

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155401	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/21/2013
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NAME OF PROVIDER OR SUPPLIER  BEN HUR HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 S GRANT AVE CRAWFORDSVILLE, IN 47933
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: 8/14-16, 19-21/ 2013</p> <p>Facility Number: 000461 Provider Number: 155401 AIM Number: 100275290</p> <p>Survey Team: Laura Brashear, RN, TC Mary Weyls, RN Teresa Buske, RN Karen Hartman, RN</p> <p>Census Bed Type: SNF/NF: 76 Total: 76</p> <p>Census Payor Type: Medicare: 5 Medicaid: 57 Other: 14 Total: 76</p> <p>These Deficiencies also reflect State Findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed 08/27/2013 by Brenda Marshall Nunan, RN.</p>	F000000	Submission of this plan of correction shall not constitute or be construed as an admission by Ben Hur Health and Rehab that the allegations contained in this survey report are accurate or reflect accurately the provision of service to the residents of Ben Hur Health and Rehab.	

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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F000223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview, observation, and record review, the facility failed to ensure all residents were free from abuse for 1 of 4 residents for allegations of staff to resident abuse. [Resident #70].</p> <p>Finding includes:</p> <p>Facility abuse investigations were reviewed on 8/20/13 at 11 a.m. An investigation report indicated an allegation of CNA #9 using excessive force and inappropriate behavior while providing evening personal hygiene care to Resident #70 on 8/8/13 at 9:40 p.m. The investigation report alleged QMA #10 observed CNA #9 to grab Resident #70 by her hair and pulled the resident down to the floor with her while providing evening peri-care. The report indicated the resident was very combative during the care i.e. slapping, kicking, hitting, and pulling CNA #9's hair. Documentation</p>	F000223	<p>I. The corrective action taken for the resident affected is that staff followed appropriate procedures, in that CNA #9 was sent home immediately following the incident with Resident #70 and suspended pending investigation. Following investigation, she was terminated from employment with the facility.</p> <p>II. As all residents could be affected by staff interactions, following the incident facility administrative staff began immediate 1:1 inservice training on abuse prevention and appropriate staff response to any witness of inappropriate interactions. III. The systemic change in place is that on 8/14/13, the Director of Nursing provided inservice training for nursing staff in regard to providing care for aggressive/combative residents, with emphasis on preventive techniques to avoid catastrophic reactions. Communication skills and care guidelines were also addressed. IV. As a means of ongoing compliance, formal training for nursing staff is being</p>	08/22/2013	

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	indicated QMA #10 stated CNA #9 was trying to defend herself when she grabbed the resident's hair and then pulled the resident to the floor with her. The report indicated QMA #10 assisted CNA #9 with completing care for Resident #70, and both staff exited the resident's room. QMA #10 then immediately reported the allegation to LPN #11. LPN #11 immediately notified the Director of Nursing and the Administrator. LPN #11 then instructed CNA #9 to leave the facility. The report indicated the resident was assessed with red streak on her right cheekbone, and a reddish purple knot on her right inner leg above the ankle. According to the investigation documentation, the facility was unable to determine if the injuries were self-inflicted by the resident during the struggle with CNA #9, or had been previously self inflicted by resident during the resistance of care. The follow up report dated 8/9/13 and sent on 8/9/13 at 3:06 p.m. indicated CNA #9 was terminated from employment due to "the employee should not have allowed herself to become involved in the situation to the extent that she did, thus losing her patience completely and responding in the manner she did."		conducted on September 9 and 10, 2013 by a certified trainer in Nonviolent Crisis Intervention. Facility staff will continue to provide ongoing training for all staff in abuse prevention/prohibition on a regular basis. Any allegations of abuse will be reported to the Administrator immediately, who will in turn report to the Indiana State Department of Health as required. Facility policies will be implemented and all necessary actions will be identified and applied appropriately. Any failure of facility staff to follow established policies and procedures will be reported to the Administrator upon awareness, and all such instances will be reviewed during quarterly Quality Assurance meetings. In addition, facility administrative staff will routinely monitor that there are no concerns on the part of residents and/or family members in regard to treatment by staff by conducting surveys in accordance with resident care conference schedules. V. Evidence of Inservice training for staff is provided in Attachment #1. Evidence of monitoring with resident/family surveys is provided in Attachment #2. VI. Due to evidence provided Ben Hur Health and Rehab requests paper compliance for survey tag #223.		

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	<p>Upon interview of the Administrator on 8/20/13 at 11 a.m., the Administrator indicated the staff to resident abuse was substantiated, due to when Resident #70 was interviewed regarding the incident on 8/8/13 the resident described the incident as "we had a hair pulling thing."</p> <p>Upon interview of QMA #10 on 8/20/13 at 2:30 p.m., the QMA indicated CNA #9 went to provide bedtime care to Resident #70, and the resident was combative. The QMA stated the resident called CNA #9 a "b...h." The QMA also indicated the CNA attempted to stand the resident to provide peri-care, and the resident hit CNA #9 with a closed fist and pulled her hair. The QMA indicated she tried to intervene to get the resident to stop, but the resident hit the CNA again. The QMA then indicated the CNA grabbed the resident's hair, and pulled the resident to the floor. The QMA indicated she was able to complete the resident's bedtime care. The QMA stated she then immediately informed LPN #10 of the allegation, and CNA #9 was clocked out.</p> <p>On 8/21/13 at 12:19 p.m., Resident #70 was observed to be sitting in her</p>						

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	<p>room. The resident was noted not to have any bruises on arm or legs.</p> <p>Upon interview of Resident #70 on 8/21/13 at 12:19 p.m., the resident recalled that a CNA [CNA #9] had kicked her and she had a bruise. The resident indicated the bruise was from altercation with [CNA #9] when she was trying to remove her clothes. The resident stated she had "gone down to the floor." The resident indicated she had never had any previous bad experiences with [CNA #9] prior, and that she had not had any problems with other staff during her 2 year stay.</p> <p>Upon review of the clinical record on 8//21/13 at 2 p.m., the most recent Minimum Data Set (MDS) assessment was completed on 7/24/13. The assessment identified the resident as independent in ambulation/transfers, limited assistance of one with personal hygiene, and independent in cognitive decision making skills. The resident was also identified with the diagnosis which included, but was not limited to Alzheimer Disease.</p> <p>Upon review of the facility's current policy and procedure titled "ABUSE" (no date) on 8/19/13 at 2:30 p.m., documentation was noted of "...The</p>				

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	<p>facility shall observe the resident's right to remain free from verbal, sexual, physical, and mental abuse, mistreatment, neglect, corporal punishment and involuntary seclusion...Physical Abuse- Physical abuse includes, but not limited to, hitting, slapping, pinching, and corporal punishment. 1. Actually laying hands on a resident in an abrupt manner. 2. Striking a resident with any object..."</p> <p>3.1-27(a)(1)</p>				

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225	I. Please note that no residents	08/22/2013			

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	<p>review, the facility failed to ensure all alleged violations of abuse were reported immediately to State officials for 4 of 4 allegations of staff to resident abuse. (Resident #70, Resident #85, Resident #51, Resident # 36).</p> <p>Findings include:</p> <p>1. Facility abuse investigations were reviewed on 8/20/13 at 11 a.m. An investigation report indicated an allegation of CNA #9 using excessive force and inappropriate behavior while providing evening personal hygiene care to Resident # 70 on 8/8/13 at 9:40 p.m. The investigation report alleged QMA #10 observed CNA #9 to grab Resident #70 by her hair and pulled the resident down to the floor with her while providing evening peri-care. The report indicated the resident was very combative during the care i.e. slapping, kicking, hitting, and pulling CNA #9's hair. Documentation indicated QMA #10 stated CNA #9 was trying to defend herself when she grabbed the resident's hair and then pulled the resident to the floor with her. The report indicated QMA #10 assisted CNA #9 with completing care for Resident #70, and both staff exited the resident's room. QMA #10</p>		<p>were adversely affected by the facility's failure to immediately notify state officials of the allegations noted, and that all of the situations were thoroughly investigated by facility staff upon occurrence. II. As all residents could potentially be affected, the following corrective measures have been implemented: III. As a means to assure the deficient practice does not recur, upon occurrence of any future allegation of staff to resident abuse, the Administrator will be immediately notified, and in turn will immediately notify the Indiana State Department of Health via telephone call, email, or fax. Follow up reports will be completed as necessary to advise of the outcome of the investigation of the allegation. IV. As a means of ongoing compliance, the Administrator will maintain a log of allegations reported, including the time of notification to the Administrator as well as the Indiana State Department of Health. The log will be reviewed by the Administrator with the Quality Assurance committee during quarterly meetings. V. Evidence of the log of allegations to be maintained by the Administrator is provided in Attachment #3. (No staff to resident allegations have been reported since survey completion.) VI. Due to evidence provided Ben Hur Health and Rehab requests paper</p>		

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	<p>then immediately reported the allegation to LPN #11. LPN #11 immediately notified the Director of Nursing and the Administrator. LPN #11 then instructed CNA #9 to leave the facility. The report indicated the resident was assessed with red streak on her right cheekbone, and a reddish purple knot on her right inner leg above the ankle. According to the documentation, the facility was unable to determine if the injuries were self-inflicted by the resident during the struggle with CNA #9, or had been previously self inflicted by resident during the resistance of care. The follow up report dated 8/9/13 and sent on 8/9/13 at 3:06 p.m. indicated CNA #9 was terminated from employment due to "the employee should not have allowed herself to become involved in the situation to the extent that she did, thus losing her patience completely and responding in the manner she did."</p> <p>Upon interview of the Administrator on 8/20/13 at 11 a.m., the Administrator indicated the staff to resident abuse was substantiated, due to when Resident #70 was interviewed regarding the incident on 8/8/13 the resident described the incident as "we had a hair pulling thing."</p>		compliance for survey tag #225.		

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	<p>Upon interview of QMA #10 on 8/20/13 at 2:30 p.m., the QMA indicated CNA #9 went to provide bedtime care to Resident #70, and the resident was combative. The QMA stated the resident called CNA #9 a "b...h." The QMA also indicated the CNA attempted to stand the resident to provide peri-care, and the resident hit CNA #9 with a closed fist and pulled her hair. The QMA indicated she tried to intervene to get the resident to stop, but the resident hit the CNA again. The QMA then indicated the CNA grabbed the resident's hair, and pulled the resident to the floor. The QMA indicated she was able to complete the resident's bedtime care. The QMA stated she then immediately informed LPN #10 of the allegation, and CNA #9 was clocked out.</p> <p>On 8/21/13 at 12:19 p.m., Resident #70 was observed to be sitting in her room. The resident was noted not to have any bruises on arm or legs.</p> <p>Upon interview of Resident #70 on 8/21/13 at 12:19 p.m., the resident recalled that a CNA [CNA #9] had kicked her and she had a bruise. The resident indicated the bruise was from altercation with [CNA #9] when she</p>				

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	<p>was trying to remove her clothes. The resident stated she had "gone down to the floor." The resident indicated she had never had any previous bad experiences with [CNA #9] prior, and that she had not had any problems with other staff during her 2 year stay.</p> <p>Upon review of the clinical record on 8//21/13 at 2 p.m., the most recent Minimum Data Set (MDS) assessment was completed on 7/24/13. The assessment identified the resident as independent in ambulation/transfers, limited assistance of one with personal hygiene, and independent in cognitive decision making skills. The resident was also identified with the diagnosis which included, but was not limited to Alzheimer Disease.</p> <p>Upon review of electronic mail dated 8/9/13 at 9:47 a.m. on 8/21/13 at 9:45 a.m., the immediate notification to ISDH of the abuse allegation dated 8/8/13 was lacking.</p> <p>Upon interview of the Administrator on 8/21/13 at 9:49 a.m., the Administrator indicated ISDH was notified initially of the allegation of staff to resident abuse identified on 8/8/13 at 9:40 p.m. on 8/9/13 at 9:47 a.m. (12 hours and 7 minutes) via</p>						

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	<p>electronic mail After allegation of abuse.</p> <p>2. Upon review of abuse investigation dated 7/18/13 on 8/20/13 at 11 a.m., the investigation involved CNA #17 and Resident # 51. The allegation indicated CNA #17 spoke inappropriately and was "rough" in providing care on 7/18/13 at 9 p.m. The allegation was found to be unsubstantiated. The allegation was initially reported to ISDH via electronic mail on 7/18/13 at 9:59 a.m.</p> <p>Upon review of the electronic mail dated 7/19/13 at 9:59 a.m. on 8/21/13 at 9:45 a.m., the immediate notification to ISDH of the abuse allegation dated 7/18/13 was lacking.</p> <p>Upon interview of the Administrator on 8/21/13 at 9:49 a.m., the Administrator indicated ISDH was notified initially of the allegation of staff to the resident abuse identified on 7/18/13 at 9 p.m. on 7/19/13 at 9:59 a.m. (12 hours and 59 minutes) via electronic mail after allegation of abuse.</p> <p>3. Upon review of abuse investigation dated 6/14/13 on 8/20/13 at 11 a.m., the investigation involved Resident # 36. The allegation indicated the</p>						

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	<p>cognitively impaired Resident #36 told CNA #15 that someone came into her room, grabbed her right arm, and threw her into a chair. The allegation was found to be unsubstantiated. The allegation was initially reported to ISDH via electronic mail on 6/14/13 at 4:49 pm.</p> <p>Upon review of the electronic mail dated 6/14/13 at 4:49 a.m. on 8/21/13 at 9:45 a.m., the immediate notification to ISDH of the abuse allegation dated 6/14/13 was lacking.</p> <p>Upon interview of the Administrator on 8/21/13 at 9:49 a.m., the Administrator indicated ISDH was notified initially of the allegation of the resident abuse identified on 6/14/13 at 10:30 a.m. on 6/14/13 at 4:49 a.m. (6 hours and 19 minutes) via electronic mail after allegation of abuse.</p> <p>4. Upon review of abuse investigation dated 5/22/13 on 8/20/13 at 11 a.m., the investigation involved QMA #18 and Resident # 72. The allegation indicated QMA #18 spoke inappropriately to Resident #72 on 5/22/13. The allegation was found to be unsubstantiated. The allegation was initially reported to ISDH via electronic mail on 8/21/13 at 9:00</p>			

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	<p>a.m.</p> <p>Upon review of the electronic mail dated 8/21/13 at 9 a.m. on 8/21/13 at 9:45 a.m., the immediate notification to ISDH of the abuse allegation dated 5/22/13 was lacking.</p> <p>Upon interview of the Administrator on 8/21/13 at 9:49 a.m., the Administrator indicated ISDH was notified initially of the allegation of staff to the resident abuse identified on 5/22/13 on 8/21/13 at 9 a.m. via electronic mail. The Administrator indicated the allegation was investigated on 5/22/13; however, the Administrator indicated ISDH had not been notified previously as allegation was found to be unsubstantiated.</p> <p>3.1-28(c)</p>				

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F000226 SS=D	<p>483.13(c) 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 interview and record review, the facility failed to implement their policies and procedures to immediately report allegations of abuse to state officials for 4 of 4 allegations of staff to resident abuse. (Resident #70, Resident #85, Resident #51, Resident # 36).</p> <p>Findings include:</p> <p>1. Facility abuse investigations were reviewed on 8/20/13 at 11 a.m. An investigation report indicated an allegation of CNA #9 using excessive force and inappropriate behavior while providing evening personal hygiene care to Resident # 70 on 8/8/13 at 9:40 p.m. The investigation report alleged QMA #10 observed CNA #9 to grab Resident #70 by her hair and pulled the resident down to the floor with her while providing evening peri-care. The report indicated the resident was very combative during the care i.e. slapping, kicking, hitting, and pulling CNA #9's hair. Documentation</p>	F000226	<p>I. Please note that no residents were adversely affected by the facility's failure to immediately notify state officials of the allegations noted, and that all of the situations were thoroughly investigated by facility staff upon occurrence. II. As all residents could potentially be affected, the following corrective measures have been implemented: III. As a means to assure the deficient practice does not recur, upon occurrence of any future allegation of staff to resident abuse, the Administrator will be immediately notified, and in turn will immediately notify the Indiana State Department of Health via telephone call, email, or fax. Follow up reports will be completed as necessary to advise of the outcome of the investigation of the allegation. IV. As a means of ongoing compliance, the Administrator will maintain a log of allegations reported, including the time of notification to the Administrator as well as the Indiana State Department of Health. The log will be reviewed by the Administrator with the Quality Assurance committee during</p>	08/22/2013			

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	<p>indicated QMA #10 stated CNA #9 was trying to defend herself when she grabbed the resident's hair and then pulled the resident to the floor with her. The report indicated QMA #10 assisted CNA #9 with completing care for Resident #70, and both staff exited the resident's room. QMA #10 then immediately reported the allegation to LPN #11. LPN #11 immediately notified the Director of Nursing and the Administrator. LPN #11 then instructed CNA #9 to leave the facility. The report indicated the resident was assessed with red streak on her right cheekbone, and a reddish purple knot on her right inner leg above the ankle. According to the documentation, the facility was unable to determine if the injuries were self-inflicted by the resident during the struggle with CNA #9, or had been previously self inflicted by resident during the resistance of care. The follow up report dated 8/9/13 and sent on 8/9/13 at 3:06 p.m. indicated CNA #9 was terminated from employment due to "the employee should not have allowed herself to become involved in the situation to the extent that she did, thus losing her patience completely and responding in the manner she did."</p> <p>Upon interview of the Administrator</p>		<p>quarterly meetings. V. Evidence of the log of allegations to be maintained by the Administrator is provided in Attachment #3. VI. Due to evidence provided Ben Hur Health and Rehab requests paper compliance for survey tag #226.</p>				

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	<p>on 8/20/13 at 11 a.m., the Administrator indicated the staff to resident abuse was substantiated, due to when Resident #70 was interviewed regarding the incident on 8/8/13 the resident described the incident as "we had a hair pulling thing."</p> <p>Upon interview of QMA #10 on 8/20/13 at 2:30 p.m., the QMA indicated CNA #9 went to provide bedtime care to Resident #70, and the resident was combative. The QMA stated the resident called CNA #9 a "b...h." The QMA also indicated the CNA attempted to stand the resident to provide peri-care, and the resident hit CNA #9 with a closed fist and pulled her hair. The QMA indicated she tried to intervene to get the resident to stop, but the resident hit the CNA again. The QMA then indicated the CNA grabbed the resident's hair, and pulled the resident to the floor. The QMA indicated she was able to complete the resident's bedtime care. The QMA stated she then immediately informed LPN #10 of the allegation, and CNA #9 was clocked out.</p> <p>On 8/21/13 at 12:19 p.m., Resident #70 was observed to be sitting in her room. The resident was noted not to</p>				

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	<p>have any bruises on arm or legs.</p> <p>Upon interview of Resident #70 on 8/21/13 at 12:19 p.m., the resident recalled that a CNA [CNA #9] had kicked her and she had a bruise. The resident indicated the bruise was from altercation with [CNA #9] when she was trying to remove her clothes. The resident stated she had "gone down to the floor." The resident indicated she had never had any previous bad experiences with [CNA #9] prior, and that she had not had any problems with other staff during her 2 year stay.</p> <p>Upon review of the clinical record on 8/21/13 at 2 p.m., the most recent Minimum Data Set (MDS) assessment was completed on 7/24/13. The assessment identified the resident as independent in ambulation/transfers, limited assistance of one with personal hygiene, and independent in cognitive decision making skills. The resident was also identified with the diagnosis which included, but was not limited to Alzheimer Disease.</p> <p>Upon review of electronic mail dated 8/9/13 at 9:47 a.m. on 8/21/13 at 9:45 a.m., the immediate notification to ISDH of the abuse allegation dated 8/8/13 was lacking.</p>						

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	<p>Upon interview of the Administrator on 8/21/13 at 9:49 a.m., the Administrator indicated ISDH was notified initially of the allegation of staff to resident abuse identified on 8/8/13 at 9:40 p.m. on 8/9/13 at 9:47 a.m. (12 hours and 7 minutes) via electronic mail after allegation of abuse.</p> <p>2. Upon review of abuse investigation dated 7/18/13 on 8/20/13 at 11 a.m., the investigation involved CNA #17 and Resident # 51. The allegation indicated CNA #17 spoke inappropriately and was "rough" in providing care on 7/18/13 at 9 p.m. The allegation was found to be unsubstantiated. The allegation was initially reported to ISDH via electronic mail on 7/18/13 at 9:59 a.m.</p> <p>Upon review of the electronic mail dated 7/19/13 at 9:59 a.m. on 8/21/13 at 9:45 a.m., the immediate notification to ISDH of the abuse allegation dated 7/18/13 was lacking.</p> <p>Upon interview of the Administrator on 8/21/13 at 9:49 a.m., the Administrator indicated ISDH was notified initially of the allegation of staff to the resident abuse identified</p>				

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	<p>on 7/18/13 at 9 p.m. on 7/19/13 at 9:59 a.m. (12 hours and 59 minutes) via electronic mailn after allegation of abuse.</p> <p>3. Upon review of abuse investigation dated 6/14/13 on 8/20/13 at 11 a.m., the investigation involved Resident # 36. The allegation indicated the cognitively impaired Resident #36 told CNA #15 that someone came into her room, grabbed her right arm, and threw her into a chair. The allegation was found to be unsubstantiated. The allegation was initially reported to ISDH via electronic mail on 6/14/13 at 4:49 p.m.</p> <p>Upon review of the electronic mail dated 6/14/13 at 4:49 a.m. on 8/21/13 at 9:45 a.m., the immediate notification to ISDH of the abuse allegation dated 6/14/13 was lacking</p> <p>Upon interview of the Administrator on 8/21/13 at 9:49 a.m., the Administrator indicated ISDH was notified initially of the allegation of the resident abuse identified on 6/14/13 at 10:30 a.m. on 6/14/13 at 4:49 a.m. (6 hours and 19 minutes) via electronic mail.</p> <p>4. Upon review of abuse investigation dated 5/22/13 on 8/20/13 at 11 a.m.,</p>						

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	<p>the investigation involved QMA #18 and Resident # 72. The allegation indicated QMA #18 spoke inappropriately to Resident #72 on 5/22/13. The allegation was found to be unsubstantiated. The allegation was initially reported to ISDH via electronic mail on 8/21/13 at 9:00 a.m.</p> <p>Upon review of the electronic mail dated 8/21/13 at 9 a.m. on 8/21/13 at 9:45 a.m., the immediate notification to ISDH of the abuse allegation dated 5/22/13 was lacking.</p> <p>Upon interview of the Administrator on 8/21/13 at 9:49 a.m., the Administrator indicated ISDH was notified initially of the allegation of staff to the resident abuse identified on 5/22/13 on 8/21/13 at 9 a.m. via electronic mail. The Administrator indicated the allegation was investigated on 5/22/13; however, the Administrator indicated ISDH had not been notified previously as allegation was found to be unsubstantiated.</p> <p>Upon review of the facility's current policy and procedure titled "ABUSE" (no date) on 8/19/13 at 2:30 p.m., documentation indicated "...PROCEDURE:...3.) Should the incident be deemed an "unusual</p>				

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	<p>occurrence," the state survey and certification agency shall be notified as well as the ombudsman and/or Adult Protective Services, as applicable..." Upon review of the facility's current policy and procedure titled "ACCIDENT AND INCIDENT REPORT" (no date) on 8/19/13 at 2:30 p.m., documentation indicated "...It is the responsibility of administrative personnel to report unusual occurrences to the Department of Health per ISDH policy and procedure for Reportable Unusual Occurrences..."</p> <p>3.1-28(a)</p>			

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F000253 SS=D	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation, and interview the facility failed to maintain 2 of 7 resident areas in a comfortable manner in that carpeting in a hallway to Wing 6 was loose and wrinkled and an area of Wing 9 hall had a soft depression in the middle of the hallway.</p> <p>Findings include:</p> <p>1. On 8/14/13 at 1:00 p.m., loose and wrinkled carpeting was observed on the hallway ramp to Wing 6. Residents were noted to use the ramp.</p> <p>The carpeting was noted in the same condition on 8/15/13 at 12:00 p.m. and 8/16/14 at 11:15 a.m.</p> <p>On 8/16/13 at 11:15 a.m., CNA #8 was interviewed. The staff member indicated the ramp was utilized to transfer residents to Desk 2. CNA #8 indicated Resident #28 ambulated per self up and down the ramp, and Resident #40 utilized an electric scooter per self to transfer up and down the ramp.</p>	F000253	<p>I. Please note that no residents have experienced any adverse consequences due to the carpeting on Wing 6 or Wing 9.</p> <p>II. As residents who reside on Wing 9, and those who travel Wing 6 or Wing 9 could be affected by variations in the floor covering, the following corrective measures have been implemented: III. A contractor has been scheduled to install new floor covering on the Wing 6 hallway on September 16, 2013. The area noted to be a soft depression between rooms 70 and 74 has been repaired by maintenance staff. In order to assure that flooring is appropriately maintained, the Environmental Services Supervisor will monitor daily on scheduled days of work for any needed repairs, and will note at least monthly a thorough evaluation of all patient care areas. IV. As a means of ongoing compliance, the Environmental Services Supervisor will conduct and document a thorough evaluation of all patient care areas at least monthly, and report findings to the Administrator, who will ensure that repairs are completed as necessary. V. Evidence of</p>	09/16/2013			

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	<p>2. On 8/16/13 at 10:00 a.m., Wing 9 was observed with a dip in the middle of the floor of the hallway. The area was between rooms 70 and 74. The area had a soft area of flooring, which depressed when stepped on. At that time, Housekeeper #12 was in the area and indicated she was aware of the location of the dip. The housekeeper stated "Oh that is a dip in the floor."</p> <p>On 8/21/13 at 7:15 p.m., during the exit interview with the Director of Nursing, Administrator, Personnel Manager and Social Service Directorstaff indicated they were aware of the "dip." in the hallway of Wing 9. They did not indicate how long the area had existed.</p> <p>3.1-19(f)</p>		<p>scheduled repair to the carpet on Wing 6 is noted in Attachment #4. Evidence of monitoring is provided in Attachment #5. VI. Due to evidence provided Ben Hur Health and Rehab requests paper compliance for survey tag #253.</p>		

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review the facility failed to ensure a resident with an indwelling catheter received services to prevent urinary tract infections and to identify a clinical condition for use of the catheter for 1 of 2 resident's reviewed with an indwelling Foley urinary catheter. (Resident #12)</p> <p>Finding includes:</p> <p>On 8/14/13 at 1 p.m., Resident #12 was noted in a wheel chair in a resident lounge. The resident's urinary drainage bag tubing was noted draped down and laying on the floor.</p> <p>On 8/19/13 at 10 a.m. Resident #12 was in a wheelchair in the room. A portion of the resident's urinary drainage bag tubing was laying on the</p>	F000315	<p>I. Please note that Resident #12 does now have a diagnosis of "neurogenic bladder". As this resident as well all other residents who have indwelling catheters have the potential to be affected by the appropriate provision of care of the catheter, as well as an identified clinical condition for use of the catheter, the following corrective measures are being taken: II. An audit was conducted of all residents who have indwelling catheters to ensure all have an appropriate diagnosis for use of the catheter. III. As a means to ensure the deficient practice does not recur, the Director of Nursing is conducting an Inservice for all nursing staff on September 6, 2013 to review appropriate technique for provision of catheter care, to include emphasis on placement of catheter tubing and drainage bag. Additionally, the MDS Coordinator has been instructed to verify at each completion of an</p>	09/06/2013			

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	<p>floor. At 2:30 p.m., while in a wheelchair in the resident room, a portion of the resident's urinary drainage tubing was laying on the floor.</p> <p>Resident #12's clinical record was reviewed on 8/21/13 at 3 p.m. A diagnosis to indicate the reason for the use of the indwelling urinary catheter was lacking.</p> <p>Documentation was noted on a form titled "Problem Summary", identifying "Problem Statement" with original date of 12/23/12, of "... requires Foley catheter due to open areas on buttocks. Catheter assessment dated 6/27/13, indicated benefits continue to outweigh risks. Continued use remains appropriate and no complications have been noted." Documentation dated 12/22/12 indicated "Cetin (antibiotic) 250 mg [milligram] po [per os] BID [twice daily] x 10 days.... 4/23/13 areas healed at this time... 6/26/13 Rocephin (antibiotic) 1 gm [gram] QD [every day] x 8 days for UTI [urinary tract infection]... 6/27/13 Nursing Progress Notes indicate Foley Cath [catheter] change 6/19/13." Another "Problem Statement" was noted, with an original date of 7/12/13, indicating "I am at risk for an Urinary Tract</p>		<p>MDS Assessment for a resident with an indwelling catheter that an appropriate diagnosis for use of the catheter is recorded in the medical record. IV. As a means to ensure ongoing compliance, the Director of Nursing or her designee will conduct observations at least twice weekly to ensure staff is following proper technique in the provision of catheter care. As a means of quality assurance, results of these monitoring observations will be reported to the Administrator on a weekly basis. The Director of Nursing will be responsible to report to the Quality Assurance Committee during quarterly meetings any failure of facility staff to follow proper procedures. V. Evidence of inservice training for nursing staff is provided in Attachment #6. Evidence of monitoring is provided in Attachment #7. VI. Due to evidence provided Ben Hur Health and Rehab requests paper compliance for survey tag #315.</p>		

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	<p>Infection r/t [related to] Foley catheter placement 6/23/13 Rocephin (antibiotic) 1 gm [gram] IM [intramuscularly] QD [every day] X [times] 8 days for UTI [urinary tract infection]."</p> <p>During interview on 8/21/13 at 4:02 p.m., the DON [Director of Nursing] indicated the urinary drainage tubing should be kept off of the floor. The DON indicated the current diagnosis for the use of an indwelling Foley catheter was "chronic skin breakdown."</p> <p>3.1-41(a)(2)</p>			

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NAME OF PROVIDER OR SUPPLIER  BEN HUR HEALTH & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 1375 S GRANT AVE CRAWFORDSVILLE, IN 47933			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000371 SS=E	<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 Based on observation, interview and record review the facility failed to serve or prepare food under sanitary conditions for 1 of 2 kitchen observation in that the steam table failed to maintain safe temperatures and food was not thawed according to manufactures directions.</p> <p>Finding includes:</p> <p>During kitchen tour on 8/14/12 at 11:00 a.m., with the FSS (food service supervisor) the following was noted:</p> <p>a. A frozen container of orange juice was sitting in a sink. The bottom of the sink was covered with water. A label on the juice indicated "...should be thawed at 40 degrees." The FSS indicated should be thawed in a refrigerator.</p> <p>b. On 8/14/13 at 11:10 am, the FSS checked the temperatures on the steam table in the kitchen, Three</p>	F000371	<p>I. Dietary staff responsible for the preparation and serving errors noted by the surveyors were immediately addressed by the Dietary Supervisor. II. As all residents have the potential to be affected by failure of staff to follow appropriate procedures for preparation and serving of food, the following corrective measures have been taken: III. As a means to assure these deficient practices do not recur, the Dietary Supervisor has conducted 1:1 Inservice training for all dietary staff to review proper procedures for thawing food items, as well as proper procedures for ensuring appropriate temperatures for food items being served from the steam table. IV. As a means to ensure ongoing compliance, the Dietary Supervisor will conduct observations at least twice weekly of food items being thawed properly for meals. Additionally, the Dietary Supervisor will assess the temperature of food items on the steam table prior to serving at least twice weekly. Any failure of staff to follow appropriate procedures for thawing food or serving will be addressed</p>	08/29/2013			

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	<p>areas of the steam table was turned on. One area of the steam table contained pureed meat and pepper steak. The pureed meat measured 110 degrees Fahrenheit and the pepper steak measured 60 degrees.</p> <p>During interview of the FSS on 8/14/13 at 11:15 a.m., the FSS indicated the orange juice had been placed in the sink to thaw. The FSS indicated the juice should have been placed in a refrigerator while thawing. The FSS indicated 4 of 5 dining rooms receive food from the steam table in the kitchen. The FSS also indicated the main dining room was served from a separate steam table.</p> <p>During interview of the FSS on 8/21/12 at 1:38 p.m., the FSS indicated the reason the third area of the steam table temperatures .."weren't up" was due to inadequate amount of water in the pan to keep the food hot enough. The FSS Indicated she re-inserviced staff concerning thawing foods and steam table temperatures.</p> <p>During interview of the Administrator on 8/21/13 at 4 p.m., the Administrator indicated 36 of 76 residents ate their meals in the main dining room.</p>		<p>immediately by the Dietary Supervisor, with a re-education or counseling report completed as appropriate to ensure understanding and compliance. As a means of quality assurance, the Dietary Supervisor will report to the Administrator each week any failure of staff to follow these procedures properly, and will also report same to the Quality Assurance Committee during quarterly meetings. V. Evidence of Inservice training for dietary staff is provided in Attachment #8. Evidence of monitoring is provided in Attachment #9. VI. Due to evidence provided Ben Hur Health and Rehab requests paper compliance for survey tag #371.</p>		

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	<p>On 8/21/13 at 4 p.m., polycys' titled "Pureed Food" and "Thawing Frozen Foods" were received from the Administrator. The policy titled "Pureed Food" indicated, but was not limited to "...Heat food to 160 degrees with the exception of fruits and desserts, and place in a steam table pan to be held between 140 degrees to 160 degrees until served." The policy titled "Thawing Frozen Foods" indicated "The cook in charge will check the menu daily for frozen items required for the next three days. The cook will take the frozen foods from the freezer and place them on trays in the walk-in cooler. Meats will be placed on the bottom shelf for thawing. (eggs are not to be stored above the meats)."</p> <p>3.1-21(i)(3)</p>						

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F000441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> 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 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review the facility failed to</p>	F000441	I. Please note that Resident #11 was not negatively affected as a	09/06/2013			

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	<p>ensure hand hygiene was maintained for 2 of 3 residents observed receiving incontinence care and 1 of 1 resident with a gastrostomy tube. (Residents #11 and #1]</p> <p>Findings include:</p> <p>1. On 8/16/13 at 2:20 p.m., CNA #1 and #2 were observed to provide incontinence care to Resident #11. The resident was observed to have an incontinence brief on, heavily saturated with urine and small amount of bowel movement.</p> <p>While wearing gloves, CNA#1 picked up a multi-use bottle of liquid soap from the bed side table, applied soap to wash cloths and cleansed the resident's peri area. The CNA washed, rinsed, and dried the area, The CNA then repositioned the resident on the right side and with the same gloves, picked up the soap bottle and applied soap to more cloths to repeat process on the posterior side. After completion of cleansing, the CNA with the same gloves on, opened another bedside table in the room and retrieved a disposable brief. The brief was positioned beneath the resident. The CNA then picked up a multi-use</p>		<p>result of the failure to ensure hand hygiene by staff members during provision of incontinence and gastrostomy care. CNAs #1 and #2, as well as LPN #4 have been addressed in regard to the observations made at the time of the survey. II. As all residents have the potential to be affected by appropriate hand hygiene by staff members, the following corrective measures are being taken: III. As a means to ensure the deficient practice does not recur, the Director of Nursing conducted an Inservice for all nursing staff on September 6, 2013 to review appropriate technique for provision of incontinence care to include emphasis on handwashing, changing of gloves, and contamination with soiled gloves. Licensed Nurses were also inserviced on September 6, 2013 in the appropriate technique for provision of gastrostomy feeding and medications. IV. As a means to ensure ongoing compliance, the Director of Nursing or her designee will conduct observations at least twice weekly to ensure staff is following proper technique in the provision of peri-care and gastrostomy feedings/medication administration. As a means of quality assurance, results of these monitoring observations will be reported to the Administrator on a weekly basis. The Director of Nursing will be responsible to</p>		

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	<p>container of body powder and applied to the resident's front and back sides. With the same gloves on CNA #1 repositioned the resident, applied a body pillow behind the resident for positioning, adjusted the resident's covers, attached the call light to the covers, touched the gastrostomy tubing before removing the gloves.</p> <p>2. On 8/21/13 at 1:48 p.m., LPN #4 was observed to administer a medication, water, and tube feeding to Resident #11. While wearing gloves the LPN utilized a stethoscope kept in the resident's room, and checked the gastrostomy [g-tube] placement by instilling air. The LPN then flushed the tube with water, by holding the tube up, administered a can of feeding, followed by medication administration and another water flush. After completion and with the same gloves on, the LPN capped the tube, placed the syringe back into a plastic bag laying on the bed side table, picked up the stethoscope and hung it on the wall, readjusted the resident's clothing and then removed the gloves.</p> <p>3. On August 20, 2013 at 12:54 pm, CNA #7 and #8 were observed to transfer Resident #7 with a mechanical lift from a chair into bed.</p>		<p>report to the Quality Assurance Committee during quarterly meetings any failure of facility staff to follow proper procedures. V. Evidence of inservice training for nursing staff is provided in Attachment #6. Evidence of monitoring is provided in Attachment #7. VI. Due to evidence provided Ben Hur Health and Rehab requests paper compliance for survey tag #441.</p>		

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	<p>While wearing gloves, CNA #7 removed an incontinence brief. The resident had been incontinent of bowel movement. The CNA cleansed the resident and with the same gloves on, repositioned the resident in bed and then removed the soiled gloves and washed hands.</p> <p>A facility policy titled "Perineal Care," dated 11/98, provided by the Director of Nursing (DON) on 8/21/13 at 4:08 p.m., included, but was not limited to steps of the provision of care, and after completion, remove gloves, and perform necessary post-care final steps."</p> <p>The DON was interviewed on 8/21/13 at 3:58 p.m. The DON indicated staff are instructed to wash hands after completion of a task before moving to a clean area.</p> <p>3.1-18(a)</p>				

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F000456 SS=C	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview the facility failed to maintain an accurate exterior dial measuring temperature of the rinse water for 1 of 1 dish machine.</p> <p>Findings include:</p> <p>On 8/21/13 at 1:05 p.m. two external gauges were noted on the outside of the dish machine. Documentation was noted on the exterior of the machine indicating wash cycle should be 140 degrees Fahrenheit and the rinse should be 180 degrees Fahrenheit.</p> <p>With the FSS (food service supervisor) present, Dishwasher #1 ran a rack of dishes through the dishmachine. The wash temperature gauge measured 164 degrees and the rinse temperature gauge measured 140 degrees. The FSS indicated the only way the water temperatures were checked was with the external gauges. The FSS placed an internal thermometer in the dishwasher and the rinse temperature measured 192 degrees Fahrenheit.</p>	F000456	<p>I. Please note that no residents were adversely affected by the function of the gauges of the dishmachine. II. As all residents could be affected by improper maintenance of the dishmachine, the following corrective measures have been taken: III. A contractor was asked to evaluate the function of all components of the dishmachine on 8/21/13. Based upon his assessment, it was determined to begin using a chemical sanitizing agent to ensure adequate disinfection. The chemical which has always been available for staff to use with the dishmachine in the event hot water temperatures were not sufficient for disinfecting is now in routine use with every tray of dishes and kitchen item being sanitized in the dishmachine. Information on Avance Chlorine Sanitizer, the disinfecting agent recommended by the contractors for our warewashing chemicals, is in Attachment #10. As a means to ensure the deficient practice does not recur, the Dietary Supervisor has conducted 1:1 inservice training for dietary staff to address proper chemical sanitation, and testing of the concentration of the sanitizing solution as it disburses through</p>	08/29/2013			

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	<p>During interview of Dishwasher #1, the dishwasher indicated he has ran dishes through four times before to try to raise the the temperature.</p> <p>During interview of the FSS on 8/21/13 at 1:15 p.m., the FSS indicated no one told her the gauge was not working.</p> <p>A facility policy (no date) titled "Temperature Dish Machine" received from the Administrator on 8/21/13 at 4 p.m., indicated "The dish machine will be operated at correct temperatures. The dishwasher checks and charts the wash and rinse temperatures of the dish machine at 8:30 a.m., 12:30 p.m., and 6:30 p.m. If the temperatures are not at correct levels report immediately to the dietary supervisor or the administrator.</p> <p>3.1-19(bb)</p>		<p>the machine during washing to ensure at least 50 ppm of concentration, per recommendation of the manufacturer. Staff was instructed to record the ppm level from the dishmachine three times daily to monitor for any necessary adjustments in the dispensing equipment. IV. As a means to ensure ongoing compliance, the Dietary Supervisor will conduct observations at least twice weekly of the chemical sanitizing process with the dishmachine, and also that ppm levels are being recorded properly by staff. Any concern of inadequate sanitization will be reported to the Administrator immediately, and also discussed by the Dietary Supervisor at quarterly Quality Assurance meetings. V. Evidence of Inservice training for dietary staff is provided in Attachment 8. Evidence of monitoring is provided in Attachment #11. VI. Due to evidence provided Ben Hur Health and Rehab requests paper compliance for survey tag #456</p>		