

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/26/2014
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00156709.</p> <p>Survey dates: September 22, 23, 24, 25, and 26, 2014</p> <p>Facility number: 000146 Provider number: 155242 AIM number: 100291200</p> <p>Survey Team: Toni Maley, BSW, TC Ginger McNamee, RN Karen Lewis, RN Tina Smith-Staats, RN</p> <p>Census bed type: SNF/NF: 120 Total: 120</p> <p>Census payor type: Medicare: 16 Medicaid: 97 Other: 7 Total: 120</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>This Plan of Correction is the facility's credible allegation of compliance. The facility respectfully requests a desk review and has provided evidence of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</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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F000221 SS=D	<p>Quality review completed by Debora Barth, RN.</p> <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, record review and interview, the facility failed to identify a potential restraint for 1 of 1 resident reviewed for restraints. (Resident #1)</p> <p>Findings include:</p> <p>During an observation on 9/23/14 at 10:05 a.m., Resident #1 was observed sitting in her wheelchair with a lap belt in place.</p> <p>During a medication observation on 9/24/14 at 12:45 p.m., Resident #1 was observed sitting in her wheelchair with a lap belt in place.</p> <p>During an observation on 9/25/14 at 10:44 a.m., Resident #1 was observed sitting in her wheelchair with a lap belt in</p>	F000221	<p>1. Resident #1 has been assessed for the need of restraints. The seatbelt used does not restrict her freedom of movement or normal access to her body. A physician's order has been obtained to use the belt for her safety. 2. Any resident using a restraint has the ability to be affected. All residents have been audited for restraint usage, pre-restraint assessments and physician orders using the QAPI tool "restraint audit". Nursing staff has been trained in restraint policy and procedure. 3. Unit managers will audit each resident for restraint use quarterly and ensure that the restraint assessment is completed and physician orders are updated. Nursing staff has been trained in restraint policy and procedure. 4. The Director of Nursing or designee will ensure</p>	10/09/2014

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	<p>place.</p> <p>The clinical record for Resident #1 was reviewed on 9/24/14 at 2:52 p.m. Diagnoses for Resident #1 included, but were not limited to, microencephallis, mental retardation, deafness, contractures, and seizures.</p> <p>Resident #1 had a quarterly Minimum Data Set assessment dated 7/16/14. The assessment indicated the resident was severely cognitively impaired and had impairment on both sides for upper and lower extremities.</p> <p>Resident #1 had a health care plan, dated 3/17/14, for the problem of impaired mobility. An intervention for this problem was "PROTECTIVE DEVICES PRN [as needed]."</p> <p>The clinical record lacked a physician's order, assessment, and monitoring for the lap belt.</p> <p>During an interview with Unit Manager #2, on 9/25/14 at 11:59 a.m., she indicated the lap belt was the protective device in the impaired mobility health care plan. Additional information was requested related to a physician's order, assessment, and monitoring of the lap belt for Resident #1.</p>		<p>that the pre restraint assessment is completed and physician orders are received before any resident is restrained. The DON or designee will audit residents for restraint usage weekly for 4 weeks and monthly for 6 months. The DON will present the results of the audits to the QAPI committee monthly for 3 months and quarterly for 2 quarters and then adjust accordingly to ensure compliance. 5. Date of Compliance is 10-9-14</p>	

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	<p>During an interview with the Health Facility Administrator, on 9/26/14 at 8:52 a.m., he indicated the lap belt had not been considered a restraint and an assessment had not been completed.</p> <p>Review of the current facility policy, revised 12/2008, titled "Use of Restraints", provided by Admissions Coordinator on 9/25/14 at 2:54 p.m., included, but was not limited to, the following:</p> <p>..."Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully....</p> <p>...6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms....</p> <p>...9. Restraints shall only be used upon the written order of a physician..."</p> <p>3.1-3(w)</p>			

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure dependent residents were served meals in a manner to preserve dignity for 3 of 3 dependent residents reviewed for dignity in dining (Residents #78, #123 and #27.)</p> <p>Findings include:</p> <p>1. On 9/22/14 at 11:16 a.m., cognitively impaired, dependent, Resident #78 was escorted into the West Dining Room by nursing staff. Resident #78 was placed in her wheelchair facing the table as if prepared to dine. Resident #78 requested coffee at 11:40 a.m. Resident #78 was served coffee at 11:45 a.m. The coffee was placed on the table out of Resident #78's reach. Resident #78 was informed the coffee needed to cool. Resident #78 did not receive assistance to consume her coffee until the meal arrived. Resident #78 was presented her meal and assisted to eat at 12:19 p.m. (1 hour and 3 minutes after she was escorted into the dining room). During the 1 hour and 3 minute</p>	F000241	<p>1. Resident #78, #123 and #27: Resident Clinical records in regards to Diagnoses have been reviewed and have been found to be accurate and up to date. The MDS and Care Plan have been reviewed for assistance in: decision making; mobility; ADL's, and have been found to be accurate and up to date. These residents will be provided with pre-meal activities appropriate for their cognition level in an area separate from the dining room and transported the dining room as necessary at the actual time of meal service. Dietary staff has been in-serviced including but not be limited to: time-management promotion strategies including focus of timely meal service. Nursing staff has been in-serviced including but not be limited to: time-management promotion strategies including focus of timely meal service, ensuring that residents receive appropriate activities during the period before meals are served.</p> <p>2. The MDS and Care Plan have been reviewed for all Residents within the facility for Residents</p>	10/09/2014

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	<p>wait, a trivia activity was presented for 20 minutes. Resident #78 did not participate in the activity. Staff members spoke to Resident #78 on and off throughout this 1 hour and 3 minute time period. Conversations lasted no longer than 2 minutes at a time. Resident #78 received approximately 10 minutes of interaction with staff during this 1 hour and 3 minute wait.</p> <p>On 9/24/14 at 11:13 a.m., cognitively impaired, dependent Resident #78 was escorted into the West Dining Room by nursing staff. Resident #78 was placed in her wheelchair facing the table as if prepared to dine. Resident #78 sat facing the table until the steam table arrived in the dining table at 11:45 p.m. (32 minutes). An activity was offered for approximately 15 minutes of Resident #78's wait. The resident did not participate in the activity. Staff spoke to the resident on and off during her meal wait. Resident #78 was engaged in conversation no longer than a total of 5 minutes.</p> <p>On 9/25/14 at 7:17 a.m., cognitively impaired, dependent Resident #78 was escorted into the West Dining Room by nursing staff. Resident #78 was placed in her wheelchair facing the table as if prepared to dine. Resident #78 sat facing</p>		<p>deemed needing assistance in : decision making, mobility and ADL's. These residents will be provided with pre-meal activities appropriate for their cognition level in an area separate from the dining room and transported the dining room as necessary at the actual time of meal service. Dietary staff has been in-serviced including but not be limited to: time-management promotion strategies including focus of timely meal service. Nursing staff has been in-serviced including but not be limited to: time-management promotion strategies including focus of timely meal service ,ensuring that residents receive appropriate activities during the period before meals are served.</p> <p>3. Dietary staff has been in-serviced including but not be limited to: time-management promotion strategies including focus of timely meal service. Nursing staff has been in-serviced including but not limited to: time-management promotion strategies including focus of timely meal service , insuring that residents receive appropriate activities during the period before meals are served. A NurseManager will monitor the dining rooms to ensure residents are able to participate in pre meal activities or are provided alternative activities appropriate for their cognition level. A Dietary leader will be present in the dining</p>	

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	<p>the table until she received her meal and assistance to dine at 7:47 a.m. (30 minutes). Staff spoke to the resident on and off during her meal wait. Resident #78 was engaged in conversation no longer than a total of 5 minutes.</p> <p>Resident #78's clinical record was reviewed on 9/25/14, at 8:50 a.m. Resident #78's current diagnoses included, but were not limited to, muscle weakness, debility and depression.</p> <p>Resident #78 had a current, 9/17/14, care plan problem/need regarding depression. An approach to this problem was to provide one to one interaction as needed. Resident #78 had a current, 9/17/14, care plan problem/need regarding short term memory loss. An approach to this problem was to converse with the resident.</p> <p>Resident #78 had a current, 9/15/14, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was sometimes understood by others, had poor decision making skills and required cues and supervision, needed extensive assistance for mobility and required extensive assistance for eating.</p> <p>2. On 9/22/14 at 11:16 a.m., cognitively impaired, dependent, Resident #123 was</p>		<p>room for each meal to ensure meal service is timely.</p> <p>4. The Director of Nursing or designee will audit and monitor the dining room pre meal activities 3 times a week for 4 weeks and then weekly for 4 weeks and monthly for 6 months and will then adjust accordingly to ensure compliance. The Director of Nursing or designee will report the findings to the QAPI committee monthly for two months and then quarterly for two quarters and then adjust accordingly. The Dietary Manager or designee will monitor meal service times 3 times a week for 4 weeks and then weekly for 4 weeks then monthly for 6 months and will then adjust accordingly to ensure compliance. The Dietary Manager will report the findings to the QAPI monthly for two months and then quarterly for two quarters and then adjust accordingly.</p> <p>5. Date of Compliance is 10-9-14</p>				

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	<p>escorted into the West Dining Room by nursing staff. Resident #123 was placed in her wheelchair facing the table as if prepared to dine. Resident #123 sat with her chin to her chest while awaiting her meal. She never spoke to anyone, made eye contact with anyone, smiled or responded to conversation at anytime during her wait. Staff members did speak to her on and off during her pre-meal wait. The total time she was conversed with totaled less than 5 minutes. Staff members did straighten Resident #123 in her chair at one time during her wait. Resident #123 was provided her meal and assisted to dine at 12:22 p.m. (a 1 hour and 6 minutes after she was escorted into the dining room). During this wait, an activity was offered for 20 minutes. Resident #123 did not participate in the activity.</p> <p>On 9/24/14 at 11:10 a.m., cognitively impaired, dependent Resident #123 was escorted into the West Dining Room by nursing staff. Resident #123 was placed in her wheelchair facing the table as if prepared to dine. Resident #123 sat facing the table until the steam table arrived in the dining table at 11:45 p.m. (35 minutes). An activity was offered for approximately 15 minutes of Resident #123's wait. The resident did not participate in the activity. Resident #123</p>			

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	<p>never spoke to anyone, made eye contact with anyone, smiled or responded to conversation at anytime during her wait. Resident #123 sat the majority of the time with her chin to her chest. Staff members did speak to her an and off during her pre-meal wait. Resident #123 was spoken to no longer than a total of 5 minutes.</p> <p>On 9/25/14 at 7:25 a.m., cognitively impaired, dependent Resident #123 was escorted into the West Dining Room by nursing staff. Resident #123 was placed in her wheelchair facing the table as if prepared to dine. Resident #123 sat facing the table until she received her meal and assistance to dine at 7:47 a.m. (23 minutes). Staff spoke to the resident on and off during her meal wait. Resident #123 was spoken to no longer than a total of 5 minutes. Resident #123 never spoke to anyone, made eye contact with anyone, smiled or responded to conversation at anytime during her wait. Resident #123 sat the majority of the time with her chin to her chest.</p> <p>Resident #123's clinical record was reviewed on 9/25/14 at 8:20 a.m. Resident #123's current diagnoses included, but were not limited to, expressive aphasia, decreased appetite and dementia.</p>			

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	<p>Resident #123 had a current, 9/11/14, care plan problem/need regarding the need for individualized or small group visits. Approaches to this problem included, but were not limited to, "speak to the resident throughout visit even with minimal response."</p> <p>Resident #123 had a current, 9/11/14, care plan problem/need regarding dementia. An approach to this problem was to converse with the resident.</p> <p>Resident #123 had a current, 9/10/14, Minimum Data Set (MDS) assessment which indicated the resident rarely understood others, was rarely understood by others, was severely cognitively impaired and rarely or never made choices, was totally dependent for mobility and needed extensive assistance to eat.</p> <p>3. On 9/22/14 at 11:27 a.m., cognitively impaired, dependent, Resident #27 was escorted into the West Dining Room by nursing staff. Resident #27 was placed in her wheelchair facing the table as if prepared to dine. Resident #27 never spoke to anyone, made eye contact with anyone, smiled or responded to conversation at anytime during her wait. Staff members did speak to her on and</p>			

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	<p>off during her pre-meal wait. The total time she was spoken to totaled less than 5 minutes. Resident #27 was provided her meal and assisted to dine at 12:22 p.m. (55 minutes after she was escorted into the dining room). During this wait, an activity was offered for 20 minutes. Resident #27 did not participate in the activity.</p> <p>Resident #27's clinical record was reviewed on 9/25/14 at 8:35 a.m. Resident #27's current diagnoses included, but were not limited to, weakness, debility and chronic pain.</p> <p>Resident #27 had a current, 7/17/14, care plan problem/need regarding potential for decline in mood state. An approach to this problem was to provided one to one interaction as needed.</p> <p>Resident #27 had a current, 6/30/14, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was sometimes understood by others, had poor decision making skills and required cueing and supervision when making choices, needed extensive assistance for mobility and extensive assistance to eat.</p> <p>4. During a 9/25/14, 9:50 a.m., interview, the Activity Director indicated</p>			

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	<p>the pre-meal activities provided in the West Dining Room were not designed for cognitively impaired residents. She indicated resident must be conversational to participate in the activity. She indicated Residents #123, #78 and #27 were not good candidates for the pre-meal activity and she had not asked nursing staff to escort these residents to this specific activity. She additionally indicated these three residents were candidates for sensory stimulating actives scheduled at another time.</p> <p>During a 9/26/14, 11:05 a.m., interview, the Administrator indicated, lengthy pre-meal waits for cognitively impaired, dependent residents were not an acceptable practice and this was not the facility's quality standard. He indicated the facility would begin to correct this concern immediately.</p> <p>An undated, untitled, facility, document, provided by the Administrator on 9/26/14 at 12:40 p.m., indicated the West Dining Room meal services times were as follows: Breakfast: 7:30 a.m. Lunch: 11:15 a.m.</p> <p>A current, 4/13, facility policy, titled</p>			

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F000309 SS=D	<p>"Federal Resident/Patient Rights, which was provided by the Social Services Director on 9/26/14 at 12:40 p.m., indicated the following: " The resident has the right to a dignified existence..."</p> <p>3.1-32(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure diet recommendations from the dialysis center were followed up on for 1 of 1 residents reviewed for dialysis. (Resident #103)</p> <p>Findings include: Resident #103's clinical record was reviewed on 9/25/14 at 12:40 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease and anemia associated with chronic kidney disease.</p>	F000309	<p>1.All Dialysis Communication forms for resident#103 have been reviewed and appropriately acted upon. 2.All Dialysis Residents have the potential to be affected. All current Dialysis communication forms have been audited to ensure recommendations are implemented. An audit tool titled "Dialysis Audit" has been implemented to track recommendations and communication between Dialysis and the facility. Nursing staff has been in serviced on the use of the Dialysis communication form and appropriate implementation of Dialysis recommendations.</p>	10/09/2014			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303
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	<p>The resident's current diet order was for a mechanical soft diet with a 1500 cc fluid restriction.</p> <p>Review of a hemodialysis communication form, dated 8/29/14, indicated Resident #103's phosphate level was low at 1.3. The dialysis center recommended the resident's phosphate intake be increased through the intake of foods such as cheese, ice cream, or grilled cheese. The form indicated a list of foods were included.</p> <p>A hemodialysis communication form, dated 9/5/14, indicated the resident's potassium and phosphate were still low and recommended trying to offer more orally. The attached labs indicated her potassium was 3.4 with normal range being 3.5 to 5.1 and her phosphate was 1.6 with normal range being 2.6 to 4.5.</p> <p>Review of the nurse's notes and dietary notes lacked any indication the recommendations from the dialysis center were acted on.</p> <p>During an interview with Unit Manager #1 on 9/25/14 at 1:50 p.m., she indicated nursing should have notified dietary about the need to increase the resident's intake of foods high in phosphate.</p>		<p>3.Nursing Staff has been in serviced on the use of the Dialysis communication form and appropriate implementation of Dialysis recommendations.</p> <p>4.The Director of Nursing or designee will audit the Dialysis communication forms daily for 30 days and then weekly for 4 weeks and monthly for 2 quarters then adjust accordingly to ensure compliance. The Director of Nursing will report the findings to the QAPI monthly for 3 months and then quarterly for 2 quarters and then adjust accordingly.</p> <p>5.Date of Compliance is 10-9-14</p>	

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	<p>During an interview with the Certified Dietary Manager on 9/25/14 at 3:00 p.m., she indicated she had not received any communication from nursing related to sending more cheese or foods with high phosphate for resident #103. She indicated she only received the information about the resident being on a fluid restriction and requiring a mechanical soft diet.</p> <p>During a 9/26/14, 10:35 a.m., interview with Resident #103 she indicated she liked cheese. She indicated no one had talked to her about her low phosphate level and the need to eat more cheese or foods high in phosphate. She indicated she would eat more cheese if it were offered.</p> <p>The "Affiliation Agreement" between the facility and the dialysis center was provided by the Administrator on 9/26/14 at 1:40 p.m. The agreement indicated the dialysis center would provide residents of the nursing facility outpatient hemodialysis services, including pre and post treatment evaluation, the administration of dialysis, the provision of intra-dialytic medications related to resident's renal condition, arranging for the provision of laboratory tests related to the resident's renal condition, dietary services and social services.</p>			

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F000323 SS=D	<p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a resident was not injured during the re-inflation of an air mattress for 1 of 4 residents reviewed for accidents. (Resident #65)</p> <p>Findings include:</p> <p>Resident #65's clinical record was reviewed on 9/25/14 at 8:35 a.m. The resident's diagnoses included, but were not limited to, aphasia, fracture trochanter left hip, bilateral total hip replacement, and Parkinson's disease.</p> <p>The resident had a 6/30/14, significant change Minimum Data Set assessment. The assessment indicated the resident was severely cognitively impaired, could not speak and was totally dependent with the assist of two for bed mobility.</p>	F000323	<p>1. Resident remains on low air loss mattress. Staff has been in serviced on the manufacturer's guidelines for operation and use.</p> <p>2. All residents that use specialty mattresses have the potential to be affected. Staff has been in serviced on the manufacturer specific guidelines for operations and use.</p> <p>3. The Director of Nursing or designee will audit all residents on specialty mattresses weekly to ensure that staff assigned to that resident are in serviced on the mattresses manufacturer specific guidelines for operation and use.</p> <p>4. The Director of Nursing or designee will audit all residents on specialty mattresses weekly to ensure that staff assigned to that resident are in serviced on the mattresses manufacturer specific guidelines for operation and use. The Director of Nursing will report the findings of the audits to the QAPI monthly for three months and quarterly for two quarters to ensure continued compliance.</p>	10/09/2014

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F000371	<p>Review of a 8/20/14 "Non-pressure Skin Condition Record" indicated the resident had a 3.2 cm long by 0.5 cm wide abrasion above her right eye with no drainage.</p> <p>Review of a 8/20/14, 1:50 p.m., incident investigation indicated the resident's low air loss mattress was noted unplugged on 8/19/14 during second shift. The low air loss mattress was plugged back in. When the mattress re-inflated it pushed the resident against the bed rail causing an abrasion above the right eye.</p> <p>During an interview with Unit Manager #1 at 9/26/14 at 9:54 a.m., she indicated there were instructions on the mattress pump on the foot of the bed. She indicated the mattress was to be inflated and the resident was to be placed on the mattress after inflation.</p> <p>An observation was made of the instructions on the mattress pump on 9/26/14 at 10:16 a.m. The instructions indicated the mattress was to be inflated and the resident was to be placed on the mattress after inflation.</p> <p>3.1-45(a)(2)</p> <p>483.35(i)</p>		5.Date of Compliance is 10-9-14	

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SS=F	<p>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure food was prepared and stored under sanitary conditions and that equipment was being monitored for effectiveness and proper functioning. This deficient practice had the potential to impact 118 of 118 residents who ate meals prepared in the facility kitchen.</p> <p>Findings include:</p> <p>During the initial kitchen tour on 9/22/14 at 9:37 a.m., with the Dietary Director, one partially used jar of sliced jalapeno peppers and one partially used jar of stuffed olives were observed in one of the refrigerators. Both jars had no open dates. A bag of carrots were noted on the top shelf of a refrigerator. The carrots were in a plastic bag and were brown and mushy to the touch. There was no received date on the bag. The Dietary Director indicated the opened containers should have had open dates on them. The Dietary Director indicated all items should have a received date on them. Six</p>	F000371	<p>1.All food stored in the dietary department has been examined to ensure appropriate dates are present and that the items are within the dates allowed for usage. All coolers and the dry storage room have been cleaned. The vendor that supplies the dishwasher and the automatic chemical sanitizing system has inspected the system and found it to be operating appropriately.</p> <p>2.All residents who consume food prepared by the dietary department have the potential to be affected. Dietary staff has been inserviced including but not limited to: kitchen sanitation, dry storage cleaning, food storage and chemical sanitation procedures.</p> <p>3.Dietary staff has been in serviced including but not limited to: kitchen sanitation, dry storage cleaning, food storage and chemical sanitation procedures.</p> <p>4.The Dietary Manager or designee will audit the Kitchen Cleaning Log and the Chemical Sanitation Log daily for 30 days and then weekly for four weeks and monthly for 4 months to ensure compliance. The Dietary Manager will report the findings to</p>	10/09/2014			

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	<p>packets of saltine crackers and one bag of potato chips were observed on the floor under a shelf in the dry storage room.</p> <p>During a kitchen revisit on 9/24/14 at 10:09 a.m., the crackers and the bag of potato chips were observed in the same location and had not been removed. The Dietary Director indicated the dry storage room was cleaned, to include sweeping and mopping, weekly on delivery day. The last delivery day was 9/22/14.</p> <p>Review of the cleaning schedule for September 21-27, 2014, indicated the schedule did not list the dry storage room floors as an area to be cleaned. A note at the bottom of each page said, "swept mop area (sic)" or "swept mop before leave (sic)" or "everyday swept mop (sic) after each meal", but did not specify the area.</p> <p>During the initial kitchen tour on 9/22/14 at 9:20 a.m., the dishwasher temperature was noted at 130 degrees and did not increase during the washing process. The temperature of the rinse cycle was noted at 150 degrees and did not increase during the rinse process. The Dietary Director indicated the dishwasher was both a high temperature and low temperature machine. She indicated if the cycles did not reach the appropriate temperature, then the chemical sanitation</p>		<p>the QAPI committee monthly for 3 months and quarterly for two quarters. The Dietician or designee will audit the food storage in the dietary department daily for 30 days and then weekly for four weeks and monthly for 4 months to ensure compliance. The Dietician will report the findings to the QAPI committee monthly for 3 months and then quarterly for 2 quarters and then adjust accordingly.</p> <p>5.Date of Compliance is 10-9-14</p>	

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	<p>process was automatically initiated. The Dietary Director did not know how to ascertain if the chemicals were being used or not. The Maintenance Director indicated he did not know how to ascertain if the chemicals were being used or not.</p> <p>Review of the "Dishwasher Temperature/Chemical Record" for August and September 2014, provided by the Dietary Director on 9/24/14 at 10:09 a.m., indicated the temperatures had been checked daily at breakfast, lunch and dinner. The column for the chemical check was initialed, however, the Dietary Director indicated the initials only indicated who had recorded the temperatures. The Dietary Director verbalized the sanitizer concentration for the dishwasher had not been monitored.</p> <p>During an interview on 9/24/14 at 2:00 p.m., the policy for the use and monitoring of the dishwashing machine was requested. The Administrator indicated there was no policy that specifically addressed the monitoring of the dishwashing machine, but they would continue to look for one.</p> <p>On 9/26/14 at 2:09 p.m., the policy dated October 2009, entitled "Testing Sanitizer Concentration - Low Temperature</p>			

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	<p>Machine" was provided by the Administrator. The policy indicated the following: "Policy Rinse water of low temperature dish machine will contain 50-PPM [parts per million] chlorine for proper sanitation. Procedure 1. At least daily, test sanitizer concentration by using Micro Chlorine Litmus Paper provided by chemical vendor or ordered with supplies.... 7. Record litmus paper results on the form kept in the kitchen area. 8. Completed record forms are kept on file, along with copies of service records to correct any procedural problems. 9. Record temperature of the dish-machine during wash and rinse cycle. If the temperatures do not meet those recommended by machine manufacturer, report to the dietary manager. Temperatures, which are too high, can make the sanitizing agent ineffective." 3.1-21(a)(3)</p>			