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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 08/14/2015 |
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| NAME OF PROVIDER OR SUPPLIER AZALEA HILLS | STREET ADDRESS, CITY, STATE, ZIP CODE 3700 LAFAYETTE PKWY FLOYDS KNOBS, IN 47119 |
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| R 0000 Bldg. 00 | <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: August 12, 13 and 14, 2015</p> <p>Facility number: 012161 Provider number: 012161 AIM number: N/A</p> <p>Census bed type: Residential: 64 Total: 64</p> <p>Census payor type: Medicaid: 29 Other: 35 Total: 64</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> | R 0000 | | |
| R 0029 Bldg. 00 | <p>410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated</p> | | | |

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | <p>with consideration, respect, and recognition of their dignity and individuality.</p> <p>Based on interview and record review, the facility failed to ensure staff treated the residents with dignity for 2 of 6 residents reviewed for resident rights. (Resident # E and Resident # I)</p> <p>Findings Include:</p> <p>1. During an interview on 8/12/15 at 2:15 P.M., Resident # E indicated the Dietary Manager is rude and harsh towards the residents. He did not feel comfortable expressing a dissatisfaction towards the food due to a fear of reprisal from the Dietary Manager. He indicated he had a suggestion about the food preparation that he previously made to the Dietary Manager and has since been ignored and the Dietary Manager's attitude towards him has been negative.</p> <p>During an interview on 8/13/15 at 12:35 p.m., Certified Nursing Assistant (CNA) #1 indicated the Dietary Manager has a rude demeanor towards the residents at the meal services. If a resident needs assistance she [Dietary Manager] will become rude to the resident and has a negative demeanor.</p> <p>During an interview on 8/14/15 at 2:15</p> | R 0029 | <p>R029-Resident Rights 1. The Dietary Manager and Assistant Dietary Manger were reprimanded and relieved of duty for 3 days. They were both in-serviced on resident dignity and abuse prohibition. The Dietary Manager and Assistant Dietary Manager have undergone Customer Service Training .The Managers have been advised non-compliance will result in further disciplinary action. A different staff member has been deemed as resident liaison for council meetings. 2. As all residents could be affected, the following actions will be taken. 3. All staff on all shifts were in-serviced on ensuring residents are treated with consideration, respect, and with recognition of their dignity and individuality. In-servicing on Resident Abuse is conducted upon initial orientation of new employees and at least bi-annually with all staff, and as situations arise which warrant additional training. 4. As a means to ensure compliance with ensuing residents are treated with dignity, random interviews with at least three residents will be conducted by the Administrator on a weekly basis. Should concerns be identified, said concerns shall be addressed and any applicable staff will be addressed, re-educated and/or disciplinary action taken as</p> | 08/31/2015 |

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| | <p>p.m., Certified Nursing Assistant (CNA) #3 indicated the Dietary Manger is rude to the residents during meal services. She indicated the Dietary Manager will roll her eyes at the residents, have a rude demeanor, and be condescending if a resident needs help or has a comment about the food.</p> <p>During an interview on 8/14/15 at 2:45 p.m., the Administrator indicated the rude behavior of the Dietary Manager was not acceptable towards the residents. She indicated she had known the Dietary Manager had complaints from the dietary staff about her rude behavior, but she was unaware the Dietary Manager was also rude to the residents. She indicated that the Dietary Manager also has the role of the Activities Director, and having this duel role has put increased stress on the employee. She indicated the Dietary Manager's mood and behavior has changed, due to stress, since she took over both the Dietary Manager and Activities Director positions four months ago. The Administrator indicated she has told the Dietary Manager/Activities Director she has to choose which department because having both is too stressful on the employee.</p> <p>A policy, that is undated and titled, "Abuse Educational Program -</p> | | warranted. | |

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| R 0144 Bldg. 00 | <p>Recognizing Staff Burn-out," was provided by the Administrator on 8/14/2015 at 10:40 a.m. and was identified as current. The policy indicated, "staff burn-out could lead to staff members experiencing impatience or frustration in routine care of residents and staff members displaying briskness in conversation with residents".</p> <p>2. During an interview on 08/13/14 at 8:45 a.m., Resident # I , indicated the Activities Director/Dietary Manager raises her voice in the dining room. The resident also indicated, "The residents are talked to like children. The cooks are excellent and they are treated badly by the Dietary Manager. The Dietary Manager and the Assistant Dietary Manager snap back at the residents. I can't stand to go in there [Dining Room]." The resident indicated the Resident Council was also run by the Dietary Manager and the resident will not go to the meetings because she runs it.</p> <p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> | R 0144 | R144-Sanitation and Safety I. | 08/31/2015 |

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| | <p>Based on observation, interview, and record review, the facility failed to maintain a clean environment in resident rooms and common areas for 2 of 3 residents reviewed (Resident # E and Residents # I) in that trash was not emptied in a timely manner and dust was not removed from resident rooms and common areas. This deficiency had the potential to affect 64 of 64 residents residing in the facility.</p> <p>Findings include:</p> <p>During an interview on 08/12/15 at 8:45 P.M., Resident # I, indicated the underside of the bed in the resident's room was thick with dust. The resident also indicated a problem with allergies and shortness of breath. The staff do not deep clean the rooms. The resident indicated the staff were informed about the dust.</p> <p>During an interview on 8/12/15 at 2:15 P.M., Resident # E indicated he has a problem with environmental allergies, including dust. The resident indicated in his room he would have to move the television on his own to be dusted. He also indicated when he goes to the dining area, he can only stay a short time because if he stays longer, he will start sneezing and coughing due to the dust.</p> | | <p>The handrails in the building were dusted along with upstairs lounge area window sills. Resident #1's apartment was cleaned, including the area under her bed.</p> <p>II. Other areas/furniture throughout the facility were also inspected for potential dust build up with corrective actions taken, as warranted.</p> <p>III. As a means to ensure ongoing compliance with maintaining a clean environment, the cleaning schedule was reviewed and updated to include dusting at least twice weekly. The trash will be emptied daily during afternoon rounds per CNA's. For Residents that require more housekeeping, they will be placed on twice weekly housekeeping in order to keep dust to a minimum. Staff were addressed regarding the revised cleaning schedule.</p> <p>IV. As a means of quality assurance, the Administrator shall monitor to ensure that the revised schedule is sufficient to maintain a clean environment. Weekly rounds by the Administrator or designee will be conducted to ensure compliance with the cleaning schedule. Should concerns be noted, staff will be addressed and/or the schedule amended as necessary.</p> | |

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| | <p>The resident also indicated that he does not like to leave his room due to the facility is not being dusted properly.</p> <p>During an observation on 8/12/15 at 2:45 P.M., the handrails on the first floor and second floor had a build up of dust. When a finger was swiped along the handrail, dust was visibly seen on the finger.</p> <p>During an observation of the second floor sitting area on 08/13/15 at 11:21 a.m., dust was observed along the top area of the wood trim under the middle window and the right window, behind the curtains.</p> <p>During an observation on 08/14/15 at 9:04 a.m., dog fur, shoes, and miscellaneous items were observed under Resident # I's bed. The resident indicated no family was available to deep clean the resident's room.</p> <p>On 08/13/15 at 10:40 a.m., the DON (Director of Nursing) indicated housecleaning was done by the CNAs (Certified Nursing Assistants) . We use a daily cleaning schedule for the resident rooms. The CNAs dust, vacuum, do the dishes, clean the sinks and toilets. She further indicated if the carpets become stained, and the CNAs or Maintenance</p> | | | |

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| | <p>Director cannot clean them, an outside source is contacted. When dusting, the CNAs dust knick knacks, surface areas and TVs They don't dust under furniture.</p> <p>The DON provided an example of the CNA Assignment Sheet on 08/13/15 at 10:55 a.m. It indicated the resident rooms assigned to each CNA. Extra duties included, but was not limited to, dusting in the dining room and facility (ledges, banisters, library, etc.).</p> <p>On 08/13/15 at 11:30 a.m., the "Resident Council Feedback" [minutes from the Resident Council meeting], dated 12/23/14, was reviewed with the permission of the Administrator. Minutes indicated Resident # J voiced concern about the trash not being emptied. During the meeting the resident indicated the staff members told her they were too busy to take care of it. Resident # K also indicated the trash was not being picked up. The resident also indicated the floor was supposed to be cleaned and it didn't look like it had been done. Resident # K also requested the baseboard around the toilet be cleaned. The Dietary Manager indicated on the minutes, as a follow up response to the resident's concerns, the garbage pickup had been addressed with all of the staff. The staff reasoning indicated the</p> | | | |

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| | <p>weekend staff had a lot of sick residents in the building. The Department response after the follow up on 12/20/14, was the staff were instructed by the Dietary Manager, that patient care came before the garbage pickup on the particular weekend in question. The Dietary Manager documented she had also addressed the cleaning issues with the staff.</p> <p>During an interview on 08/13/15 at 12:26 p.m., CNA # 1 and CNA # 2 indicated they cleaned the bathrooms, showers, sinks, and the laundry, unless the resident or their family do their own laundry. The CNAs both indicated the facility had a couple of residents who won't let them clean their rooms. They also indicated the schedule given to the CNAs included cleaning 2 to 4 resident's rooms during each shift. If these rooms are finished, the CNAs indicated they pick up a duster or mop and dust the common areas or they may obtain some of the blood pressures of the residents for that month.</p> <p>During an interview with the Administrator on 08/13/15 at 3:00 p.m., she indicated the facility did not have a housekeeping policy. She also indicated the CNAs do the cleaning for the residents.</p> | | | |

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| R 0216 Bldg. 00 | <p>The review of the CNA Job Description, on 08/13/15 at 3:08 p.m., did not indicate cleaning the resident's rooms under the Job Functions.</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on observation, interview and record review, the facility failed to assess the residents ability to self administer medication on 7 of 7 residents observed during medication pass. (Resident #F, Resident #L, Resident #M, Resident #N, Resident #O, Resident #P, and Resident #Q)</p> <p>Findings include:</p> | R 0216 | <p>R216 Evaluation-Noncompliance I. Level of Service and Assessments for the residents listed will be reviewed. Should any of the residents request to self administer medication(s), necessary assessment will be completed, documented and the same denoted on the Level of Service Assessment/Service Plan. II. Medical records of all residents were audited to identify those residents who have been</p> | 08/31/2015 |

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| | <p>During an observation on 8/12/15 at 11:33 a.m., Licensed Practical Nurse (LPN) # 1 entered Resident #O's room, she left the medication on the counter and exited the room before Resident #O took the medication.</p> <p>During an observation on 8/12/15 at 11:34 a.m., Licensed Practical Nurse (LPN) # 1 entered Resident #M's room, she left the medication on the counter and exited the room before Resident #M took the medication.</p> <p>During an observation on 8/12/15 at 11:35 a.m., Licensed Practical Nurse (LPN) # 1 entered Resident #N's room, she left the medication on the counter and exited the room before Resident #N took the medication.</p> <p>During an observation on 8/12/15 at 11:38 a.m., Licensed Practical Nurse (LPN) # 1 entered Resident #P's room, she left the medication on the counter and exited the room before Resident #P took the medication.</p> <p>During an observation on 8/13/15 at 11:10 a.m., Licensed Practical Nurse (LPN) # 1 entered Resident #L's room, she left the medication on the counter and exited the room before Resident #L took the medication.</p> | | <p>assessed and self – administer medications. Any residents requiring such assessment were identified to ensure necessary assessment would be completed, if applicable</p> <p>III. As a means to ensure ongoing compliance, the facility policy was reviewed with the Director of Nursing and the Nursing staff were educated as to medication administration, including but not limited to remaining with the resident until the medication is administered and consumed by the resident. Any resident who desires to self administer (i.e., not remain supervised by the nurse) must have a medication self administration assessment completed.</p> <p>IV. As a means of quality assurance, the Administrator shall monitor compliance through at least three random observations weekly of those residents identified as having medications administered by staff (to ensure staff remain with the resident until the medication is consumed) as well as those residents who self administer, to assess the ability of the resident to do so</p> | | | | |

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| | <p>During an observation on 8/13/15 at 11:10 a.m., Licensed Practical Nurse (LPN) # 1 entered Resident #L's room, she left the medication on the counter and exited the room before Resident #L took the medication.</p> <p>During an observation on 8/13/15 at 11:15 a.m., Licensed Practical Nurse (LPN) # 1 entered Resident #P's room, she left the medication on the table and exited the room before Resident #P took the medication.</p> <p>During an observation on 8/13/15 at 11:18 a.m., Licensed Practical Nurse (LPN) # 1 handed Resident #O's medicine to her in the hallway and left her site before Resident #O took her medication.</p> <p>During an observation on 8/13/15 at 11:15 a.m., Licensed Practical Nurse (LPN) # 1 entered Resident #F and Resident #Q's room, she left the medications for both residents on the counter and exited the room before Resident #F and Resident #Q took the medication.</p> <p>Record Review of the "Level of Service and Assessment" on 8/14/15 at 8:45 a.m., indicated Resident #F, Resident #L,</p> | | | |

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| | <p>Resident #M, Resident #N, Resident #O, Resident #P, and Resident #Q's medications "should be administered by the caregiver and/or observation of medications requiring judgment for necessity, dosage and/or effect". The clinical records for Resident #F, Resident #L, Resident #M, Resident #N, Resident #O, Resident #P, and Resident #Q did not have a written physician's order to self administer medications.</p> <p>A policy, that is dated 12/2003 and titled, "Medication Administration," was provided by the Administrator on 8/14/2015 at 9:30 a.m. and was identified as current. The policy indicated, "for a resident to self administer medications there must be a written physicians order, and if not, the medication administration will be executed by a licensed nurse or a qualified medication aide".</p> <p>During an interview on 8/14/15 at 11:00 a.m., the Director of Nursing (DON) indicated if a nurse brings medications to the resident's room, then it is acceptable to leave the medications in the room and leave the resident, even if that resident is not assessed to self administer medication. Later, during the same interview, the DON indicated that if the resident has not had a self administration assessment or doctors order, then that</p> | | | |

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| R 0244 Bldg. 00 | <p>would not be acceptable to leave the medication in the room for the resident to self administer.</p> <p>410 IAC 16.2-5-4(e)(4) Health Services - Noncompliance (4) Preparation of doses for more than one (1) scheduled administration is not permitted.</p> <p>Based on observation, interview and record review, the facility failed to ensure no more than one scheduled medication administration per resident was prepared in advance and failed to ensure medications were labeled properly. This deficient practice affected 2 of 4 medication carts and 1 of 1 medication storage rooms observed for medication storage. (Resident #F, Resident #L, Resident #M, Resident #N, Resident #O, Resident #Q, Resident #R, Resident #S, Resident #T, Resident #U, Resident #V, Resident #W, Resident #X, Resident #S, Resident #T, Resident #Y, and Resident #Z)</p> <p>Findings include:</p> <p>During an observation of medication storage room, with the Director of Nursing (DON), on 8/13/15 at 3:20 p.m.,</p> | R 0244 | <p>R244</p> <p>I. The Director of Nursing and LPN #1 were addressed and educated as to the prohibition of preparation of scheduled doses beyond one scheduled administration. II. As all residents could potentially be affected, the following actions were taken. III. All nurses were re-educated as to the prohibition of preparation of scheduled doses beyond one scheduled administration. The facility policy was amended to include this prohibition. IV. As a means of quality assurance, the Administrator shall inspect the medication room/carts randomly at least three times weekly to confirm continued compliance with the prohibition of preparation of scheduled doses beyond one scheduled administration. Should non-compliance be observed,</p> | 08/31/2015 |

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| | <p>the following was observed:</p> <ol style="list-style-type: none"> In the refrigerator was an opened, undated and unlabeled Homology Insulin Lisper vial. <p>During the medication storage observation of the 100 Hall Medication Cart, with the Licensed Practical Nurse #2 (LPN), on 8/13/15 at 3:30 p.m., the following was observed:</p> <ol style="list-style-type: none"> In the top drawer of the cart were medication cups with only room numbers written on the side of the medication cups containing the residents medications for the 4 o'clock medication pass. These medications being stored in the top drawer were for Resident #F, Resident #L, Resident #M, Resident #N, Resident #O, Resident #Q, Resident #R, Resident #S, Resident #T, Resident #U, Resident #V, Resident #W, Resident #X, Resident #S, Resident #T, Resident #Y, and Resident #Z's 4:00 p.m. medication pass. On top of the medication cart were medication cups containing the residents medications for the 6:00 p.m. and 8:00 p.m. medication passes, with only room numbers written on the side of the medication cups . These medications being stored on top of the cart were for Resident #F, Resident #L, Resident #M, | | disciplinary action shall be taken. | |

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| | <p>Resident #N, Resident #O, Resident #Q, Resident #R, Resident #S, Resident #T, Resident #U, Resident #V, Resident #W, Resident #X, Resident #S, Resident #T, Resident #Y, and Resident #Z's 6:00 p.m. and 8:00 p.m. medication passes.</p> <p>During an interview on 8/13/2015 at 3:20 p.m., Licensed Practical Nurse (LPN) #2 indicated all the medications in the top drawer during the observation were for the 4:00 p.m. medication pass and the medications on top of the medication cart, which were for the same residents, were for the 6:00 p.m. and 8:00 p.m. medication pass.</p> <p>During an interview on 8/10/2015 at 11:55 a.m., the Director of Nursing (DON) indicated medication cups that are pulled prior to medication administration and stored in the medication cart should be labeled with the resident's identifier and medication administration time on the medication cup. The DON indicated that the nurses can prepare doses for more than one scheduled administration as long as it is kept in separate containers. The DON indicated later in the same interview that she had concerns with the above issues.</p> <p>A policy, undated and titled, "Storing Drugs", was provided by the</p> | | | |

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| R 0273 Bldg. 00 | <p>Administrator on 8/14/2015 at 9:30 a.m. and was identified as current. The policy indicated, "...medications should be closed and labeled if stored in the refrigerator. Medication storage areas are to be kept clean, well lit, and free of clutter."</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, record review and interview, the facility failed to ensure sanitary handling of kitchen equipment/utensils for hydration services and failed to label food packaging with open dates, after the packages had been opened. This deficiency had the potential to affect 64 of 64 residents residing in the facility.</p> <p>Findings include:</p> <p>During an initial tour of the kitchen on 8/12/15 at 9:30 a.m., the following was observed:</p> <p>1. In the dry storage area, the powdered sugar was observed to be open and did</p> | R 0273 | <p>R273 Food and Nutritional Services-Deficiency. 1. Undated, opened food items were discarded. A policy has been drafted as well as a written reminder placed on the ice machine to alert staff to ensure the scoop is properly stored when not in use, so as not to contaminate the ice with the handle.</p> <p>2. An observation was conducted to ensure all opened food items are appropriately labeled and dated.</p> <p>3. As a means to ensure ongoing compliance, all dietary and applicable nursing staff will receive education as dating food items when they are opened and ensuring food items are appropriately labeled.</p> | 08/31/2015 |

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| | <p>not have an open date on the package.</p> <p>2. In the refrigerator, the broccoli, carrots, and onions were observed to be open and did not have an open date on package.</p> <p>3. In the walk in freezer, the baked bread/cake was observed to be wrapped in plastic wrap and did not have a date on the wrapper.</p> <p>4. The ADM (Assistant Dietary Manager) lifted the lid to the ice machine and the ice scoop and handle was observed to be laying on the ice inside the ice machine.</p> <p>During an interview on 8/12/15 at 9:15 a.m., the ADM indicated all food packages should be tabled with an open date. She indicated she did not know who opened the packages.</p> <p>During an interview on 8/12/15 at 9:30 a.m., the ADM indicated the ice scoop should not be inside the ice machine. She also indicated the ice scoop should be placed inside the blue container beside the ice machine.</p> <p>During an interview on 8/14/15 at 9:50 a.m., the Morning Cook indicated there was not a policy and procedure for ice</p> | | <p>Additionally, all staff has been addressed as appropriate use and storage of the ice scoop in a manner to prevent contamination. Facility policy is accessible to all staff.</p> <p>4. As a means of quality assurance, random observations will be made of the food storage areas, refrigerators and ice machines at least three times weekly to confirm compliance. Should non-compliance be observed, corrective action shall be taken including re-education and/or disciplinary action, if warranted.</p> | |

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| | <p>and the ice scoop. She also indicated the ice scoop was to be placed in the blue container by all staff. The Morning Cook also indicated when she opened a food package she would write the open date on each package. She indicated she would also put food in a plastic zip lock bag and then put the date on the bag. She indicated all food packages should be labeled with an open date.</p> <p>During an interview on 8/14/15 at 10:30 a.m., the DON (Director of Nursing) indicated there was no ice scoop policy for dietary aides and CNA's (Certified Nursing Assistants). She indicated the ice scoop should not be left in the ice</p> <p>On 8/13/15 at 2:30 p.m., the Administrator provided a copy of the Indiana State Rules and indicated this was the policy currently used by the facility. The Administrator indicated there was no policy and procedure specifically for the ice scoop.</p> | | | |