

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/20/2014
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NAME OF PROVIDER OR SUPPLIER  CORYDON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN 47112
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F000000	<p>This visit was for a Recertification and State Licensure survey. This visit was also for the Investigation of Complaint IN00154205.</p> <p>Complaint IN00154205 - Substantiated - No deficiencies related to the allegations are cited.</p> <p>Survey date: August 17, 18, 19 and 20, 2014</p> <p>Facility number: 000338 Provider number: 155441 AIM number: 100287590</p> <p>Survey team: Gloria J. Reisert, MSW/TC Jenny Sartell, RN Trudy Lytle, RN, Gwen Pumphrey, RN (August 17, 18, and 19, 2014)</p> <p>Census bed type: SNF/NF: 32 Total: 32</p> <p>Census payor type: Medicare: 04 Medicaid: 23 Other: 05 Total: 32</p>	F000000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 19,2014 to the annual licensure survey conducted on August 17, 2014 through August20, 2014. The facility also requests that our plan of correction be considered for paper review compliance. The facility would be happy to submit to you any compliance paper work you would need.</p>	
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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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F000242 SS=D	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on August 29, 2014, by Brenda Meredith, R.N.</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview, the facility failed to ensure residents were provided a menu and were helped to choose what they wanted to eat. This deficient practice affected 2 of 4 residents reviewed for food choices. (Resident # 9 and #44)</p> <p>Findings include:</p> <p>1. During an interview on 8/17/14 at 5:00</p>	F000242	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 19,2014 to the annual	09/19/2014

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	<p>p.m., Resident # 9 indicated she had a lot of allergies - pizza, pasta, wheat and sauces - and that the dietary people just couldn't seem to get it right. She indicated that she would have to send the food item back and get something else.</p> <p>On 8/20/14 at 10:25 a.m., she indicated they do not come around with a menu to choose from for the next day, but that it would be nice to get a menu the day before to know what she could choose from. She further indicated that maybe this way they would get her meal right and would not get some of the things she couldn't eat or disliked.</p> <p>Review of the list of residents who received a menu everyday, presented by the Dietary Manager on 8/20/14 at 10:10 a.m., indicated Resident # 9 was not on the list to receive a menu.</p> <p>2. Review of the 8/14/14 Dietitian's note indicated : "Doing well, no new concerns. Discussed in NAR [Nutrition at Risk] meeting- d/c [discontinue] large portion due to eating only 92% [percent] of meals; he is a picky eater. Give him a menu so he can choose what he wants to eat."</p> <p>In an interview with Resident #44 on 8/18/14 at 9:57 a.m., he indicated that the</p>		<p>licensure survey conducted on August 17, 2014 through August 20, 2014. The facility also requests that our plan of correction be considered for paper review compliance. The facility would be happy to submit to you any compliance paper work you would need.</p> <p>F242 It is the practice of Corydon Nursing and Rehabilitation Center to assure that Resident Rights are honored, including but not limited to food choices. <b>The correction action taken for those residents found to be affected by the deficient practice include:</b> (1) The DSM met with Resident #9. Allergies and dislikes were updated and added to tray card. Dietary Manager or designee will send out menus, assist with filling out as needed, and collect for next day's meals. (2) Dietary Manager met with Resident #44. Resident is aware that he may request eggs or other alternative if he does not like the items served on the regular breakfast menu. In addition, Dietary Manager has ordered boiled eggs and scrambled eggs to add to the menu. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> All interviewable residents have been interviewed related to their meal preferences, and tray cards updated as needed. All</p>		

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	<p>facility served the same thing all the time, such as biscuits and gravy several times a week in the mornings. He indicated he would like more eggs but that it did no good to tell anyone as wouldn't get it anyway. He also indicated that the substitutes were not much better either.</p> <p>On 8/20/14 at 10:10 a.m., the Dietary Manager indicated that she passed out menus to 14 residents for them to choose their next day's meal from and that if the residents returned them to her, then they would get what they chose. She further indicated that otherwise if the menu was not returned, then she would have to serve the regular menued item and they can then always ask for a sub. She also indicated she did not go back and pick up the menus because she was gone after they are delivered, but guessed she could go back and get them. The residents were supposed to bring them to her.</p> <p>On 8/20/14 at 10:50 a.m., resident #44 indicated that he did get a menu, but needed help in order to pick out food choices and that no one helped him do so.</p> <p>On 8/19/14 at 9:00 a.m., the Administrator presented a copy of the current "Resident Rights" given to the residents. Review of these "Resident Rights" at this time included, but were</p>		<p>residents were notified of newly formed Food Council at the facility and encouraged to attend. Please see below for additional corrective actions and monitoring. <b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> (1) Dietary Manager or designee will daily provide menus for the next day. Dietary Manager or designee will collect daily menus and assist residents will filling menus out as needed. (2) A Food Council will be established. Minutes will be kept to address any concerns, including but not limited to meal choices, food temps, timeliness, and palatability of meals. Administrator or designee will review minutes of food council and follow up as needed to ensure that a method of resolution is achieved. Food Council meetings will be held weekly x4, and monthly thereafter. QAA Committee will review minutes at the scheduled meetings and offer new recommendations as needed. <b>The date these systematic changes will be completed:</b> September 19, 2014</p>		

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F000314 SS=D	<p>not limited to: "Resident Rights: As a resident of this facility, you have the right to a dignified existence...The facility will protect and promote your rights as designated below...Accommodation of Needs:...You have the right to make choices about aspects of your life in the facility that is important to you...."</p> <p>3.1-3(u)(1)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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. Based on observation, interview and record review, the facility failed to ensure residents received proper measures to prevent or promote the healing pressure ulcers. This deficient practice affected 2 of 3 residents reviewed for pressure ulcers. (Resident #14 and #32).  Findings include:</p>	F000314	F314 It is the practice of Corydon Nursing and Rehabilitation Center to ensure residents who enter the facility without pressure sores do not develop sores unless the individual's clinical condition demonstrates that they were unavoidable. <b>The correction action taken for those residents found to be affected by the deficient practice</b>	09/19/2014			

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	<p>1. On 8/19/14 at 3:19 p.m., Resident #14's clinical record was reviewed. She had diagnosis including but not limited to dementia, heart failure, high blood pressure, hard of hearing, and PEG tube placement (tube used to provide nutrition for residents unable to eat). She had an accident at the facility on 4/13/14 resulting in a fracture to her right leg. She was treated with an immobilizer to her right leg.</p> <p>Review of the weekly skin assessment sheets indicated on 5/3/14 a stage 3 (full thickness tissue loss), measuring 3 X 2 X 0.2 centimeters (cm), pressure ulcer was acquired in the facility to the back of the residents calf, close to her heel.</p> <p>A care plan intervention, initiated on 5/6/14, included, but was not limited to, leave immobilizer to RLE (Right Lower Extremity) loose while in bed.</p> <p>The wound center consultation note, dated 5/15//14, indicated, ..."She was treated conservatively with a knee immobilizer; however the knee immobilizer created a wound to her right distal calf...." The assessment of the wound indicated, "....measures 2.1 x 3.3 x 0.2 cm. The base of the wound is entirely necrotic and exposed tendon. There is no</p>		<p><b>include:</b> (1) Resident #14's wound was healed at the time of survey. When wound was identified previously, MD was notified. Treatments were reviewed for appropriateness. Resident was seen by wound care, and resident was monitored through interdisciplinary Nutritional at Risk program until wound was healed. (2) Resident #32's sacrum is free from breakdown. Resident #32 receives services from wound clinic to left heel. Left heel is showing improvement. Pressure-relieving interventions and wound treatments are in place and resident is encouraged to leave interventions in place per MD order. Resident's progress is monitored by interdisciplinary Nutritional at Risk program per facility policy. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> (1) Skin checks were performed on all residents. No other residents were found to be affected by this practice. (2) Braden scale was applied to all residents to identify those at higher risk for potential skin breakdown. 12 of 34 residents were identified as being at risk. Current interventions were reviewed for appropriateness. Will continue weekly skin checks per facility policy. Will complete Braden Scale for new residents</p>	

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	<p>healthy granulation tissue within the wound. The surrounding tissue has some erythema but is otherwise intact. There is a small amount of serous exudate present on her dressing. The dressing that was removed was in place for four days and therefore she actually is having very minimal drainage. There was no sign of infection."</p> <p>The physician order, dated 6/12/14, indicated, "Silvasorb 4/25 x 4/25 dressing cleanse wound to right posterior calf with wound cleanser. Apply Silvasorb to wound bed. cover with phone foam dressing and secure with tegaderm. change 2 times weekly. "</p> <p>The care plan for Resident #14, updated on 6/23/14, indicated:at risk for impaired skin and discolorations related to history of skin tears and stage 3 wound to right posterior ankle.</p> <p>The most recent skin assessment, dated 8/11/14, indicated the pressure ulcer had deteriorated to a stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) measuring 2.2 X 3.1 X 0.2 cm.</p> <p>On 8/19/14 at 3:13 p.m., the DON indicated the certified nurse aides notify the nurse of any skin changes to residents skin on shower days. She indicated</p>		<p>upon admission, then weekly x4 weeks,and then quarterly thereafter per facility policy. <b>The measures or systematic changes that have been put in place to ensure that the deficient practice does not recur include:</b> All nursing staff have been in-serviced related to pressure ulcer prevention. Emphasis was given to preventative measures and risk factors.Staff that missed in-service will be prohibited from working until they are in-serviced. Pressure relieving interventions will be administered as needed.Facility will continue weekly skin checks per facility policy. Will complete Braden Scale for new residents on admission, then weekly x4 weeks, and then quarterly thereafter per facility policy. <b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> (1) A skin sweep to be completed for all residents by September 19, 2014. Skin assessments will be updated to reflect current status and pressure-relieving interventions added as needed. Skin sweeps will continue 1x per month for six months, then quarterly x2. (2) In addition, the DON or designee will use a tool to observe treatments. This practice will occur weekly x3, monthly x3, then quarterly x3. The QA Committee will review the tool at scheduled meetings, with</p>				

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	<p>showers are generally given twice a week. In addition, nurses perform weekly skin assessments and document in the treatment administration record. She indicated if a resident has a wound, the nurse is expected to measure the wound weekly and document on the wound sheet.</p> <p>In an interview on 8/19/14 at 3:43 p.m., RN#1 indicated Resident #14's pressure area was a stage 4 to the right achilles. RN#1 indicated, the resident fractured her leg and the pressure area is where she had the immobilizer.</p> <p>On 8/19/14 at 4:12 p.m., Resident#14's right leg was observed to have a dressing to her right lower leg. The next dressing change was scheduled for 8/21/14 therefore wound care was not observed.</p> <p>2. On 8/19/14 at 9:55 a.m., Resident #32's clinical record was reviewed. He had diagnosis including, but not limited to pneumonia, muscle atrophy, and diabetes.</p> <p>A nursing assessment, dated 7/2/14, indicated the resident had an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and or eschar in the ulcer bed)</p>		<p>recommendations as needed based on outcome of the tool. <b>Completion Date:</b> September 19, 2014</p>				

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	<p>to the left heel.</p> <p>The recorded measurements (length, width and depth) included:</p> <ul style="list-style-type: none"> <li>- 7/14/14 - 1.8 x 2 x 0.1 cm (centimeters)</li> <li>- 7/21/14 - 2 x 2 x 0.1 cm</li> <li>- 7/28/14 - 3 x 2.4 x 0.1 cm</li> <li>- 8/04/14 - 3 x 2.4 x 0.1 cm</li> <li>- 8/11/14 - 3 x 2.5 x 0.1 cm</li> </ul> <p>A physician order, dated 7/26/14, indicated, "clean pressure ulcer to left heel with wound cleanser, apply Vaseline gauze to wound area and cover with foam dressing then tegaderm. Change every 3 days and PRN (as needed)."</p> <p>The care plan initiated, on 2/22/14 and updated on 7/29/14, indicated, "the resident is at risk for pressure ulcers with current and history of pressure related skin breakdown:unstageable pressure area to left heel and stage 1 pressure area to sacrum." Interventions included, but were not limited to, "follow facility policies/protocols for the prevention/treatment of skin breakdown, administer treatments as ordered and monitor for effectiveness, monitor dressing to ensure it is intact and adhering. report lose dressing to treatment nurse."</p> <p>The treatment administration record</p>						

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	<p>(TAR) indicated the last date Resident #32's dressing was changed was on 8/16/14. There was no documentation that his dressing was changed as needed for the month of August 2014.</p> <p>On 8/19/14 at 10:16 a.m., RN #1 was observed while performing wound care on Resident #32's pressure ulcer. The wound was observed to be 2 x 2 centimeter circular area to the outer left heel. There was no drainage. The wound bed was dry with 25 % (percent) slough (necrotic tissue in the process of separating form viable tissue). There was minimal granulation tissue present.</p> <p>The resident was observed to not have a dressing to the left heel. The resident indicated he had a shower the night before but was unable to recall when he last had a dressing to his heel.</p> <p>RN #1 indicated on 8/19/14 at 10:25 a.m., his dressing should have been replaced at the time it was removed.</p> <p>On 8/19/14 at 3:13 p.m., the DON indicated the nurses are expected to maintain a dressing to Resident #32's pressure ulcer at all times.</p> <p>The policy titled, "Pressure Ulcers/Skin Breakdown-Clinical Protocol" was</p>				

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F000364 SS=F	<p>provided by the Administrator on 8/19/14 at 12:55 p.m. The policy indicated, ..."The goal is to prevent skin breakdown. Based on the assessment, preventive measures will be implemented based on the resident's needs...."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to ensure food was palatable, at a pleasant temperature, and served in a timely manner for 3 of 5 residents interviewed regarding food palatability (Residents #9, #44 and #12). This deficient practice had the potential to affect 31 of 32 residents receiving meals from the dietary department.</p> <p>Findings include:</p>	F000364	<p><b>F364</b> It is the practice of Corydon Nursing and RehabilitationCenter to provide food prepared by methods that conserve nutritive value,flavor, and appearance, as well as palatable, attractive and at the proptemperature. <b>The Corrective Actions Taken for those residents found to be affectedby the deficient practice include:</b> (1) An in-service was conducted with all dietarystaff related to concerns voiced by residents. Residents #9, #44 and #12</p>	09/19/2014			

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	<p>1. On 8/17/14 at 5:00 p.m., Resident # 9 indicated that the food was often cooler or cold by the time she got her tray. She indicated she ate in the main dining room and that it varied from meal to meal. The resident verbalized that too many bologna sandwiches were used as the substitute and more fruits and vegetables needed to be served. When asked if she had told anyone about this, she indicated that they should know this if they really looked at the menu.</p> <p>In an interview, on 8/19/14 at 4:00 p.m., Resident #9 indicated that today's lunch meal was finally good and warm in a long time.</p> <p>In an interview, on 8/20/14 at 10:25 a.m., Resident #9 indicated again that the food was sometimes cold and thought it was because everyone had to sit so long in the dining room waiting for the staff to bring the trays out from the kitchen and then finally serve them.</p> <p>2. During an interview, on 8/18/14 at 9:57 a.m., Resident #44 indicated that the food was always cold and that they served the same thing over and over again in the same week, i.e. biscuits and gravy. He also voiced that it did not matter the meal, it was still cold when he got his tray in his room.</p>		<p>have been advised of plans to correct deficient practices.</p> <p>(2) All residents have been notified of the creation of a Food Council at the facility to ensure resident satisfaction with the quality of the food service program.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All interviewable residents have been interviewed related to meal temperatures and menu variety. All residents were notified of newly formed Food Council at the facility and encouraged to attend. Facility will continue to monitor meal temperatures and receive feedback from resident Food Council regarding resident satisfaction. Policies, procedures, menus will be updated as needed, based on resident feedback. Please see below for additional corrective actions and monitoring.</p> <p><b>Systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>All Dietary Staff have been in-serviced on food service temperatures. A Performance Improvement Tool has been initiated to ensure ongoing compliance with food service temperatures and resident satisfaction with the dining program.</p> <p><b>Corrective Action taken to</b></p>				

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	<p>During an interview, on 8/19/14 at 12:35 p.m., Resident #44 indicated today's meal was the first time it had been warm enough for him and he could enjoy his meal.</p> <p>On 8/17/14 at 5:00 p.m., the Administrator presented a copy of the meal times. Review of this time table indicated that Lunch was to be served in the Main Dining Room at 12:00 noon with hall trays at 12:25 p.m.. Supper was to be served at 6:00 p.m. in the Main Dining room and Hall trays at 6:15 p.m.</p> <p>3. On 8/17/14 at 4:53 p.m., Resident #12 indicated the meals were not always warm. She also indicated the eggs were sometimes cold at breakfast.</p> <p>4. On 8/19/14 between 11:40 a.m. and 12:38 p.m., the following was observed:</p> <p>a. Cook #1 was observed preparing resident trays.</p> <p>b. At 12:04 p.m., Cook #1 finished preparing resident trays and at 12:05 p.m., delivered trays to the dining room.</p> <p>c. At 12:05 p.m., while passing resident trays in the dining room, staff were observed to lift hot plate lids multiple times to verify resident's received correct</p>		<p><b>monitor performance to assure compliancethrough quality assurance is:</b></p> <p>(1) A performance improvement tool has beeninitiated that randomly reviews food service to ensure that meals are beingserved timely, and that food is attractive, palatable, and at an acceptable temperature. Administrator or designee will receive a test tray at the end of ameal randomly three times a week x3 weeks, then once monthly x3 months, thenonce quarterly x3 quarters. Results ofthese audits will be reviewed in QAA committee with recommendations as neededbased on the outcomes of the tool.</p> <p>(2) A resident Food Council will meet at thefacility once weekly x3 weeks, and then monthly thereafter to ensure ongoingresident satisfaction with the food service program. Food Council Minutes willbe reviewed by the QAA Committee with recommendations as needed based on theoutcome of Food Council Minutes.</p> <p><b>The date the systemicchanges will be completed: September 19, 2014</b></p>				

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F000371 SS=F	<p>meals.</p> <p>d. Between 12:32 p.m. and 12:38 p.m., hallway trays were passed to resident's eating in their rooms.</p> <p>e. On 8/19/14 at 12:39 p.m., the test tray food temperatures readings were:</p> <p>Puree tray: -Mashed potatoes with gravy = 110.3 degrees Fahrenheit (F) -Pureed meat with gravy = 117.9 F -Pureed vegetables = 106 F</p> <p>Regular tray: -Mashed potatoes with gravy = 118.8 F -Mixed vegetables = 114.6 F -Meat patty with gravy = 117.9 F</p> <p>Tasting of the test trays indicated food was lukewarm.</p> <p>3.1-21(a)(1) 3.1-21(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p>						

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	<p>Based on observation, interview and record review, the facility failed failed to follow proper handwashing, prepare meals under sanitary conditions and air vents were free of dust during 2 of 2 kitchen observations. This deficient practice had the potential to affect 31 of 32 residents' currently receiving meals in the facility.</p> <p>Findings include:</p> <p>During initial tour on 8/17/14 at 2:25 p.m., the following were observed:</p> <ol style="list-style-type: none"> <li>1. The step-lid trash can would not open without pulling the lid up with the hands.</li> <li>2. A dark brown substance in a splatter pattern was observed directly over the food prep area.</li> <li>3. The paint directly above the kitchen entrance doorway was observed to be bubbled up with multiple cracked areas.</li> </ol> <p>On 8/19/14 at 10:19 a.m., resident drinking glasses were observed, open-end up, sitting next to the employee handwashing sink directly below the hand towel dispenser.</p> <p>On 8/19/14 during the lunch meal between 11:30 a.m. and 12:05 p.m., the</p>	F000371	<p>F371</p> <p>It is the practice of Corydon Nursing and RehabilitationCenter to prepare, distribute and serve food under sanitary conditions.</p> <p><b>The correction actiontaken for those residents found to be affected by the deficient practiceinclude:</b></p> <ol style="list-style-type: none"> <li>(1) Step lid trash can was replaced with a new one.</li> <li>(2) Dark brown substance has been eliminated fromabove food prep area.</li> <li>(3) Paint directly above kitchen entrance doorwayhas been repaired.</li> <li>(4) Resident drinking cups have been removed fromarea next to employee hand washing sink.</li> <li>(5) Step-lid trash can remains closed while residenttrays are being prepared.</li> <li>(6) Cloth silverware napkins were removed from areanear the employee hand-washing sink.</li> <li>(7) Dust was cleaned from AC unit and tape wasreplaced as needed.</li> <li>(8) Condensation to be addressed and eliminated asadvised by a professional AC Maintenance vendor.</li> <li>(9) Tiles beneath storage racks have been cleanedand repaired.</li> <li>(10)All dietary staff have beenin-serviced on facility hand washing policy.</li> <li>(11)All dietary staff have beenin-serviced on hand washing</li> </ol>	09/19/2014			

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	<p>following was observed:</p> <p>1. The step-lid trash can was open and remained open while resident trays were being prepared.</p> <p>2. Cloth silverware napkins were lying next to the employee handwashing sink directly below the hand towel dispenser. There were multiple wet spots on them.</p> <p>On 8/19/14 at 11:35 a.m., Cook #1 removed her gloves and placed them on top of the food preparation table next to an open bag of dinner rolls. She removed foil from multiple pans, walked over to the employee sink and washed her hands for 10 seconds.</p> <p>On 8/19/14 at 11:49 a.m., Cook #1 grabbed an open tray cart with her gloved hands to turn it around. She continued preparing trays and placing rolls on plates. She did not don new gloves nor did she wash her hands.</p> <p>On 8/19/14 at 12 p.m., the Dietary Manager was observed entering the kitchen. She walked over the employee sink and washed her hands for 10 seconds.</p> <p>On 8/19/14 at 12:02 p.m., the Dietary</p>		<p>and glove policy for food workers.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>Any person receiving meal service at the facility has the potential to be affected. Please see below for corrective actions and monitoring.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>(1) All facility staff have been in-serviced on proper hand washing techniques. (2) All Dietary Staff have been in-serviced on proper hand washing and glove use for food workers.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool was initiated which</p>				

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	<p>Manager placed a removable part of the food processor in the dishwasher. She walked over to the employee sink and washed her hands for 7 seconds.</p> <p>On 8/19/14 at 12:52 p.m., the dry storage area contained an air conditioner unit with condensation throughout the length of the unit. Large amounts of thick gray colored dust was observed in the vents. Silver tape was observed on the unit to be loose, some strips hanging from the unit.</p> <p>Directly beneath the unit, crates of bread, canned goods, dry cereal, sugar packets, and plastic bottles of juice was stored.</p> <p>The tile was noted to have dark black stains and cracks under the storage racks.</p> <p>On 8/19/14 at 12:52 p.m., the Dietary Manager confirmed the observations stating, "This area is used for stock and my office. Housekeeping comes and cleans every day. I have made a request for maintenance to come and look at the air conditioner but they haven't done it yet. "</p> <p>On 8/19/14 at 12:55 p.m., the policy and procedure titled "Handwashing" was provided by the Administrator. It included, but was not limited to the following: "Policy:...Procedure:...6.</p>		<p>randomly reviews sanitary conditions in the kitchen, as well as assesses the cook on duty to ensure that he/she is performing hand washing and glove use according to policy. The DON, Administrator, or other designee will complete this tool weekly x3, monthly x3, and quarterly x3. Any noncompliance identified will be corrected immediately, with education provided. The QAA Committee will review these audit tools at scheduled meetings, with new recommendations as needed.</p> <p><b><i>The date the systemic changes will be completed: September 19, 2014</i></b></p>	

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	<p>Lather all areas of the hands and wrists rubbing vigorously for 20 seconds..."</p> <p>During an interview on 8/19/14 at 4 p.m., Cook #1 indicated hands should be washed every time you take off your gloves and when you enter and leave the kitchen. She also indicated hands should be washed for 15-20 seconds.</p> <p>During an interview with the Dietary Manager on 8/19/14 at 4:03 p.m., she indicated hands should be washed for 20 seconds.</p> <p>On 8/20/14 at 12:05 p.m., the Dietary Manager entered the kitchen and washed her hands for 13 seconds.</p> <p>On 8/20/14 at 12:16 p.m., the Administrator provided a copy of the policy and procedure titled "Dietary: Hand Washing and Glove Use." It included, but was not limited to, the following: "Dietary employees are required to follow facility policy for handwashing. In addition to this, Dietary employees will wash hands...after touching anything that might result in contamination of hands...Always change gloves if the gloves get ripped, torn, or contaminated...Food worker hands must be washed thoroughly and be cleaned before wearing new gloves...."</p>			

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F000441 SS=D	<p>During an interview with the Dietary Manager on 8/20/14 at 2 p.m., she indicated the step-lid trash can was broken. She also indicated they leave the lid open because if they close it they would have to open it with their hands which would be unsanitary.</p> <p>On 8/20/14 at 2:30 p.m., the Dietary Manager indicated she fixed the step-lid trash can the best she could and did not know how long it would last.</p> <p>3.1-21(i)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</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</p>						

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	<p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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 ensure employees received proper training for proper disposal of blood containing items. This deficient practice affected one kitchen employee who did dispose of personal blood testing equipment in the proper manner.</p> <p>Findings include:</p> <p>On 8/19/14 at 12:42 p.m., Cook #1 was observed to have glucometer, alcohol swab on a desk and a lancet with blood in her hand. This area also contained dry food storage items. She stated, "Let me wash my hands because I just checked my blood sugar." Then she took the lancet wrapped in tissue and threw away</p>	F000441	<p>F441 It is the practice of Corydon Nursing and RehabilitationCenter to establish and maintain an Infection Control Program to provide a safe, sanitary and comfortable environment and to help prevent the developmentand transmission of disease and infection.</p> <p><b>The correction actiontaken for those residents found to be affected by the deficient practiceinclude:</b> Cook #1received written counseling related to approved locations for checking bloodsugar and disposing of lancet in an authorized receptacle. <b>How other residents</b></p>	09/19/2014			

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	<p>in the kitchen and washed her hands.</p> <p>On 8/19/14 at 12:52 p.m., the Dietary Manager (DM) was interviewed. She indicated Cook #1 was a full time employee working about a year in the facility. She indicated about a week ago she observed Cook #1 perform a blood glucose test in the kitchen area and the cook immediately provided coaching. She stated, " I guess she decided to do it [blood glucose test] here on my desk. I don't know where she throws her stuff away at. I don't keep up with anybody's medical issue unless they are sick and I send them home."</p> <p>On 8/19/14 at 12:57 p.m., Cook #1 indicated she has been performing blood glucose tests at the dietary manager's desk for a few weeks. She then lifted plastic storage bag off the desk containing a glucometer, lancets, and test strips. She confirmed she disposed of the lancet in the kitchen, but she usually dispose of it in a sharps container.</p> <p>On 8/19/14 at 3:13 p.m., the Director of Nursing (DON) indicated she was not aware Cook #1 was performing blood glucose testing in the kitchen areas. The DON indicated it was not appropriate practice. She indicated she was not aware of a facility policy related to</p>		<p><b>having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All Dietaryworkers were interviewed related to infection control and sharps disposal, with education provided as needed. All staff were in-serviced on infection control and sharps disposal. No other employees were found to have been affected.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>All staff were in-serviced on infection control, with emphasis given to sharps safety and blood borne pathogens.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool was</p>				

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F000458 SS=D	<p>employee glucose testing.</p> <p>On 8/19/14 at 3:33 p.m., the DM indicated the facility did not have a policy related to this issue.</p> <p>3.1-18(b)(6)</p> <p>483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. Based on observation and interview, the facility failed to ensure a room with more</p>	F000458	<p>initiated to randomly assess staff awareness of infection control, sharps safety, and the approved locations for personal care including but not limited to personal blood sugar monitoring. Staff members will be randomly approached and questioned regarding infection control policies. Any problems identified will be addressed immediately with education provided. The tool will be completed weekly x3, monthly x3, and quarterly x3. The QAA Committee will review these audit tools at scheduled meetings and offer new recommendations as needed.</p> <p><b>The date the systemic changes will be completed: September 19, 2014</b></p> <p>F458 It is the practice of Corydon Nursing and Rehabilitation Center</p>	09/19/2014	

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	<p>than 2 residents had at least 80 square feet for 1 of 2 rooms capable of holding more than 2 residents. This affected Room #11 and 3 of 32 residents residing in the facility.</p> <p>Findings included:</p> <p>On 08/19/14 at 9:20 a.m., during the facility tour, the Maintenance Director measured the square footage of Room 11 at 224 square feet, indicating 75 square feet for each of the three residents living in Room 11.</p> <p>On 08/19/14 at 11:27 a.m., an interview with the Administrator indicated "It is the first I have heard about Room 11 being too small for three residents. We have never had a room waiver that I have heard of, but I will look for one. We will apply for a room waiver. The Maintenance Director is going to re-measure the room to be sure."</p> <p>On 08/20/14 at 1:10 p.m., the Maintenance Director indicated he had re-measured Room 11 and re-measured 234 square feet, which would provide 78 square feet for each of the three residents living in Room 11.</p> <p>3.1-19(1)(2)(A)</p>		<p>to ensure that adequate square footage of living space is provided to each resident.</p> <p><b>The correction action taken for those residents found to be affected by the deficient practice include:</b></p> <p>The resident most recently admitted to this room was relocated to a room designed for only two residents.</p> <p><b>Other residents that have the potential to be affected have been identified by:</b></p> <p>Three of 34 residents had the potential to be affected.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>The Administrator will apply for a room size waiver.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>The Administrator will apply for a room size waiver. If a waiver is not granted, the</p>		

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NAME OF PROVIDER OR SUPPLIER  CORYDON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN 47112
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F000460 SS=F	<p>483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident.</p> <p>In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.</p> <p>Based upon observation and interview, the facility failed to ensure visual privacy for residents residing in 15 of 18 occupied rooms. (Rooms 1, 2, 3, 5, 6, 8, 9, 10, 11, 12, 14, 15, 16, 17 and 18)</p> <p>Finding includes:</p> <p>On 08/17/14 between 3:15 p.m. and 3:45 p.m., during the resident observations in Rooms 1, 2, 3, 5, 6, 8, 9, 10, 11, 12, 14, 15, 16, 17 and 18, the privacy curtains were noted to not fully close for privacy at the foot of each resident's bed from the wall to the perpendicular privacy curtain track. The piping for the sprinkler</p>	F000460	<p>facility will not place more than two residents in room 11. <b>The date the systemic changes will be completed:</b> September 19, 2014</p> <p>F460 It is the practice of Corydon Nursing and Rehabilitation Center to ensure that bedrooms are designed to assure full visual privacy to each resident. <b>The correction action taken for those residents found to be affected by the deficient practice include:</b> (1) Eight-foot curtains will be ordered to replace six-foot curtains that do not provide full visual privacy. (2) Fasteners will be added to curtains and walls that will secure curtains to walls where sprinkler piping prevents the curtain from fully closing to the wall for full visual privacy. (3) The loose curtain track in 15B was repaired. (4) Curtains were matched to</p>	09/19/2014

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	<p>system also prevented the privacy curtains from closing fully to the wall.</p> <p>On 08/19/14 at 4:06 p.m., the Maintenance Director was notified of Room 15's loose privacy curtain track with the screws barely attached to the ceiling over the footboard of bed B. He was also shown Room 16's privacy curtains hanging by only half of the hooks at the foot of beds A and B. He indicated he relies on the staff to inform him of needed repairs and no one had told him of the problems.</p> <p>On 08/20/14 at 8:28 a.m., upon interview with the Maintenance Director, he indicated the privacy curtains measured 6 feet wide. He also indicated the sprinkler system was added to the facility years after the facility was built, and he was not sure what to do with the piping or track to allow the privacy curtains to fully close. He was going to check on ordering 8 foot wide curtains for the rooms.</p> <p>3.1-19(1)(6) 3.1-19(1)(7)</p>		<p>hooks in room 16. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> Privacy curtains have been reviewed in all rooms. Insufficient curtains will be replaced as needed. <b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> (1) Six foot privacy curtains in all rooms will be replaced with eight foot curtains. (2) Maintenance Director or designee will perform a curtain audits to ensure that curtains are fastened securely on hooks and remain in good repair. <b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool was initiated that randomly reviews condition of privacy curtains in five rooms to ensure that curtains are fastened securely on hooks; that curtains may also be fastened securely to the wall to ensure full visual privacy to residents; that curtains remain in good repair. These audits will be performed weekly x3, monthly x3, and quarterly x3. The QAA Committee will review these audit tools at scheduled</p>				

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE 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 ensure resident rooms and bathrooms were clean and in good repair for 8 of 18 resident rooms (Rooms 6, 10, 11, 13, 14, 15, 16 and 17) and 4 of 4 bathrooms (front and back halls) observed for cleanliness and homelike environment. The facility also failed to maintain the proper water temperature for 4 of 7 rooms (Rooms 11,13, 16 and 2) and the front and back hall bathrooms.</p> <p>Findings included:</p> <p>1. On 08/17/14 between 3:15 p.m. and 3:45 p.m., during the initial tour the following was observed:</p> <ul style="list-style-type: none"> <li>- Room 6 was observed to have a spider in the windowsill and bugs scattered on the air conditioner unit.</li> <li>- Room 10, the plaster wall above the window was cracked and peeling. The wall paper border was peeling at the seam.</li> </ul>	F000465	<p>meetings and offer new recommendations as needed. <b>The date the systemic changes will be completed:</b> September 19, 2014</p> <p>F465 It is the practice of Corydon Nursing and Rehabilitation Center to ensure to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. <b>The correction action taken for those residents found to be affected by the deficient practice include:</b> (1) Room 6: Air conditioning unit was cleaned. (2) Room 10: Plaster above window has been repaired. Wallpaper has been repaired. (3) Room 11: Doorknob has been repaired and door now achieves positive latch. Plaster above window has been repaired and ceiling will be painted. Wall behind Bed A will be patched and secured to studs. Ceiling to be painted. (4) Room 13: Black speckled area was cleaned from window above Bed B. (5) Room 14: Plaster above Bed B has been repaired. Electrical tape has been repaired. (6) Room 15: Food debris was immediately cleaned from Bed A. Wallpaper has been repaired. Cob webs immediately</p>	09/19/2014

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	<ul style="list-style-type: none"> <li>- Room 11, the entry door had a loose doorknob and would not shut completely. The plaster wall above the window was cracked and peeling and scattered saucer sized light brown stains were noted on the ceiling. The wall behind bed A had a 2 foot crack leading to the corner of the window and was loosely fastened to the studs when touched.</li> <li>- Room 13 had an 8 inch long black speckled area under the right corner of the window above bed B.</li> <li>- Room 14 had cracked plaster above the head of bed B. The window unit had electrical tape peeling away from the unit.</li> <li>- Room 15 bed A had food debris scattered in the bed. The wallpaper was buckled above the head of bed B at the left corner. Cob webs were noted between the window and the window unit, and the wall paper border was loose and the seam. The privacy curtain track was noted to have loose screws on the end against the wall above bed B.</li> <li>- Room 16, the vertical wood trim was broken on the left side of bed B and turned horizontally. The privacy curtains above the foot boards of beds A and B were hanging by only half of the hooks on the track.</li> <li>- Room 17 was observed with a bedside commode at the foot of bed A. There was a crack from the window sill to the</li> </ul>		<p>cleared. Curtain track has been repaired. (7) Room 16: Wood trim has been replaced and secured. Privacy curtains were secured to hooks. (8) Room 17: Crack in plaster will be repaired. Curtain was immediately washed. (9) Left Front Hall Bathroom: Grout has been cleaned. (10) Right Back Hall Bathroom: Rusty door frame has been repaired. Grout has been cleaned. Stained area has been treated. Caulk has been repaired. (11) Left Back Hall Bathroom: Dust was immediately cleaned. Cracked tile will be repaired or replaced. Light bulb was replaced. (12) Room 10: Paint above window has been repaired. Wall paper has been repaired. (13) Mixing valve has been adjusted to achieve compliance with water temperatures. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> All areas of the facility have been reviewed to assure that resident rooms and bathrooms are in good repair, and that any repairs are completed. Work orders have been entered as needed. <b>The measures or systematic changes that have been put into place to ensure that the deficient practice does</b></p>		

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	<p>electrical unit in the wall. A dark brown substance was noted at the bottom of the privacy curtain.</p> <p>- The front hall left bathroom indicated brown discolored grout between the tiles in a 3 foot by 3 foot area from the doorway to the toilet in a 3 foot by 6 foot room.</p> <p>-The back hall right bathroom door trim was rusting and crumbling away in a 4 inch area from the floor up on the right side. There was a 6 inch brown discolored area in the corner, behind the toilet, between the trim and the tile floor. The left bathroom vent was covered in dust and there was a crack 3/4 of the way across a tile in the doorway. It was also noted to be loose when stepped on. One of the two light fixtures was flickering.</p> <p>During the environmental tour with the Maintenance Director on 08/19/14 between 9:20 a.m. and 9:50 a.m., the following was observed:</p> <p>- Room 10 was noted to have peeling wall paint above the entire window. The wall paper trim was peeling at the seams of the wall above the resident in bed A and the resident in bed B. The Maintenance Director indicated the facility is currently undergoing renovation, but could not produce a work order for completion times or dates.</p> <p>- Room 11 indicated a loose door knob,</p>		<p><b>not recur include:</b> (1) Maintenance Director has been in-serviced on the importance of making rounds and identifying any potential issues in resident care areas that need repaired, as well as maintaining workorders for repairs to be done in the facility, and completing these tasks in a timely manner. (2) All staff have been in-serviced on turning in maintenance requests as needed. (3) Housekeeping staff have been in-serviced on environmental maintenance, with emphasis on the cleaning and prevention of dust, cobwebs, discolored grout, and rust. <b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> (1) A Performance Improvement Tool has been initiated that randomly reviews five rooms/areas to assure that they are clean and safe. The Maintenance Director or designee will complete these audits weekly x3, monthly x3, and quarterly x3. Any issues identified will be scheduled for repair. The QAA Committee will review these audit tools at scheduled meetings and offer new recommendations as needed. (2) A Performance Improvement Tool has been initiated to monitor daily water temperatures until documentation shows that temperatures can be resume a weekly testing schedule. Any noncompliance with</p>		

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	<p>which to Maintenance Director obtained a screwdriver to repair. The wall paint above the entire length of the window was noted to be peeling and cracked. The ceiling had brown circular saucer sized areas scattered on the ceiling. A measurement of 14 by 15 feet and 2 by 7 feet room size was obtained by the Maintenance Director. He indicated the ceilings had not been leaking water during rain storms, but he was not sure what had caused the stains.</p> <ul style="list-style-type: none"> <li>- Room 13 had a 8 inch black speckled area under the right side of the window.</li> <li>- The right back hall residential bathroom indicated the doorframe to be rusty and crumbling away 4 inches from the floor. The caulk was brown along a 6 inch length at the corner of the trim behind the toilet.</li> <li>- The left back hall bathroom the vent was observed to be covered in dust. The Maintenance Director indicated the vents are cleaned every Monday. The floor tile had a crack across 3/4 of the tile in the doorway. It was also noted to be loose.</li> <li>- The right front hall bathroom the door trim was rusting and gouges were noted on the bottom 3 inches to the floor. The Maintenance Director indicated the trim is usually bonded and sanded then repainted when the trim becomes broken.</li> <li>- The left bathroom in the front hall was observed to have brown discolored grout</li> </ul>		<p>water temperatures will be addressed immediately. If water temperatures are found to be outside of acceptable range, daily water temperature monitoring will resume as needed. The QAA Committee will review these audit tools at scheduled meetings and offer new recommendations as needed. <b>The date the systemic changes will be completed:</b> September 19, 2014</p>				

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	<p>in a 3 foot by 3 foot area from the doorway to the toilet in the 3 foot by 6 foot bathroom.</p> <p>2. On 08/19/14 at 9:20 a.m., a tour of the facility with the Maintenance Director was conducted in Room 11. The hot water temperature tested to be 100 degrees, then fell to 96 degrees. Room 13's hot water temperature was tested at 98 degrees. Room 16's hot water temperature tested at 101 degrees. Room 2's hot water temperature tested at 98 degrees. The back hall bathroom's hot water temperature in the right bathroom tested at 94 degrees, then fell to 84.9. The left bathroom's hot water temperature tested at 103 degrees. The front hall bathroom's hot water temperatures were tested in the right bathroom to be 116 degrees and the left bathroom tested to be 102 degrees.</p> <p>On 08/19/14 at 9:40 a.m., during a tour of the boiler room with the Maintenance Director, 2 water heaters were observed. The Maintenance Director stated the water heaters are inspected annually, and the Boilers are inspected every 6 months. He indicated the water temperature was checked in one room every week. He provided the water temperature logs for 1-7-14 to 8-12-14. The temperatures ranges from 103 to 108. He also</p>			

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	<p>indicated he had tripped on a pressure valve on the side of a water heater and he thought that was the cause of the falling temperatures.</p> <p>On 08/19/14 at 2:00 p.m., the Maintenance Director indicated he had corrected the valve and he thought the water temperatures were at the correct temperature now and wanted to provide another test the following day.</p> <p>On 08/20/14 at 10:10 a.m., the retest of the hot water temperatures with the Maintenance Director indicated 3 of 4 rooms to have a water temperature of 105 and 1 of 4 rooms had a temperature of 98 which began to fall upon testing. He indicated he did not know what was causing the fall in temperature in this room.</p> <p>3.1-19(f)</p>						