Employee # 5 had a start date of 5/15/12 and did not have resident rights and abuse training completed.</p> <p>During an interview on 6/18/12 at 5:15 p.m., the Executive Director indicated these two employees are contracted for the laundry and housekeeping department.</p> <p>A policy and procedure titled "Inserviced Education/Training" received on 6/18/12</p> | F0226   | <p>F 226</p> <p>Develop / Implement Abuse / Neglect, ETC Policies, the facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p><b>I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?</b></p> <p>Employees # 4 and #5 will be re-educated on Abuse and Resident Rights on July 5, 2012.</p> <p>The SDC / Designee will complete an audit by July 9, 2012 of employee records including contracted employees to ensure educational requirements are met and additional education will be provided as needed to ensure compliance.</p> <p><b>II. How other residents having the potential to be affected by the alleged deficient practice will be</b></p> | 07/16/2012  |  |   |  |

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|  | at 3:27 p.m., from the ED with a reviewed date of 4/5/12. The Policy and procedure included the following: Provide periodic training and retraining, "...Resident rights..abuse and neglect...."<br><br>3.1-28(a) |   | <p><b>identified and what corrective action(s) will be taken.</b></p> <p>Residents residing in the facility have the potential to be affected by this alleged deficient practice.</p> <p>The Healthcare Services Group (contracted laundry and housekeeping) and new hires will attend facility orientation which will receive Abuse, Resident Rights and the required education prior to starting in their department.</p> <p><b>III. What measures will be put in place or what systemic changes will be made to ensure that the alleged deficient practice does not recur;</b></p> <p>The new hires will attend the facility orientation which meets the State and Federal required abuse, neglect, and miss appropriation of funds or property education.</p> <p>SDC will be responsible for monitoring and maintaining of training provided for each individual employee including contracted employees and ensuring all required training has been completed.</p> <p><b>IV. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur;</b></p> |                      |   |

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|                    |  |               | <p>The Executive Director / Designee will utilize the audit tool "Review of Process Measures – Preventing Abuse, Neglect and Misappropriation of Residents Funds or Property" weekly times 4 weeks then monthly times 3 and then quarterly. Audit results will be presented to the Performance Improvement Committee for further action if needed until 100% compliance is achieved.</p> <p><b>Date of Compliance: July 16, 2012</b></p> |                      |

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| F0278<br>SS=D  | <p>483.20(g) - (j)<br/>ASSESSMENT<br/>ACCURACY/COORDINATION/CERTIFIED<br/>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review, observation, and interview, the facility failed to ensure the Minimum Data Set Assessments (MDS) were accurate related to pressure ulcers for 2 of 21 residents in a sample of 24 residents reviewed for accuracy of MDS assessments. (Resident #100 and 125)</p> <p>Findings include:</p> | F0278   | <p>F 278<br/>Assessment<br/>Accuracy/Coordination / Certified.<br/>The assessment must accurately reflect the resident's status.</p> <p><b>I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?</b></p> | 07/16/2012  |  |   |  |

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|  | <p>1. Resident #100's record was reviewed on 6/15/12 at 1:20 p.m. The record indicated Resident #100 was admitted with diagnoses that included, but were not limited to, low back pressure ulcer, malnutrition, anemia, and liver disease.</p> <p>Admission orders dated 5/3/12 indicated Resident #100 had a stage 4 pressure ulcer on his lower back.</p> <p>A patient nursing evaluation dated 5/3/12 indicated a stage 4 pressure ulcer on the residents lower back/sacral/coccyx area.</p> <p>Resident progress notes, dated 5/3/12 at 6:00 p.m., indicated a stage 4 wound to the coccyx</p> <p>An admission MDS assessment dated 5/14/12 indicated Resident #100 had one stage 2 pressure ulcer upon admission, which was inaccurate.</p> <p>During an interview, on 6/18/12 at 3:40 p.m., the Executive Director indicated she has been trying to get the MDS coordinators to change a few things with the way they do their assessments. The Executive Director also indicated the facility uses the Resident Assessment Instrument User's Manual for their policy and procedure.</p> |   | <p>Resident # 100 had a modification completed on 6/28/2012 to code the stage IV pressure area.</p> <p>Resident # 125 has a change of condition MDS scheduled to capture the pressure areas..</p> <p><b>II. Residents who have the risk for or declining condition that could be affected by the alleged deficient practice will be identified and corrective action(s) will be taken.</b></p> <p>Residents with pressure areas have the potential to be affected by this alleged deficient practice.</p> <p>Licensed nurses and MDS staff will be re-educated July 10, 2012 by the SDC/Designee on the head-to-toe weekly skin assessment documentation, Policy &amp; Procedures "Preventative Skin Care" and Pressure Ulcer /non pressure Ulcer Assessment"</p> <p>The nurse management team completed a full skin sweep on 7/3/2012.</p> <p>An audit of the residents braden scores was completed by 7/3/2012.</p> <p><b>III. What measures will be put in place or what systemic changes will be made to</b></p> |   |  |   |  |

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|  | 2. Resident #125's record was reviewed on 6/12/12 at 8:53 a.m. The MDS dated   |   | <p><b>ensure that the alleged deficient practice does not recur;</b></p> <p>MDS Coordinator/ Designee will attend the weekly Nutritional /wound meetings.</p> <p>Director of Nursing / Designee will utilize the audit tool "Review of Process Measures – Skin Prevention / Pressure Ulcer" weekly times 4 weeks, then monthly times 3. Non compliance issues will be addressed with re-education and / or disciplinary action up to and including termination.</p> <p><b>IV. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur;</b></p> <p>Director of Nursing / Designee will utilize the audit tool "Review of Process Measures – Skin Prevention / Pressure Ulcer" weekly times 4 weeks, then monthly times 3.</p> <p>Audit results will be presented to the Performance Improvement Committee for further action if needed until 100% compliance is achieved.</p> <p><b>Date of Compliance: July 16, 2012</b></p> |                      |   |

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|  | <p>4/11/12 had a zero. The skin assessment sheets showed an initial observation date of 3/2/12 with wounds to both heels and one to the sacrum/buttocks areas.</p> <p>During an observation of wound care on 6/15/12 at 10:53 a.m., the wound on the sacrum was very large. When asked about the measurement the ADNS (Assistant Director of Nursing Services) stated the measurements are done once a week. The ADNS indicated the wound on the right heel was healed. The wound on the left heel was half dollar size with reddish, sanguineous drainage. Both wounds were cleansed and the new dressings were applied.</p> <p>In an interview on 6/18/12 at 8:10 a.m., with the ADNS, she indicated there had been someone else doing the wound care and she had just recently taken over. To the best of her knowledge the wounds were there for "quite some time". She stated, "(name of resident) wounds have been opened and then closed but are worse now."</p> <p>In review of a wound progress note received on 6/13/12 at 9:55 a.m. this resident has an "unstageable pressure, bilat (bilateral - both sides) buttocks/sacrum" Wound measurements for this same assessment are as follows:</p> |   |   |   |  |   |  |

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|                    | <p>Right buttocks, left buttocks and sacrum - 11.5 cm (centimeters) x 7.0 cm x 0.2 cm. This is "all one wound now".</p> <p>This resident also had a wound on his left heel. The skin sheet dated 2/17/12 showed bilateral heels with wounds plus the wound on the buttocks were being treated. No measurements were found for this wound. The ADNS indicated this wound was debrided by [name of local surgeon] on 6/14/12.</p> <p>Review of the "Resident weekly skin check sheet" received on 6/13/12 at 9:55 a.m., had no documentation showing wound care or skin assessments had been done on 4/6/12, 4/13/12, 4/27/12 or 6/2/12.</p> <p>Review of a policy and procedure titled "Preventive Skin Care" received 6/18/12 at 10:20 a.m., with a revised date of 4/28/11 stated "...5. Document weekly head-to-toe skin assessments in patient's medical record. 6. Document assessment and status of patient's current pressure wounds and/or development of pressure wounds on designated form in patients medical record..."</p> <p>Review of a policy: Pressure Ulcer/non-pressure Ulcer Assessment received 6/18/12 at 10:20 a.m.</p> |               |   |                      |

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|                    | indicates"...17. Monitor daily progress of the pressure ulcer/non-pressure ulcer toward healing and for potential complications...."<br><br>3.1-31(g)<br>3.1-31(j) |               |   |                      |

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| F0279<br>SS=D  | <p>483.20(d), 483.20(k)(1)<br/>DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record reviews and interviews, the facility failed to ensure care plans were developed for 1 resident on fluid restrictions (resident #89), and 1 resident with a pacemaker. (Resident #83) This affected 2 of 21 residents reviewed for care plan development in a sample of 24.</p> <p>Findings include:</p> <p>1. Resident #89's record was reviewed on 6/14/12 at 10:35 a.m. The record indicated Resident #89 was admitted with diagnoses that included, but were not</p> | F0279   | <p>F 279<br/>Develop Comprehensive Care Plans</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p><b>I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?</b></p> <p>Resident # 89 had the care plan reviewed and updated to include fluid restriction.<br/>Resident # 83 had his care plan</p> | 07/16/2012           |   |

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|  | <p>limited to, chronic kidney disease, heart disease, and high blood pressure.</p> <p>Physician's recapitulation orders dated 6/1/12 through 6/30/12 indicated an order for 1500 ml (milliliters) fluid restriction.</p> <p>A physician's telephone order dated 6/8/12 indicated: "1500 ml fluid restriction clarification. Dietary - Breakfast 360 ml, Lunch 240 ml and Supper 240 ml. Nursing: Healthy Shot Double Protein 30 ml po (by mouth) 3x daily. 6A- 2P 240 ml, 2P - 10P 180 ml. 10P - 6A 150 ml."</p> <p>Review of care plans, with goal dates of 6/28/12, failed to indicate a care plan that addressed the fluid restrictions and how the fluid restrictions are divided within a 24 hour period.</p> <p>During an interview on 6/15/2012 at 1:38 p.m., the ADON looked through the care plans and said she didn't see a care plan that addressed the fluid restrictions.</p> <p>A policy and procedure for "Fluid Restriction", with a last review date of 1/20/12, was provided by the Executive Director on 6/18/12 at 4:00 p.m. The policy included, but was not limited to: "If medically necessary, a fluid restriction may be ordered by the physician to limit</p> |   | <p>reviewed and updated to include the pacemaker.</p> <p><b>II. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken.</b></p> <p>Residents with pacemakers and residents on fluid restriction have the potential to be affected by this alleged deficient practice.</p> <p>The DNS/Designee has completed an audit to identify residents on fluid restriction and with pacemakers and care plans has reviewed and updated.</p> <p><b>III. What measures will be put in place or what systemic changes will be made to ensure that the alleged deficient practice does not recur;</b></p> <p>Licensed nurses and Interdisciplinary Care Planning Team will be re-educated July 10, 2012 by the SDC/Designee on the Policy &amp; Procedure "Comprehensive Plan of Care".</p> <p>The Interdisciplinary Team will develop a comprehensive care plan on at least a quarterly basis and PRN to address areas identified and ensure each plan of care is individualized.</p> |   |  |   |  |

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|  | <p>the amount of fluid provided to the patient. When a fluid restriction is ordered, the amount of fluid per day is divided among meals, in-between snacks, and medication administration...4. Initiate and/or update patient progress notes and care plan with fluid restriction. Update as necessary. Documentation may include, but is not limited to: a. Amount of fluids for meals b. Amount of fluids for in-between meal snacks, c. Amount of fluid for medication administration, d. Amount of fluid from other sources (e.g., activities, family, etc.), and e. Amount of urinary output, any vomiting or diarrhea...."</p> <p>2. Resident #83's clinical record was reviewed on 6/14/12 at 10:40 a.m. An x-ray report dated 1/25/07 stated, "post pacemaker placement". That was the only documentation found in this resident's record regarding a pacemaker or appointments for check-ups with the pacemaker clinic.</p> |   | <p>Director of Nursing / Designee will randomly monitor weekly times 4, then monthly times 3, and then quarterly basis to assure comprehensive care plans are developed for the residents.</p> <p><b>IV. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur;</b></p> <p>The Interdisciplinary Care Plan Team/ Designee will utilize the audit tool "Review of Process Measures --"Care Planning" during Care Plan Conference for residents to ensure the care plans are accurate and reflect the resident current condition.</p> <p>Audit results will be presented to the Performance Improvement Committee for further action as needed until 100% compliance is achieved.</p> <p><b>Date of Compliance: July 16, 2012</b></p> |                      |   |

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|  | <p>During interview with the ADNS (Assistant Director of Nursing Services) on 6/18/12 at 8:10 a.m., she indicated she did not know he had a pacemaker but would see if she could find any information where he had had the pacemaker checked.</p> <p>A fax from [the name of the local hospital] with a test date of 2/23/12 indicated this resident did have his pacemaker checked. On the fax cover letter there was a comment made: "Pt (patient) also had ICD [pacemaker] checked on 5/30/12. Report from 5/30/12 not available yet."</p> <p>When the record was reviewed on 6/14/12 at 10:40 a.m. there was no mention of a pacemaker in the care plan. (copy of the care plan was requested twice but never received) This resident was admitted 7/20/2007.</p> <p>A policy and procedure titled "Comprehensive Plan of Care" received on 6/14/12 at 1:21 p.m., indicated: "...24. Ensure that any care cues are placed appropriately to remind caregivers of resident's special needs..."</p> <p>3.1-35(a)<br/>3.1-35(b)(1)</p> |   |   |   |  |   |  |

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| F0314<br>SS=D  | <p>483.25(c)<br/>TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on record review, observation and interview the facility failed to ensure that Resident #125 did not develop pressure wounds while in the facility. The facility failed to provide treatment to prevent the wounds from worsening. This affected 1 of 6 residents reviewed for pressure ulcers in a sample of 24.</p> <p>Findings include:</p> <p>Resident #125's clinical record was reviewed on 6/12/12 at 8:53 a.m. This resident had diagnoses which included, but were not limited to, diabetes, peripheral vascular disease, and dementia. There was no documentation in the record to show this resident arrived to facility on 1/19/12 with skin ulcers but date of initial observation on the "rating sheet to evaluate pressure ulcer status" is 3/2/12.</p> | F0314   | <p>F314</p> <p>1. Resident #125 had all wounds measured and treatment orders for each pressure area have been received and implemented.</p> <p>2. All residents with pressure areas have the potential to be affected. All resident's have had a head to toe assessment completed for identification of any pressure areas. Any areas identified have been measured, MD and family notified and treatment initiated.</p> <p>3. The SDC/designee will in-service all nursing staff on Pressure Ulcer Care and Prevention with emphasis on weekly skin assessments for identification of pressure areas, measuring and receiving treatment orders for each area.</p> <p>4. The DNS/Designee will</p> | 07/16/2012  |  |   |  |

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|  | <p>In interview on 6/18/12 at 8:10 a.m., with the ADNS she indicated there had been someone else doing the wound care and she had just recently taken it over. To the best of her knowledge the wounds were there for "quite some time". She stated, "(name of resident) wounds have been opened and then closed but are worse now."</p> <p>In review of a wound progress note received on 6/13/12 at 9:55 a.m. this resident has an "unstageable pressure, bilat (bilateral - both sides) buttocks/sacrum" Wound measurements for this same assessment are as follows:<br/>Right buttocks, left buttocks and sacrum - 11.5 cm (centimeters) x 7.0 cm x 0.2 cm. This is "all one wound now".</p> <p>This resident also has a wound on his left heel. The skin sheet dated 2/17/12 shows bilateral heels with wounds plus the wound on the buttocks were being treated. There were no measurements found in the chart for the heel wounds.</p> <p>Review of the "Resident weekly skin check sheet" received on 6/13/12 at 9:55 a.m., has no documentation showing wound care or skin assessments had been done on 4/6/12, 4/13/12, 4/27/12 or 6/2/12.</p> |   | <p>complete weekly rounds to verify pressure areas have measurements and treatment orders for 3 months. Then the DNS/Designee will review all weekily skin assessments for identification of pressure areas and recieving treatments weekly for 3 months. All findings will be reviewed in the PI monthly meeting until 100% compliance is achieved.</p> <p>5. The DNS/Designee is responsible for compliance.</p> |   |  |   |  |

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|                    | <p>Review of the care plan received on 6/18/12 at 10:20 a.m. had a focus as "[resident's name] has actual impairment to skin integrity r/t (related to) incontinent, decreased mobility, current pressure areas noted, dx [diagnosis] pvd [peripheral vascular disease]". Goals included but were not limited to: "will have no complication r/t pressure areas through the review date...Staff will have interventions in place to prevent altered skin integrity...Resident will not develop any new areas of skin breakdown through review date...."</p> <p>Review of a policy and procedure titled "Preventive Skin Care" received 6/18/12 at 10:20 a.m., with a revised date of 4/28/11 indicates"...5. Document weekly head-to-toe skin assessments in patient's medical record. 6. Document assessment and status of patient's current pressure wounds and/or development of pressure wounds on designated form in patients medical record..."</p> <p>Review of a policy: Pressure Ulcer/non-pressure Ulcer Assessment received 6/18/12 at 10:20 a.m. indicates"...17. Monitor daily progress of the pressure ulcer/non-pressure ulcer toward healing and for potential complications..."</p> |               |   |                      |

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|                    | 3.1-40(a)(1)<br>3.1-40(a)(2)   |               |   |                      |

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| F0323<br>SS=E  | <p>483.25(h)<br/>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br/>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the environment remained free of accident hazards in that power cords were observed lying in floors which could be a trip hazard, for 3 of 3 observations, 6 of 14 resident rooms, and 1 of 5 resident lounges.</p> <p>Findings include:</p> <p>During the environmental tour on 6/13/12 at 1:30 p.m., with the Maintenance Director, Licensed Administrator, Housekeeping Supervisor and employee #6, the following was identified:<br/>Resident rooms 530, 532, 535, 536, 538, 540, and the 200 hall lounge had power cords from in room ventilation systems lying in the floor creating a trip hazard.</p> <p>During an environmental tour on 6/14/12 at 10:30 a.m., resident rooms 530, 532, 535, 536, 538, 540 and 200 hall activity room had power cords lying in the floor.</p> | F0323   | <p>F 323<br/>Free of Accident Hazards / Supervision / Devices<br/>The facility must ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p><b>I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?</b></p> <p>The Maintenance Director attached the power cords to the ventilation units through out the facility. The correction were completed by June15, 2012.</p> <p><b>II. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken.</b></p> <p>The residents residing in the facility have the potential to be affected by this alleged deficient practice.</p> | 07/16/2012  |  |   |  |

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|  | <p>During an environmental tour on 6/15/12 at 9:00 a.m. power cords were attached to the ventilation units and were no longer lying in the floor.</p> <p>On 6/13/13 at 1:30 p.m., during an interview with the Maintenance Director during the environmental tour, it was indicated the power cords were in an area that would increase the risk of falls by residents, staff, and family.</p> <p>Policy and procedure titled "Accidents and Supervision to Prevent Accidents" indicated: "The center provides an environment that is free from accident hazards over which the center has control and provides supervision...to each patient to prevent avoidable accidents...."</p> <p>3.1-45(a)(1)<br/>3.1-45(a)(2)</p> |   | <p>The Maintenance Director and Executive<br/>Director has completed a facility tour and any issues identified were corrected.</p> <p><b>III. What measures will be put in place or what systemic changes will be made to ensure that the alleged deficient practice does not recur;</b></p> <p>The Maintenance Director/Designee will make rounds in the facility five times per week and observe for power cords lying on the floor, and corrections will be made when concerns identified.</p> <p>The Maintenance Director / Designee will ensure that the ventilation unit power cords are attached when new units are installed.</p> <p><b>IV. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur;</b></p> <p>The Executive Director / Designee will utilize the audit tool "Review of Process Measures – "Maintaining Safe and Clean Environment" to identify any concerns weekly times 4 weeks then monthly times 3 then quarterly.</p> |                      |   |

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|                          |  |                     | <p>Audit results will be presented to the Performance Improvement Committee until 100% compliance is achieved.</p> <p><b>Date of Compliance: July 16, 2012</b></p> |                            |

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| F0364<br>SS=F  | <p>483.35(d)(1)-(2)<br/>NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP<br/>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.</p> <p>Based on observation, record review, and interview the facility failed to provide food that was palatable and at the proper temperature in that the ice cream was melted, the vegetables were crunchy, the bread was stale, and the milk was 84 degrees. This had the potential to affect 140 out of 140 residents receiving food from dietary. (Residents #84, #99, and #142)</p> <p>Findings include:</p> <p>During the dietary tour on 6/11/12 at 11:20 a.m. ice cream was in a container sitting on the counter with only a small amount of ice. It was already melting. It was being served to residents. The thickened milk was sitting out on a tray on the counter with no ice. The temperature of the milk was 84 degrees. The tea, lemonade, and fruit juices were poured into glasses and sitting on the counter with no ice.</p> <p>During the kitchen observation on</p> | F0364   | <p>F 364<br/>Nutritive Value/Appear palatable<br/>Prefer temp. Each resident receives<br/>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.</p> <p><b>I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?</b></p> <p>Residents #84, #99 and #142 have been reviewed for likes and dislikes by the Registered Dietitian and have been invited to attend bi-weekly Food Council.</p> <p>Ice cream is kept in a cooler covered and surrounded with ice on tray line. Ice Cream to be served on units is sent to units in an insulated cooler surrounded with ice and passed as the resident trays are delivered. Corrections made on 6/12/12.</p> <p>The thickened milk and milk are</p> | 07/16/2012           |   |

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|  | <p>6/11/12 at 4:45 p.m., the milk was in a tub, stacked 3 high with 2 bags of ice lying on top. There was no ice down in the tub. The temperature of the chocolate milk at this time was 54 degrees.</p> <p>During the dining room observation on 6/11/12 at 5:30 p.m. one resident received ice cream that was completely liquid. The CNA poured it out to show how much it had thawed.</p> <p>During the group meeting on 6/13/12 at 10:30 a.m., 3 residents stated, "The potatoes are not done when we receive them, the bread is stale and the vegetables are sometimes too crunchy. (Residents 84, 99 and 142)</p> <p>During the interview with Resident #30 on 6/13/12 at 2:00 p.m., she indicated the vegetables are not cooked. They are steamed and too hard to eat. "I love vegetables but can't eat them."</p> <p>A policy and procedure "Internal Food Temperature Matrix" was received on 6/12/12 at 2:25 p.m. This policy contains: "... Minimum holding temperatures on the tray line for potentially hazardous food is 41 degrees or less for cold foods...At the point of service to the resident, the food temperature should be such that the food</p> |   | <p>stored in the refrigerator to ensure it is chilled to 41 degrees or less and milk temperatures are checked and documented at beginning, middle and end of tray service.</p> <p>The tea, lemonade and fruit juices are prepared and stored in refrigerator until serving time then the drinks are covered and placed in a tub surrounded with ice while on the tray line. Dietary staff will remove 1 tray of drinks at a time during the meal service.</p> <p><b>II. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken.</b></p> <p>Residents residing in the facility have the potential to be affected by this alleged deficient practice.</p> <p>The Certified Dietary Manager (CDM) /Designee will randomly survey residents twice a week regarding food taste, texture and temperature.</p> <p>The Certified Dietary Manager re-inserviced the dietary staff as issues were identified and on June 29, 2012 on Principles of Food Temperature Control, Tray line set-up and service and Food Preparation and Presentation.</p> <p><b>III. What measures will be put</b></p> |   |  |   |  |

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|  | <p>is palatable. Typically, this is around 120 degrees to 130 degrees for most hot foods and 40 degrees to 50 degrees for most cold foods..."</p> <p>A policy and procedure titled, "Principles of Safe Food Handling" was received on 6/12/12 at 10:50 a.m. This policy contains: "... Danger Zone Temperatures above 41 degrees Fahrenheit (F) and below 140 degrees F...Potentially Hazardous Foods or Time/Temperature Control for Safety Food (TCS) Food that requires time/temperature control for safety to limit the growth of pathogens or toxin formation. This includes foods that consists in whole or in part of the following: milk and milk products...Overview...Receive, store, prepare, cook, hold, serve and cool foods under sanitary conditions in a manner that conserves the nutritive value of the foods; and serve foods that are attractive, palatable, and in the form best tolerated and accepted by the residents..."</p> <p>3.1-21(a)(2)<br/>3.1-21(a)(3)</p> |   | <p><b>in place or what systemic changes will be made to ensure that the alleged deficient practice does not recur;</b></p> <p>Certified Dietary manager will hold Food Council bi-weekly and randomly survey 5 residents per week times 4 weeks then 5 residents per month, the quarterly to identify foods are palatable and arriving at a desirable temperature. Any identified issues will be addressed with a plan of action and reviewed monthly at Performance Improvement Committee.</p> <p>The Certified Dietary Manager/ Designee will execute a test tray once a week to monitor for temperature and taste.</p> <p>The ED or Designee will eat a dietary tray weekly to also assist in monitoring the food temperature and taste.</p> <p><b>IV. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur;</b></p> <p>The Certified Dietary manager / Designee will monitor through observation and log reviews at least weekly for 4 weeks, then monthly for three months then at least quarterly.</p> <p>The Certified Dietary Manager</p> |                      |   |

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|                          |  |                     | /Designee will discuss findings at<br>the monthly Performance<br>Improvement Committee until<br>100% compliance is achieved.<br><br><b>Date of Compliance: July 16,<br/>2012</b> |                            |

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| F0368<br>SS=F  | <p>483.35(f)<br/>FREQUENCY OF MEALS/SNACKS AT BEDTIME</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>Based on interview and record review, the facility failed to offer snacks at bedtime daily for 7 of 9 residents interviewed. This has the potential to affect 143 of 143 residents residing in the facility. (Residents #18, #27, #84, #95, #99, #129, #141)</p> <p>Findings include:</p> <p>A group meeting for residents was held on 6/13/12 at 10:30 a.m., with 9 residents attending. During the group meeting, 7 residents (Residents #18, #27, #84, #95, #99, #129, #141)</p> | F0368   | F 368<br>FREQUENCY OF MEALS/SNACKS AT BEDTIME. Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing | 07/16/2012  |  |   |  |

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|  | <p>indicated they are not offered a bedtime snack. One resident said: "Snacks are set at the nurse's station, some residents help themselves to snacks so others don't get any snacks" and all 9 residents agreed with this statement.</p> <p>A policy and procedure for "Snacks &amp; Supplements", with a last review date of 1/20/12, was provided by the Executive Director on 6/15/12 at 1:24 p.m. The policy indicated, but was not limited to: "Between-meal snacks are provided to appropriate residents to provide additional energy and nutrients and/or to normalize eating patterns for residents who are accustomed to eating between meals. A snack at bedtime is offered to all residents, except when contraindicated by medical condition or diet order...."</p> <p>During an interview on 6/15/12 at 2:00 p.m., the Executive Director indicated Dietary takes snacks to each unit, CNA's are supposed to take them to each resident and offer a snack, and the nurses are supposed to document if the resident accepted or refused.</p> <p>3.1-21(e)</p> |   | <p>snack is served.</p> <p><b>I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?</b><br/>Residents #18, #27, #84, #95, #99,#129, #141 have been reviewed for likes and dislikes by the Registered Dietitian and have been invited to attend bi-weekly Food Council.<br/>Nursing Center Bulk Snacks are prepared by the Nutrition Services department according to the HS Snack Rotation schedule and delivered by dietary to each nursing unit by 8:00 p.m.<br/>Nursing Center Bulk Snacks are delivered by the assigned nursing staff and percentage consumed and ml of fluid accepted is documented on each specific resident flow sheet.</p> <p><b>II. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken.</b><br/>Residents residing in the facility have the potential to be affected by the alleged deficient practice. The Registered Dietitian will re-in serviced nursing staff on July 5, 2012 on procedure 65037 "Snacks and Supplements"</p> <p><b>III. What measures will be put in place or what systematic changes will be made to</b></p> |   |  |   |  |

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|  |  |   | <p><b>ensure that the alleged deficient practice does not recur?</b></p> <p>Registered Dietitian/Designee will randomly survey 5 residents times 4 weeks, then 5 residents per month, then 5 residents quarterly to identify bedtime snacks are being offered. Activities Director / Designee will survey residents monthly during Resident Council meeting to identify bedtime snacks are being offered. Any individual issues will be addressed with a plan of action and reviewed monthly at Performance Improvement Committee.</p> <p><b>IV. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur?</b></p> <p>The Registered Dietitian /Designee will monitor through observation and log reviews at least weekly for 4 weeks, then monthly for three months then at least quarterly.</p> <p>The Registered Dietitian/Designee will discuss findings at the monthly Performance Improvement Committee until 100% compliance is achieved.</p> |                      |   |

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| F0371<br>SS=F  | <p>483.35(i)<br/>FOOD PROCURE,<br/>STORE/PREPARE/SERVE - SANITARY<br/>The facility must -<br/>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br/>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>A. Based on record review, observation, and interview the facility failed to store, prepare, distribute, and serve food under sanitary conditions in that hair was not completely covered, there were 4 boxes of chemicals in the dry food storage room, the plates being used to serve residents were wet, bread was handled with bare hands, a box of garlic bread was on the floor in the freezer, boxes were stacked to the ceiling in the freezer, 2 residents had dirty spoons for use during a meal, and 2 dirty pans, ready to be used in the kitchen. This had the potential to affect 140 out of 140 residents receiving food from the kitchen. (Dietary staff #7, 8, and 2)</p> <p>B. Based on observation, record review, and interview the facility failed to ensure sanitary conditions were maintained in dietary, in that gloves were worn to serve food, move a tray cart and go back to serving food without changing gloves or washing hands and the sanitizer being</p> | F0371   | <p>F 371</p> <p>Food Procure,<br/>Store/Preserve/Serve-Sanitary.</p> <p>The facility must-<br/>Procure food from sources approved or considered satisfactory by federal, state or local authorities; and Store, Prepare, distribute and serve food under sanitary conditions.</p> <p><b>I. What corrective action will be accomplished for those residents found to have been affected by alleged deficient practice?</b></p> <p>All Dietary Staff was immediately verbally re-educated on hair restraints and that all their hair must be covered including facial hair. Staff were informed hats were unacceptable, unless worn over hair that completely covered with hair nets. And that beard restraints must be worn when facial hair present.<br/>Corrections made on 6/11/12</p> <p>Disciplinary action was taken against employee's who did not</p> | 07/16/2012           |   |

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|  | <p>used in the dish room was too weak to perform it's disinfection duties. This had the potential to affect 140 out of 140 residents receiving food from the facility kitchen. (Dietary staff #1, 9, and 10)</p> <p>Findings include:</p> <p>A. During the kitchen observation of 6/11/12 at 10:20 a.m.,the Dietary Manager had bangs hanging out of her hairnet and Staff #8 had hair around her face, out of the hairnet. On 6/11/12 at 1:45 p.m., Staff #7 had a beard and mustache that were not covered.</p> <p>During the dietary tour on 6/11/12 at 10:20 a.m., there were 4 boxes of chemicals sitting on the floor in the dry storage room. There were small cups of ice cream in the freezer in a dirty tub. There was a box of garlic toast sitting on the floor in the freezer. There were 3 boxes on the top shelf in the freezer up to the ceiling.</p> <p>During the observation of the food being served for residents on 6/11/12 at 4:30 p.m., there was water between the plates. Staff #2 was putting bread into wrappers to put on the residents' trays with her bare hands.</p> <p>During the observation of the kitchen on</p> |   | <p>put the chemicals in proper storage room. Dietary employees were verbally re-educated on proper storage of chemicals. Chemicals was immediately removed and stored in proper storage room. Corrections made on 6/11/12.</p> <p>Ice cream and container was immediately removed from freezer. Garlic bread was removed from freezer and discarded. Items on top shelf were removed from top shelf. Staff were re-educated on proper storage of foods. Corrections made 6- 11-12</p> <p>Dietary Staff were re-educated on No Bare hand contact with ready to eat foods. And proper use/storage of utensils/dishes/pots and pans Dietician removed items from clean dish storage area. And checked the remaining stored dishes for dryness and cleanliness corrections made on 6/11/12</p> <p>Dietary Staff were verbally re-educated on " Glove Use". Sanitation water was changed. And staff was assigned specific times to change out sanitizing solution. Staff was verbally re-educated on proper procedure of sanitizing dish room equipment. Corrections made on 6/13/12.</p> |   |  |   |  |

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|  | <p>6/11/12 at 1:45 p.m., there were two baking pans found to be soiled with dried food and grease in the location ready to be used. This observation was done with the Dietician. She stated she would remove the dirty pans from the kitchen and be sure the rest of the pans were checked very carefully later today before use.</p> <p>In an interview with the Dietary Manager and the Dietician on 6/11/12 at 10:40 a.m., they indicated the hair covering would be corrected "today".</p> <p>A policy and procedure titled "Principles of Safe Food Handling" received on 6/12/12 at 10:50 a.m., from the ED (Executive Director) states "...Overview Receive, store, prepare, cook, hold, and cool foods under sanitary conditions in a manner that conserves the nutritive value of the foods;...Employee Hygienic Practices 1. Practice good personal hygiene. c. Restrain hair appropriately. Hair restraints such as hats, hair covering or nets are worn to effectively keep hair from contacting food and keep food handlers from touching their hair. Food handlers with facial hair should wear beard restraints...2. Avoid bare-hand contact with food that is cooked or ready-to-eat...23. Store cleaning supplies away from food storage and preparation areas and away from paper products used</p> |   | <p><b>II. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken.</b></p> <p>Residents residing in this facility have the potential to be affected by the alleged deficient practices.</p> <p>The Dietary Manager/Designee re-educated staff as issues were identified and on 7/5/12 and 7/10/12 on "Principles of Safe Food Handling", "Food Safety and Sanitation", "Sanitizing Stationary Food Equipment and Food Contact Surfaces", "Principles of Food Storage", "Principals of Ware washing", "Chemical Storage" and "Glove Use"</p> <p><b>III. What measures will be put in place or systemic changes will be made to ensure that the alleged deficient practice does not recur;</b></p> <p>Certified Dietary Manger/Designee will Perform Kindred's Quick rounds weekly times 4, then monthly there after..</p> |   |  |   |  |

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|  | <p>to serve food.</p> <p>The "Retail Food Establishment Sanitation Requirements" with an effective date of November 13, 2004 states on page 41 "...Food Storage Sec. 177 (a) Except as specified in subsections (b) and (c), food shall be protected from contamination by storing the food as follows: (1) In a clean, dry location. (2) Where it is not exposed to splash, dust, or other contamination. (3) At least six (6) inches above the floor...."</p> <p>B. During a dietary observation on 6/12/12 at 11:00 a.m., Staff #1 wore the same gloves to serve food, move a food cart, and go back to serving food.</p> <p>During tour of the dish room on 6/12/12 at 11:15 a.m., the sanitizer bucket was checked. The strip did not register any sanitizer present. The Dietician changed out the water and rechecked . It was within limits at this time.</p> <p>In interview with the Dietary Manager on 6/12/12 at 9:45 a.m., she indicated the buckets are emptied and refilled every shift.</p> <p>During interview on 6/12/12 at 9:55 a.m., with Staff #9, she indicated she would</p> |   | <p>Any identified issues will be addressed with a plan of Correction and reviewed monthly at Performance Improvement Committee.</p> <p><b>IV. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur?</b></p> <p>The Dietary Manager/Designee will monitor compliance with Dietary Policy &amp; Procedures thru observation and Log reviews at least three times weekly.</p> <p>The Dietary Manager will discuss Findings monthly at the monthly Performance Improvement Committee until 100% compliance is achieved.</p> <p><b>Date of Compliance: July 16, 2012</b></p> |   |  |   |  |

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|                    | <p>spray the counters in the dish room with water, use a squeegee to remove the water , scrub the counter, rinse with water and use the squeegee again.</p> <p>During interview with Staff #10 on 6/13/12 at 10:00 a.m., she indicated "she cleans the dish room as she cleans at home". When asked how that was she said she rinses all the counters with water, uses a rag to clean anything off that hasn't already come off, rinses again and then towel dries the entire counter.</p> <p>A policy and procedure titled, "Principles of Safe Food Handling" was received on 6/12/12 at 10:50 a.m., from the Executive Director. It indicates: "...Employee Hygienic Practices...3. When disposable latex-free gloves are worn, change gloves as frequently as handwashing would indicate: ...a. Change gloves before and after non-food contact and between contacts with raw and cooked food...Sanitary Conditions...24. Keep everything that touches food clean and sanitized - food contact surfaces, countertops, dishware, pots/pans, utensils, food thermometers, gloves and hands..."</p> <p>3.1-21(i)(3)</p> |               |   |                      |

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| F0372<br>SS=F  | <p>483.35(i)(3)<br/>DISPOSE GARBAGE &amp; REFUSE PROPERLY<br/>The facility must dispose of garbage and refuse properly.</p> <p>Based on observation, interview and record review the facility failed to dispose of garbage and refuse properly in that there was trash and larger items around the dumpster. There were items to be thrown away sitting around a shed. There was an area around the shed not mowed. This was observed 2 out of 3 observations. This had the potential to affect 143 out of 143 residents.</p> <p>Findings include:</p> <p>During the observation of the area in back of the facility on 6/15/12 at 12:42 p.m., with the Dietary Manager, there were cups, spoons, straws, cigarette butts and a trash can lid at the base of the dumpster. There were 3 boxes, 15 skids, a night stand, a shower chair, a recliner and cigarette butts off to the side of the dumpster. The Dietary Manager indicated "it is maintenance' job to keep the area clean".</p> <p>During the observation on 6/15/12 at 1:00 p.m., the Maintenance Supervisor indicated the pile of things by the dumpster had been there 2-3 weeks. In</p> | F0372   | <p>F 372<br/>Dispose Garbage &amp; Refuse Properly<br/>The facility must dispose of garbage and refuse properly.</p> <p><b>I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?</b></p> <p>The Maintenance Director and Certified Dietary Manger cleaned the area around the dumpster and the shed, corrected June 16, 2012.</p> <p><b>II. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken.</b></p> <p>The residents residing in the facility have the potential to be affected by this alleged deficient practice.</p> <p>The Maintenance Director / Designee will make outside rounds 5 times a week and clean-up any trash or cigarette butts from the grounds to include around the dumpster and shed.</p> | 07/16/2012           |   |

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|  | <p>looking around there was a shed sitting behind the facility outside the dining room. There was a Christmas tree stand, 4 - 2 x 4s nailed together, a reclaiming tank, a piece off the shed, 2 - trash can lids with water standing in them, and tall weeds/grass around the shed. The Maintenance Supervisor indicated he would get it cleaned up right away.</p> <p>In interview with the Executive Director on 6/15/12 at 1:30 p.m., she stated, "that mess will be cleaned up before you return on Monday".</p> <p>In interview with the Executive Director on 6/18/12 at 10:00 a.m., she stated, "the clean up around the shed really makes a big difference looking out the dining room".</p> <p>A policy and procedure titled, "Non-hazardous Waste Disposal" was received 6/15/12 at 1:35 p.m., from the Executive Director. This policy states: "...9. Transport trash to the dumpster... (Do not leave any trash along side or on top of the dumpster..."</p> <p>A policy and procedure titled, "Pest Control" was received from the Executive Director on 6/14/12 at 9:10 a.m. This policy states, "...10. Keep center grounds free of trash and brush. Keep the</p> |   | <p><b>III. What measures will be put in place or what systemic changes will be made to ensure that the alleged deficient practice does not recur;</b></p> <p>The Facility staff will be re-educated to the policy and procedure "Non-hazardous Waste Disposal" and "Pest Control" with emphasis on keeping the area around the dumpster and shed clean and debris free.</p> <p><b>IV. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur;</b></p> <p>The Executive Director / Designee will utilize the audit tool "Review of Process Measures – "Maintaining Safe and Clean Environment" to identify any concerns weekly times 4 weeks then monthly times 3 then quarterly.</p> <p>Audit results will be presented to the Performance Improvement Committee until 100% compliance is met.</p> <p><b>Date of Compliance: July 16, 2012</b></p> |                      |   |

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|  | dumpster area clean and the lid closed..."<br><br>3.1-21(i)(5)   |   |   |                      |   |

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| F0425<br>SS=D  | <p>483.60(a),(b)<br/>PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on record review and interview the facility failed to provide routine medications for each resident on a daily basis. This affected 2 of 21 residents in a sample of 24 plus an additional resident that attended the group meeting. This had the potential to affect 143 out of 143 residents. Residents involved were #84, #95 and #142. Resident #95 was from the group meeting and not in our sample of residents.</p> <p>Findings include:</p> | F0425   | <p>F 425<br/>Pharmaceutical Services – Accurate Procedures.</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in of this part.</p> <p><b>I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?</b></p> <p>A medication error report was completed for resident # 84.</p> <p>The Director of Nursing/</p> | 07/16/2012  |  |   |  |

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|  | <p>Resident #84's clinical record was reviewed on 6/14/12 at 3:00 p.m. Diagnoses included, but were not limited to: HTN (high blood pressure), CHF (Congestive heart failure), COPD (chronic obstructive lung disease), CAD (coronary artery disease).</p> <p>The medication administration record received on 6/15/12 at 1:30 p.m., from the Executive Director indicated the resident did not receive Losartan potassium - HCTZ 100 mg - 12.5 mg for his high blood pressure for 4 days (June 5, 6, 7, &amp; 8, 2012).</p> <p>During the group meeting on 6/13/12 at 10:30 a.m., there were 3 residents who stated they ran out of medication and it took the facility 2 - 3 days to get it in. (Residents 84, 95 and 142)</p> <p>In an interview with the Assistant Director of Nursing Services (ADNS) on 6/18/12 at 8:10 a.m., she indicated a resident should never be without his/her medication. "We have a back-up pharmacy, which is here in town, and we always have the EDKs (emergency drug kits). We keep all the medications used in those."</p> <p>A policy and procedure titled, "Medication Administration" was</p> |   | <p>Designee has completed an audit of the medication administration records for residents # 95 and 142 to ensure compliance with medication administration.</p> <p><b>II. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken.</b></p> <p>The residents receiving medication in the facility have the potential to be affected by this alleged deficient practice.</p> <p>The Director of Nursing/Nurse Management Team/Pharmacy has completed an audit of resident medication administration records and the medication carts to ensure the medications for each resident are available for administration.</p> <p><b>III. What measures will be put in place or what systemic changes will be made to ensure that the alleged deficient practice does not recur;</b></p> <p>The Licensed Staff will be re-educated on July 10, 2012 on the policy and procedure "Medication Administration" with an emphasis on how to utilize the EDK (Emergency Drug Kits) and the back-up pharmacy to obtain needed medications.</p> |   |  |   |  |

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|  | <p>received on 6/14/12 at 1:21 p.m. from the Executive Director. This procedure indicates: "...5. Medications are administered within 60 minutes of the scheduled time of administration, except for before and after meals, which are based on scheduled meal times and administered within 30 minutes of the meal. Unless specified by the prescriber, medications are administered by the center's established medication administration schedule...."</p> <p>3.1-25(a)</p> |   | <p><b>IV. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur;</b></p> <p>The Director of Nursing/ Designee will utilize the audit tool "Review of Process Measures – "Medication Administration" weekly times 4 weeks then monthly times 3 then quarterly.</p> <p>Audit results will be presented to the Performance Improvement Committee until 100% compliance is met.</p> <p><b>Date of Compliance: July 16, 2012</b></p> |                      |   |

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| F0441<br>SS=D  | <p>483.65<br/>INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program<br/>The facility must establish an Infection Control Program under which it -<br/>(1) Investigates, controls, and prevents infections in the facility;<br/>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br/>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection<br/>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br/>(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.<br/>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens<br/>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> | F0441   | F 441 POC   | 07/16/2012           |   |

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|  | <p>Based on record review and interview, the facility failed to maintain their infection control program in that a resident did not receive the second step of a two step tuberculin skin test for 1 of 24 residents reviewed in a sample of 24. (Resident #142)</p> <p>Findings include:</p> <p>Resident #142's clinical record was reviewed on 6/18/12 at 1:15 p.m. The immunization record indicated a Mantoux test was administered on 3/9/12 and read on 3/12/12 with 0 mm result (negative). There was no documentation to show a 2nd step was given.</p> <p>In interview with the Executive Director on 6/18/12 at 1:30 p.m., she indicated, "I know. We've messed up with the PPD's."</p> <p>Review on 6/18/12 at 1:45 p.m., of the policy, "Reading the Mantoux Tuberculin Skin Test", which was provided on 6/15/12 at 1:35 p.m., from the ADNS (Assistant Director of Nursing Services), indicates: "...18. If results were negative, administer the second step 1 - 3 weeks after the first TST (tuberculin skin test) was read, if applicable..."</p> <p>3.1-18(f)</p> |   | <ol style="list-style-type: none"> <li>1. Resident #142 had the two step tuberculin skin test started again. MD, Resident #142 and family notified. Documentation on the Immunization record of resident #142.</li> <li>2. All residents that are not PPD positive have the potential to be affected. An audit of all resident's immunization records has been completed for completion of the Two Step Tuberculin skin test when the first step is negative and then the second step is administered within 1-3 weeks after the first TST was read. Any resident requiring the initiation of the Mantoux Tuberculin Skin Test have had their MD and family notified.</li> <li>3. The DNS/Designee has educated all nurses on the Mantoux Tuberculin Skin Test.</li> <li>4. The DNS/Designee will the MAR and immunization record weekly for 3 months for accuracy in administering the Mantoux Tuberculin Skin Test and then monthly for 3 months for accuracy with administration of the Mantoux Tuberculin Skin Test. All findings will be addressed immediately and in monthly PI meeting until 100% compliance is achieved.</li> <li>5. The DNS/Designee is responsible for compliance.</li> </ol> |   |  |   |  |

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| F0465<br>SS=F  | <p>483.70(h)<br/>SAFE/FUNCTIONAL/SANITARY/COMFORT ABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview the facility failed to provide a safe and sanitary laundry area for 3 of 3 observations. This had the potential to affect all 143 residents.</p> <p>Findings included:</p> <p>During the environmental tour on 6/13/12 at 1:30 p.m., with the Maintenance Director, Licensed Administrator, Housekeeping Supervisor and employee #6, the following was identified:<br/>The sink in the soiled laundry was inoperable and the inside of the sink was coated with a bark brown dried, caked on substance.<br/>The area behind the washers was littered with heavy caked lint on the pipes, walls and floors.<br/>Behind the washers was a sump pump trough for water which had standing water and was coated with lint.</p> <p>During an environmental tour on 6/14/12 at 10:30 a.m., the above items had not changed.</p> | F0465   | <p>F 465<br/>Safe/Functional/Sanitary/Comfort able Environment. The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. <b>I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?</b> The Maintenance Director removed and capped off the inoperable sink on June 14, 2012 and cleaned the laundry area including behind the washers and the water trough on June 14, 2012. <b>II. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken.</b> The residents residing in the facility have the potential to be affected by this alleged deficient practice. The Housekeeping Supervisor / Designee will make rounds 5 days per week to ensure compliance with the laundry room cleaning policy. <b>III. What measures will be put in place or what systemic changes will be made to ensure that the</b></p> | 07/16/2012  |  |   |  |

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|  | <p>In an interview with the Housekeeping Supervisor during the environmental tour, it was indicated the sink was inoperable but a date for cleaning could not be identified. The area behind the washers, no cleaning date could be identified.</p> <p>Policy and Procedure documents, provided by the housekeeping supervisor on 6/18/12 at 11:10 a.m., with a review date of 1/2012 included:<br/>"Cleaning Schedule for Laundry...C)<br/>Clean all pipes, and vents...on any shift if the floor needs to be cleaned/mopped from an accident, you must do it."<br/>"Laundry work scheduled for 1st shift...Before going home you must clean out the drain behind the washers..."<br/>"Daily laundry cleaning schedule...Dust off pipes once a week..."<br/>"Laundry extra cleaning items...1. All sinks are to be cleaned, and the rinse in the soiled laundry area. There are two sinks in the soiled area, and one in the clean area...All pipes...to be dust free...No dust on water hoses, and soap hoses behind washers...drain and pump is free from all lint..."<br/>"Items to be cleaned in the laundry room...clean behind washers, the drain, the hoses, and the wall units...walls-all walls in the laundry room, pipes-all water pipes that are on the ceiling in the soiled and cleaned area...sinks-clean the sink,</p> |   | <p><b>alleged deficient practice does not recur;</b> The Housekeeping and Laundry staff will be re-educated on July 5, 2012 by the Housekeeping supervisor on the policy and procedure "Cleaning Schedule for Laundry"<br/><b>IV. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur;</b> The Executive Director / Designee will utilize the audit tool "Review of Process Measures –"Maintaining Safe and Clean Environment" to identify any concerns weekly times 4 weeks then monthly times 3 then quarterly. Audit results will be presented to the Performance Improvement Committee until 100% compliance is met. <b>Date of Compliance: July 16, 2012</b></p> |                      |   |

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|  | soiled sink, and the rinse...shelves-one in clean area, and soiled area, keep free from dust..."<br><br>3.1-19(f)      |   |   |                      |   |