STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155468	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRECKENRIDGE HEALTH & REHABILITATION	325 W NORTHWOOD DR SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: May 20, 21, 22, & 23, 2014. Facility number: 000525 Provider number: 155468 AIM number: 100267010 Survey Team: Melissa Gillis, RN-TC Cheryl Mabry, RN Angela Patterson, RN Diana McDonald, RN Census bed type: SNF/NF: 41 Total: 41 Census payor type: Medicare: 10 Medicaid: 26 Other: 5 Total: 41 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 30,	F000000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	2014; by Kimberly Perigo, RN.			
F000253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation, interview and record review, the facility failed to ensure a sanitary, orderly, and comfortable interior for 1 of 3 hallways (200 hallway) in that a odorous smell was observed; for 1 of 1 activity room in that dead bugs were observed in 3 of 5 overhead lights, 1 of 3 overhead lights were cracked, and the vent next to the overhead light was covered with dust; a Resident's room (Resident #35) had black marks along the interior wall, the soap dish container was broken, and the caulking around the sink was not attached to the counter below. Findings include: 1. On 5/20/2014 at 11:01 a.m., observation of 200 hallway indicated a smell of feces between room 202-209; for two hours.	F000253	F253 Requires that the facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The facility will ensure this requirement is met through the following corrective measures. 1) Overhead lights in the activity room were cleaned and repaired. Vents were cleaned. The soap container was repaired and the sink was caulked to attach to the counter below. 2) All residents environment has the potential to be affected. A complete audit was completed to ensure all overhead lights and vents are clean and in good repair. Sinks were inspected to ensure they are caulked to the counter. Interior walls were inspected for markings. See corrective measures below. 3) The policy and procedure for light covers and vents were reviewed with no changes made. (see attachment	06/13/2014

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	On 5/21/2014 at 11:30 a.m., an observation of the 200 hallway indicated a smell urine on the hall; for two hours. On 5/22/2014 at 11:00 a.m., an observation of the 200 hallway indicated a smell of feces between room 202-206; for an hour. On 5/23/2014 at 1:00 p.m., an observation of the 200 hallway indicated a smell of urine on the hallway; for 4 hours. On 5/23/2014 at 2:15 p.m., an interview with the Administrator indicated they have a very incontinent resident on the 200 hallway that causes the smell of urine on the hallway. 2. A. On 5/20/2014 at 11:00 p.m., an observation of the activity room indicated 3 of 3 overhead lights that were covered also contained dead bugs. The vent next to the lights was covered in a brown dried substance. One of the 3 overhead lights were cracked. On 5/22/2014 at 2:00 p.m., an observation of the activity room indicated 3 of 3 overhead lights that were covered also contained dead bugs. The vent next to the lights was covered in a brown dried substance. One of the 3 overhead lights		A & B) The maintenance staff was inserviced on the above policies and educated on the importance of caulking the sinks to the counter. (attachment C) 4) The Administrator or her designee will conduct rounds ensuring that the vents and overhead lights are clean and in good repair, sinks are caulked and no markigns on interior walls. The audits will be completed one time weekly x4 weeks, every two weeks x 2 months, then quarterly thereafter until 100% complance is obtained and maintained. These audits will be reviewed during the facility's quarterly quality assurance meetings and adjusted accordingly (Exhibit D)	

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	were cracked. On 5/23/2014 at 2:00 p.m, an interview with Maintenance Director indicated it was maintenance's responsibility to clean the lights, change them when they are broken, and clean the vents in the facility. On 5/23/2014 at 2:39 p.m., the Maintenance Director provided "LIGHT COVERS" no date, and indicated the policy was the one currently used by the facility. The policy indicated, "POLICY: Light Covers should be cleaned on a quarterly basis..." On 5/23/2014 at 2:39 p.m., the Maintenance Director provided "VENTS" undated policy and indicated the policy was the one currently used by the facility. The policy indicated,"POLICY: Vents are to be cleaned at least on a quarterly basis. Majority of vents are to be cleaned on a daily basis as part of the 5-step and 7-step cleaning method. For vents located in the hallways and dining rooms, schedule on a regular basis..." 3. On 5/20/2014 at 10:13 a.m., an observation of Resident #35's room, indicated black marks all over the interior wall opposite the bathroom. The bathroom had a loose soap dispenser that			

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	was empty. The caulking around the sink was loose and not attached to the counter below the sink. On 5/23/2014 at 1:45 p.m., an observation of Resident #35's room, with the Maintenance Director indicated, black marks all over the interior wall opposite the bathroom. The bathroom had a loose soap dispenser that was empty. The caulking around the sink was loose and not attached to the counter below the sink. On 5/23/2014 at 1:50 p.m., an interview with the Maintenance Director indicated it was maintenance's responsibility to repair the soap dispenser and caulking in Resident #35's bathroom. On 5/23/2014 at 2:15 p.m., an interview with the Administrator indicated it was Maintenance's responsibility to repair broken items in the facility. 3.1-19(f)			
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive			

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	care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on interview and record review, the facility failed to ensure a care plan was developed for a resident who was at for risk for bleeding, in that a resident was receiving 3 anticoagulant medications and a care plan was not developed for risk of bleeding for 1 of 5 residents reviewed for unnecessary medication use. (Resident #24). Findings include: On 5/22/2014 at 10:00 a.m., the clinical record was reviewed for Resident #24. Diagnoses included, but were not limited to: peripheral vascular disease, transient ischemic attacks, and gastroesophageal reflux disease. Current May 2014; physician orders indicated Resident #24 was prescribed	F000279	F0279 Requires that the facility must develop a comprehensive care plan for each resident that includes measurable objectives and time tables to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. 1) Resident #24 who receives anticoagulants had a care plan added to their clinical record regarding the risk for bleeding. 2) All residents have the potential to be affected. All residents who receive an anticoagulant had their care plans reviewed to ensure that a care plan was in place to address the risk for bleeding. See corrective measures below.3) The policy and procedure for care plans were reviewed and no changes were made. (See attachment E) The staff was inserviced on the above policy.4) The DON or her	06/13/2014

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	Plavix 75 mg daily, Pletal 50 mg twice daily, and aspirin 81 mg daily. On 5/22/2014 at 10:28 a.m., an interview with the DoN indicated Resident #24 readmitted on 12/19/2013, and the only order for laboratory studies he had ordered is a yearly TSH. No orders for routine lab monitoring of anticoagulant medications. On 5/22/2014 at 10:40 a.m., an interview with DoN indicated the physician stated he doesn't need to monitor Resident #21's labs for the use of Plavix, Pletal, and aspirin. On 5/22/2014 at 1:20 p.m., the DoN provided the care plan for Resident #24. No careplan identified for risk for bleeding related to anticoagulant therapy. On 5/23/2014 at 1::30 p.m., an interview with the DoN indicated, a resident who is on anticoagulant therapy should have a careplan related to risk for bleeding. The Lippincott Manual of Nursing Practice, 34th edition, copyright 2014, for the drug Pletal, interactions Drug-drug-Asprin, NSAIDS may increase risk of GI (gastrointestinal [the stomach and intestines]) bleeding. Monitor patient. Effects on lab test results-May decrease		designee will review 5 resident's careplans, who receive an anticoagulant, to ensure that the risk of bleeding is addressed. The audits will be completed weekly x4 weeks, every two weeks x2 months and quarterly thereafter until 100% compliance is obtained and maintained. The audits will be reviewed during the facility's quarterly quality assurance meetings and adjusted accordingly.(See attachment F)	

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	platelet count. May 22, 2014; a request to administrative staff for care plan policy was made and no policy or procedure provided for care plan development. 3.1-35(a)			
F000281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on observation, interview, and record review, the facility failed to meet professional standards as indicated by recommended manufacturer guide in that a nurse failed to have residents rinse their mouth and spit after administering a steroid inhaler for 1 out 6 residents observed for medication administration. (Resident #24) (LPN #2) Findings include: On 5/22/14 at 8:12 a.m., observed LPN #2 during medication administration enter Resident #24's room and	F000281	F-281 Requires the facility to meet professional standards as indicated by recommended manufacturer guide.1) Resident #24 had her mouth rinsed after receiving the steroid, once the nurse was educated per guidance. 2) All residents have the potential to be affected. All residents who receive a steroid inhaler will have their mouth rinsed after receiving the steroid inhaler. See corrective measures below. 3) The medication administration policy and procedure was reviewed with no changes made (see attachment G). The staff was inserviced on	06/13/2014

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	administered his Symbicort inhaler (steroid inhaler that treats asthma and chronic obstructive pulmonary disease). No rinsing of the mouth was observed after the administration of the inhaler. LPN #2 was observed to handwash and exit the room. On 5/22/14 at 11:12 a.m., the Nurse Consultant provided "METERED DOSE INHALER (MDI) ADMINISTRATION" no date, and indicated the policy was the one currently used by the facility. The policy indicated, " PURPOSE: To administer medication per physician's order via MDI. ... " There was no indication to have residents rinse and spit after administering inhalers. Review on 5/19/2014; of Symbicort.com dosage and administration "... Symbicort should be administered twice a daily every day by the orally inhaled route only. After inhalation the patient should rinse the mouth with water without swallowing." 3.1-35(g)(1)		the above policy (attachment H)4) The DON or her designee will monitor one medication pass every day x4 weeks, weekly x4 weeks, every two weeks x2 months then quarterly until 100 % compliance is obtained and maintained. These audits will be reviewed during facility's quarterly quality assurance meeting. (Attachment I)	
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES			

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	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 water temperatures were safe in that 1 of 39 residents' rooms the water was above 120 degrees Fahrenheit. (Resident #13, Resident #35). Findings include: On 5/21/2014 at 10:13 a.m., an observation of the water temperature in Resident #13 and Resident #35's shared bathroom indicated it felt excessively hot. On 5/23/2014 at 1:40 p.m., an observation of the water temperature in Resident #13 and Resident 35's shared bathroom indicated it felt excessively hot. On 5/23/2014 at 1:50 p.m., an observation with the Maintenance Director measuring the water temperature of the shared bathroom for Resident #13 and Resident #35, he indicated the water temperature measured 121.4 degrees Fahrenheit, with the facilities thermometer. At that time, an interview with him indicated the water temperature should be 120 degrees Fahrenheit or less.	F000323	F323 Requires the facility to ensure water temperatures are safe.1) Resident #13 and #35's water temperature was adjusted to below 120 degrees Faranheit.2) All residents have the potential to be affected. A complete audit was conducted to ensure all water temperatures were below 120 degrees faranheit. See corrective measures below. 3) The policy and procedure on weekly water temps was reviewed and no changes made. (See attachment J) The maintenance staff was inserviced on the above policy. (See attachment K)4) The Administrator or her designee will conduct rounds ensuring water temperatures remain under 120 degrees faranheit. The audits will be completed weekly x4 weeks, every two weeks x2 months, then quarterly thereafter until 100% compliance is obtained and maintained. The audits will be reviewed during the facility's quarterly quality assurance meeting. (Attachment L)	06/13/2014

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	On 5/23/2014 at 1:50 p.m., an interview with the Director of Nursing indicated the water temperature should not exceed 120 degrees Fahrenheit. On 5/23/2014 at 2:00 p.m. the clinical record was reviewed for Resident #13. The annual MDS (Minimum Data Set) assessment, dated 3/19/2014, assessed Resident #13 as not interviewable for the BIMS (Brief Interview for Mental Status) score. The assessment indicated Resident #13 as totally dependent requiring assist of 2 people for ADL's (Activities of Daily Living) and totally dependent with assist of one person for personal hygiene. On 5/23/2014 at 2:30 p.m., the clinical record was reviewed for Resident #35. The quarterly MDS (Minimum Data Set) assessment, assessed Resident #35's BIMS score as a 9 out of a score of 0-15. This score indicated the resident was interviewable. The assessment indicated Resident #35 was totally dependent with assist of 2 people for ADL's and totally dependent with assist of one person for personal hygiene. On 5/23/2014 at 2:30 p.m., the Maintenance Director provided the facilities "WEEKLY WATER TEMPS"			

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	dated 4/2013. At that time, he indicated this is the only policy related to water temperature that the facility uses. The policy indicated "Temperature to be between 100-120 degrees..." 3.1-45(a)			
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, interview, and record review, the facility failed to ensure	F000329	F329 requires the facility to ensure each resident drug regimen was free from	06/13/2014

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	each residents' drug regimen was free from unnecessary drugs in that a hypnotic medication was administered in excessive dose of the physician's order for 1 of 5 resident reviewed for unnecessary medication use. (Resident #11) Findings include: Resident #11's clinical record was reviewed on 5/22/14 at 9:48 a.m. The diagnoses include, but not limited to dementia, diabetes, aphasia, hypertension, anxiety, and depression with psychotic features. Resident #11 was admitted to the facility on 12/30/13. The current MDS (Minimum Data Set) assessment dated 3/10/13, indicated a BIMS (Brief Interview Mental Status) score of 1, when 8-15 was interviewable. Review of facilities current resident listing with medication regiment review dated February 1 through April 14, 2014 indicated, Pharmacist reviewed Resident #11's medications monthly. Review of GDR (Gradual Dose Reduction) dated 4/25/14, for Ambien indicated, "Resident has an order for		unnecessary drugs. The facility will ensure this requirement is met through the following measures. 1) All residents receiving a hypnotic medication are at risk. Resident #11 chart was reviewed and orders written for reduction of Ambien. Begin 5mg Ambien tab one PO Q HS for Insomnia.2) All residents receiving sedative/hypnotic medication has been reviewed to determine if a GDR is indicated and orders have been requested as indicated. 3) All Licensed staff have been re-educated on writing physician orders after the pharmacist and physician indicate to reduce. (Exhibit M) All licensed staff have been re-educated on the sedative/hypnotic medication guidelines. (Exhibit N) 4) The DON or Designee will review all residents pharmacy GDR recommendations and ensure they are written on a Doctors order. Along with reviewing the need for GDR's daily, Monday through Friday, for two weeks, then twice weekly for 4 weeks, then weekly for 3 months, then quartlery to ensure continued compliance. The findings of these audits will be included during the facility's Quality Improvement meetings and the plan of action will be adjusted accordingly. (Exhibit O)	

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	Ambien 10 mg QHS [every night at bedtime]. It is recommended that geriatric women do not take more than 5 mg per day because of possibility of confusion. Can this order be reduced to Ambien 5 mg QHS? ... OK [medical doctor indicated in agreement to reduce dosage from 10 mg to 5 mg per day] ..." Review of the April and May 2014 MAR (Medication Administration Record) indicated, "Ambien (12/30/13) 10 mg tablet ... Give 1 tablet by mouth at bedtime. DX: [diagnosis] INSOMNIA." There was no physician's order found in the chart to decrease dose to 5 mg, as indicated by the 4/25/14 GDR recommendation sheet. Careplan "Psychotropic Drug: Sedative Hypnotic" dated 4/8/14 indicated, "the resident requires the use of a sedative/hypnotic medication: Ambien to treat insomnia and is at risk for adverse side effects. ... INTERVENTION ... Monitor for adverse side effects such as: drowsiness, sedation, somnolence, dizziness, increased confusion, ... Attempt GDR per policy, ... Provide environmental sleep aids such as: a quiet environment, soft music, massage, night light, snack. ..." On 5/23/14 at 3:01 p.m., interview with			

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	the Medical Records/LPN indicated when asked to explain the GDR notes dated 4/25/14 versus the MAR order dated April 1 through May 23, 2014. "This may be a duplicate order. Sometimes he faxes two different orders." The Medical Records/LPN asked the ADON (Assistant Director of Nursing) to go and check with the DON to confirm." On 5/23/14 at 3:15 p.m., the DON provided "FAX ORIGINAL COPY TO INNOVATIVE PHARMACY SOLUTIONS", dated 5/23/14, indicated, "D/C [discontinue] ambien 10 mg tab [tablet] one PO [by mouth] q [every] day @ [at] HS [hour of sleep] for insomnia. Begin 5 mg ambien tab one PO q day @ HS for insomnia." Resident #11 had received Ambien 10 mg for 28 days, after the pharmacist and physician indicated to reduce to 5 mg. 3.1-48(a)(1)			
F000371 SS=F	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			

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	(2) Store, prepare, distribute and serve food under sanitary conditions A). Based on observation, interview, and record review the facility failed to store, prepare and serve food under sanitary conditions in that 1 of 1 refrigerator temperatures were not in a safe range; the facility failed to properly clean and dry equipment used to puree foods for 5 of 5 residents receiving pureed food; butter stored in the walk-in refrigerator was not labeled, dated, or covered; the ceiling above the prep table had an area of stained and peeling paint. B). Based on observation and record review, the facility failed to ensure proper handwashing was followed in serving of lunch in that staff did not wash their hands according to facility policy while serving lunch to residents in the main dining room. This had the potential to affect 30 out of 30 residents who were served in the main dining room. Findings include: A) 1. Observation on 5/20/14 at 10:50 a.m., the temperature of the double door refrigerator in the kitchen was 50 degrees. The right door to the refrigerator was open about a quarter of an inch. A sign on the refrigerator door	F000371	F 371 requires the facility to 1) procure food from sources approved or considered satisfactory by Federal, State, or local authorities. 2) Store, prepare and serve under sanitary conditions. 1a) The facility food has been removed from above mentioned refrigerator. The food from this refrigerator is currently in walk-in refrigerator. Temp logs for this refrigerator indicate no temps less than 45 degrees. Refrigerator has been evaluated and new gaskets need to be located and ordered. Temporary refrigerator is in use until new gaskets for refrigerator are ordered and refrigerator repaired. Current butter pads are labeled, covered, and dated. Monitoring will include: 1) temp. logs currently in use. (Exhibit P) 1b) Area ceiling scraped and repainted. Dietary staff were re-educated on checking equipment temperatures and procedural directions were given in the event that the equipment is not functioning properly. 2a) All residents have the potential to be affected. A complete audit was completed to ensure all food has been removed from above mentioned refrigerator. 2b) All equipment is at risk for problems. A complete audit was done on checking equipment, maintenance of walls and ceilings to make sure free of paint	06/13/2014

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	said, "make sure doors are closed all the way on the fridge." Observation on 5/21/14 at 12:10 p.m., the temperature of the double door refrigerator was 48 degrees Fahrenheit, both doors were closed. Interview on 5/20/14 at 10:52 a.m., with the DM (Dietary Manager) indicated the doors do not close tight, you have to push hard and then the other door pops open. Review of on 5/20/14 at 1:00 p.m., Retail food Establishment Sanitation Requirements Title "...410 IAC 7-24-191 Ready-to-eat, potentially hazardous food;data marking. Sec. 191.(d) refrigerated, ready-to-eat, potentially hazardous food prepared and held...for more than twenty-four (24) hours shall be clearly marked to indicate the date or day which the food shall be consumed on the premises, sold or discarded, based one (1) of the temperature and time combinations specified as follows and the day of preparation shall be counted as day on (1). Forty-one (41) degree Fahrenheit or less for a maximum of seven (7) days..." 2. Observation on 5/20/14 at 11:05 a.m., in the walk in refrigerator there were 3, 12 inches long by 1.5 inches wide by 1.5		chipping, and refrigerator temp to make sure not below 45 degrees. (Exhibit Q)3) The policy and procedure on cleaning, maintaining and repair of reach-in refrigerator and freezor, and pureed foods was reviewed with no changes made to it. Staff was inserviced on the above policies. (Exhibit R) The maintenace was inserviced on repair needs of walls and ceilings in kitchen. (see attachment Exhibit S)4) The Dietary Manager or designee will observe pureed prep daily, complete sanitation rounds, temp logs, labeling and dating daily M-F for four weeks, then twice weekly for four weeks, then weekly for 2 months, then monhtly to ensure compliance. Findings of the audits will be reviewed during quarterly quality assurance meetings and adjusted accordingly. (Attachment T) June 25, 2014 Brenda Marshall, RN Surveyor Supervisor Long Term Care Division Indiana State Department of Health 2 N. Meridian Street Indianapolis, Indiana 46204 Dear Ms. Marshall: Facility #: 000525 Provider#: 155468 Survey Event ID: BYKL11	

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	inches deep single trays of single serve butter pads not labeled, dated, or covered. Interview on 5/20/14 at 11:05 a.m., with the DM indicated, "The night crew did not wrap the butter and placed in box, usually the butter pads are in the box." 3. Observation on 5/20/14 at 11:30 a.m., the cook had pureed the country fried steak and placed the bowl, cover, and blade in the dishwasher. After the bowl, cover, and blade had been cleaned, she removed the items from the dishwashing area still wet, and the cook then started to puree the potatoes in the wet bowl. Interview on 5/20/14 at 11:35 a.m., with the cook indicated, "The bowl is wet, is it not suppose to be?" "How should I do this?" The DM got the other food processor to do the beets in a clean dry bowl. Review of on 5/20/14 at 1:00 p.m., Retail food Establishment Sanitation Requirements Title 410 IAC 7-24 policy, " ...410 IAC 7-24-304 Equipment and utensils; air drying required. Sec. 304. (a) After cleaning and sanitizing, equipment and utensils: (1) shall be air-dried or used after adequate draining as specified in 21 CFR 178.1010(a), before contain with food;..."		Survey Date: May 23, 2014 Per your request for addendum dated June 24, 2014 regarding F 371: *Facility policy indicated store at less than 41 degrees. POC indicated a plan to ensure no refrigerator temps above 45 degrees. If temps aren't monitored to ensure less than 41 degrees, how will facility ensure no potentially hazardous food items?* ***Response:*** ***The facility policy will be followed and the monitoring conducted as per plan of correction to ensure temps are at or below 41 degrees. This was an inadvertent error. Appropriate staff will be addressed to verify no confusion and ensure compliance with monitoring to ensure temps are at or below 41 degrees to ensure no potentially hazardous food items.*** Should you have any further questions, please feel free to contact me. Best regards, Laurie White, Administrator	

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	4. Observation on 5/20/14 at 11:40 a.m., directly above the food preparation area the ceiling had an approximated area of 36 inches x 18 inches of rust color stain with paint peeling from the ceiling. Interview on 5/20/14 at 11:43 a.m., with the DM indicated, "Looks like a water stain and the paint is peeling." B). 1. Observation on 5/20/14 at 12:10 indicated the ADON served a lunch plate to Resident #51. After ADON served Resident #51 her food, the ADON put her hand on Resident #51's back and rubbed her shoulder. The ADON then retrieved another lunch plate and served Resident #49. After the ADON served Resident #49 her food, she rubbed Resident #49's back. The ADON then went to get another lunch plate and while she was waiting to serve another resident, the ADON was observed to place her hands on her neck, face, and hair for 10 seconds. The ADON then served Resident #22 her lunch. The ADON served Resident #22 her meal and then patted Resident #22's back. No handwashing or hand sanitizing was observed during the passing of lunch plates.			

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	2. Observation on 5/22/14 at 12:15 indicated CNA #3 took a resident's roll from the a package with her bare hands. CNA #3 then used one hand to hold the roll and with the other hand, grabbed a butter knife and cut the roll for the resident. She then applied butter to the roll and closed the roll with her bare hands. CNA #3 then went to serve Resident #52. After serving Resident #52 her tray, CNA #3 pulled out the roll from the package with her bare hands. CNA #3 then used one hand to hold the roll and with the other hand, grabbed a butter knife and cut the roll. CNA #3 then applied butter to the roll, closed the roll and placed the roll on the plate for Resident #52. CNA #3 then retrieved another plate and started to serve Resident #61. No handwashing or hand sanitizing was observed. On 5/22/14 at 11:12 a.m., the Nurse Consultant provided the "Handwashing Procedure", no date, and indicated the policy was the one currently used by the facility. The policy indicated, "Handwashing Procedure: Policy: To provide protection for the resident and staff when performing direct care procedure. To ensure that hands remain clean so as to assist in			

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	maintenance of a clean environment and assist in the prevention of and the transmission of disease and infection...Key procedural points: Specific Times Hands Must Be Washed:...2. Before and after direct resident contact. 3. Before and after handling of food...Antiseptic alcohol-based are sufficient to cleanse the surface of the hands..." On 5/23/14 review of the Centers for Disease Control and Prevention dated December 16, 2013, "Handwashing: Clean Hands Save Lives ... When and How to Wash Your Hands ... How should you wash your hands?" indicated "... Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice. Rinse your hands well under clean, running water. Dry your hands using a clean towel or air dry them ..." 3.1-21(i)(3)			

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F000431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure that all expired medication was discarded	F000431	F431 Requires the facility to ensure all expired medications are destroyed according to current facility policy 1 Resident	06/13/2014

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	according to current facility policy in 1 out of 2 medications carts and 1 storage room. (Resident #11, Resident #21, Resident #7, Resident #47,Resident #9, Resident #67) (North Hall cart) Findings include: 1. On 5/22/14 at 11:41 a.m., observed LPN #1 to remove Humalog insulin from the North hall's medication cart for Resident #7, which had an opened date of 3/19/14. When asked what is the shelf life for open insulin. LPN #1 indicated, "28-30 days. Well that's not good." LPN#1 was observed to go get a new vial at that time. 2. 5/23/14 at 11:56 a.m., observed Resident #66's eye drops trifluridine (used to treat herpes infection of the eye) with open dated of 5/20/14, in the medication cart with a label on the bottle indicating refrigerate. Interview with LPN #1 indicated when asked if the medication was kept in the medication cart. "Yes." LPN #1 was shown the label on medication bottle which indicated, "REFRIGERATE." LPN #1 indicated, "Oh, I guess I'll have to refrigerate." On 5/23/2014 at 12:13 p.m., review of " WebMD.com Viroptic ophthalmic ... Overdose ...Store in the refrigerator		#11, #21, #7, #47, #9 and #67's expired medications were destroyed. 2 All residents have the potential to be affected. A complete audit as completed to ensure no expired medications were in the medication cart (Exhibit U) 3 The policy and procedure on medication expiration was reviewed with no changes made. The staff was in serviced on the above policy4 The DON or her designee will audit the medication cart ensuring that all expired medications are destroyed The audits will be completed weekly times four weeks every two weeks times two months and quarterly thereafter. (See Exhibit V)	

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	between 36-46 degrees F (2-8 degrees C) away from light. On 5/23/14 at 12:24 p.m., interview with a local pharmacist indicated, "Viroptic should be refrigerated at all times. It will be non effective if left out." 3. On 5/23/14 at 12:50 p.m., observation of the medication storage room's refrigerator with the Nurse Consultant indicated, facility stock "Engerix-B 20 mcg/ml vial received on 7/24/12 expiration 3/17/14." 4. The following expired medications were observed in the North Hall cart: Resident #11's Novolin R vial opened date 3/25/14 and expires 28 days from open date. Resident #21's Novolog vial opened date 4/20/14 and expires 28 days from open date. Resident #7's Humalog vial opened date 3/9/14 and expires 28 days from open date. Resident #47's Novolog vial opened date 4/12/14 and expires 28 days from open date, loperamide (treats diarrhea) 2 mg Dispense date-3/22/13 expired date is 3/2014.			

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	Resident #9's Loperamide cap 2 mg dispense date 3/13/13, expired 3/2014. Resident #20's Loperamide Cap 2 mg dispense date 3/13/13, expired 3/2014. Resident #67's Lantus Solostar Pen Dispense date is 3/4/14. Expired 7-16 not in a refrigerator. The Nurse Consultant indicated, when asked is there something wrong with the box of insulin being in the medication cart? "The insulin doesn't have an open date." The Nurse Consultant indicated, when asked what is the protocol for storing unopened Lantus. "No, I don't. I would have to look it up." Observed the Nurse Consultant to remove all expired medications and tell LPN #1 they need to be destroyed. On 5/23/14 at 2:48 p.m., the Nurse Consultant provided "Lantus SoloStar" from Resident #67's Lantus manufacturer's box indicated "...Unopened SoloStar: Unopened LANTUS SoloStar devices should be stored in a refrigerator, 36 degrees F-46 degrees F..." On 5/23/14 at 2:49 p.m., the DON (Director of Nursing) provided "MEDICATION EXPIRATION no date,			

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	and indicated that was the policy currently used by the facility. The policy indicated, " ... All pharmaceuticals dispensed by the pharmacy will bear expiration date or expiration date information. ... 4. A pharmaceutical product will be considered expired on the 1st day of the month unless specified otherwise on the label. ...9. Drugs requiring storage at ' ROOM TEMPERATURE ' must be maintained between 15 degree Celsius (60 degrees Fahrenheit) and 30 degrees Celsius (86 degrees Fahrenheit). 10. Drugs requiring storage in ' A COOL PLACE ' must be stored in a refrigerator designated for medication only and be maintained between 2 degrees Celsius (35 degrees Fahrenheit) and 8 degrees Celsius (45 degrees Fahrenheit. ... 12. Any outdated, contaminated, ... must be removed from stock and destroyed according to procedures for drug destructions." On 5/23/14 at 3:45 p.m., the Medical Records/LPN provided the following drug destruction record with reason for destruction dated 5/23/14: Lantus SoloStar 2 pens expired, flushed loperamide 11 pills expired, flushed NovoLog 1 vial expired, flushed Humalog 1 vial expired, flushed NovoLog 1 vial expired, flushed			

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	Novolin R 1 vial expired, flushed loperamide 25 pills expired, flushed loperamide 24 pills expired, flushed 3.1-25(m) 3.1-25(o)			
F000441 SS=E	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. (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. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or			

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	their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. A). Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed related to hand washing during patient care as indicated by the facility policy and Center for Disease Control guidelines. This deficient practice had to potential to affect 1 randomly observed resident during stage 1. (Resident #10) (CNA #1, CNA #2) B). Based observation and interview, the facility failed to ensure that the sharps container in a residents bathroom was emptied and locked. This deficient practice had the potential to effect 1 of 41 randomly observed rooms in stage 1. (Room 200) Findings include: A). 1. On 5/20/14 at 2:47 p.m., observed CNA#1 and CNA #2 to enter Resident #10's room to assist resident to the bathroom. CNA #1 and CNA #2 placed	F000441	F441 Requires the facility to 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 infection1. Resident #10 had care provided and CNA #1 and #2 were instructed how to properly wash their hands correctly. 2. All residents have the potential to be affected. Staff was educated on how to was their hands correctly. (See exhibit W) See corrective measures below.3. The policy and procedure for handwashing was reviewed and no changes made. All staff were in-serviced on the above policy. The DON or her designee will monitor staff on proper hand washing techniques Three observations of hand washing will be observed daily times four weeks, weekly times four weeks, every two weeks for two months, then quarterly thereafter until 100% complaisance is maintained. The	06/13/2014

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	on gloves. No handwashing was observed. CNA #1 and CNA #2 placed a gait belt around the waist of Resident #10, transferred Resident #10 from the recliner to the wheelchair. CNA #2 entered the bathroom while CNA #1 pushed the wheelchair into the bathroom, the urine catheter bag was uncovered and dragging the floor. CNA #1 exited the bathroom, with the gloves still on, pushed the wheelchair back into the room, removed dirty linen from the recliner, removed the trash bag, and exited the room with the gloves on. No handwashing nor removal of gloves observed. CNA #2 was observed to exit the bathroom with gloves on, retrieve Resident #10's oxygen tubing from the bed, re-enter the bathroom and shut the door. CNA #1 was observed to re-enter Resident #10's room, no handwashing observed, placed on gloves while the resident remained in the bathroom, retrieved resident #10's water pitcher, took it into the bathroom, and closed the door. No change of gloves nor handwashing observed. CNA #1 was then observed to exit the bathroom, grab gloves from a box,		Audit will be reviewed during the facility's quarterly assurance meeting and adjusted accordingly. (See exhibit X)	

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	entered the bathroom, exited the bathroom with gloves in his hand, retrieved the wheelchair, and then entered the bathroom with the wheelchair to assist CNA #2 to put the resident into the wheelchair. CNA #1 and CNA #2 was observed with gloves on to transfer resident #10 to bed from the wheelchair. Once Resident #10 was in the bed, CNA #1 positioned pillows behind the resident's back. CNA #2 removed booties from the resident's feet, prompted feet on a pillow, and placed a sheet from the bed over Resident #10's legs. No handwashing was observed nor change of gloves. On 5/20/14 at 3:20 p.m., interview with CNA #2 indicated, when asked when should you handwash. " After resident care, when you use the bathroom, before resident care." Was that done? "I sang the ABC song twice." CNA #2 indicated, when asked when should you change your gloves? "Whenever you mess with the resident, wash hands put on gloves, when you finish you remove gloves and wash hands." Was that done? "No." On 5/20/14 at 3:31 p.m., interview with CNA #1 indicated, when asked when should you handwash? "Before and after dealing with the resident needs, all the			

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	time." When should you change gloves? "After you take them [indicating the residents] to the bathroom or anytime you handling something." Did you do that? " No, I forgot to remove my gloves and wash my hands after coming out of the bathroom." On 5/22/14 at 11:12 a.m., the Nurse Consultant provided "HANDWASHING PROCEDURE" no date, and indicated that was the policy currently used by the facility. The policy indicated, " ... To provide protection for resident and staff when performing direct care procedure. To ensure that hands remain clean so as to assist in maintenance of a clean environment and assist in the prevention of and the transmission of disease and infection. ... SPECIFIC TIMES HANDS MUST BE WASHED: 1. Before and after direct resident contact ... 4. Before and after using the restroom 5. Before and after cleaning any surface area ..." On 5/22/14 at 11:26 a.m., the Nurse Consultant provided "GENERAL INSTRUCTIONS FOR RESIDENT CARE" no date, and indicated that was the policy currently used by the facility. The policy indicated, " ... 4. Disposable			

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	gloves, sterile and non sterile, should be removed and discarded after contact with each resident, fluid item or surface. ...5. Hand-washing should follow policy and procedures of the facility. ..." On 5/23/14 review of the Centers for Disease Control and Prevention dated December 16, 2013, "Handwashing: Clean Hands Save Lives ... When and How to Wash Your Hands ... How should you wash your hands?" indicated "... · Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. · Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails. · Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice. · Rinse your hands well under clean, running water. · Dry your hands using a clean towel or air dry them ..." B). On 5/20/14 at 2:02 p.m., observed the sharps container (used to dispose used sharp items) in the bathroom for room 200 opened and full.			

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	On 5/21/14 at 3:00 p.m., observed the sharps container in the bathroom for room 200 to remain full. On 5/20/14 at 2:10 p.m., interview with LPN #1 indicated when asked who opens the sharps container. "I don't know. I didn't even know they were in here. Housekeeping has the key." When asked if the container should be open. LPN #1 indicated "No, maybe they opened it to empty and got distracted. LPN #1 was observed to lock he sharps container at that time. 3.1-18(l)			
F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review,	F000514	F514 Requires the facility to	06/13/2014

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	the facility failed to ensure the appropriate diagnosis for use of a medication for 1 of 5 residents reviewed for unnecessary medication use, in that a resident had the wrong diagnosis for use of a medication (Resident #24) Findings include: On 5/22/2014 at 10:00 a.m., the clinical record was reviewed for Resident #24. Diagnoses included, but were not limited to, peripheral vascular disease, transient ischemic attacks, and gastroesophageal reflux disease. Medications include, but are not limited to: Plavix 75 mg daily for cholesterol Pletal 50 mg two times daily for PVD (peripheral vascular disease) aspirin 81 mg daily for blood thinner On 5/22/2014 at 10:15 a.m., an interview with the DoN (Director of Nursing) indicated the diagnosis for the use of Plavix should not be high cholesterol. She indicated they generally use it for circulatory problems. On 5/22/2014 at 10:20 a.m., an interview with the pharmacist indicated the correct diagnosis for the use of Plavix would for Resident #24 would be peripheral		ensure the appropriate diagnosis for use of a medication. 1.Resident #24 received a diagnosis of peripheral vascular disease.2. All residents have the potential to be affected. All residents rewrites were reviewed to ensure appropriate diagnosis for use of medication is present. See corrective measures below.3. The staff was in serviced on ensuring that the appropriate diagnosis is present on the telephone order/rewrite when the physician orders a medication. (See exhibit H) The audits will be completed weekly times four weeks, weekly times four weeks, every two weeks times two months then quarterly thereafter until 100% is obtained and maintained. The audit will be reviewed during the quarterly assurance meetings and adjusted as needed. (see exhibit Z)	

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	vascular disease. 3.1-50 (a)(2)			
F009999	3.1-14 PERSONNEL (a). Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure that a criminal background check was obtained before a licensed practical nurse (LPN) worked the floor. (LPN #4). Findings include: On 5/22/14 at 11:00 a.m., review of	F009999	Requires the facility to ensure that a criminal background check was obtained before a licensed practical nurse work's the floor1. LPN #4's criminal background check was in her employee file.2. All employee files were reviewed to ensure criminal background checks are present.3. The office staff was in-serviced regarding the need to obtain a criminal background check prior to an employee working the floor. See Exhibit Z2)4. The Administrator or her designee will review al new hire employee files to ensure a criminal background check is obtained prior to the employee working the floor The audits will be conducted weekly times four weeks, every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. The audits will be reviewed during the facility quarterly assurance meeting and adjustments made accordingly. (See exhibit Z3)	06/13/2014

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	personnel records indicated LPN #4 was hired 2/10/14. Personnel records indicated criminal background check was completed on 2/13/14. Personnel records indicated LPN #4 had direct contact with residents on 2/11/14 and 2/12/14. Records indicated LPN #4 was on the floor with a certified nursing assistant (CNA). Interview on 5/22/14 at 11:50 a.m., with the Administrator indicated, "If we don't get a criminal background check back right away, the employees are allowed to be on the floor supervised. If the background check comes back negative, then we will escort them to the door." On 5/22/14 at 2:10 p.m., the Administrator provided a copy of a "New Employee Policy", dated May 2013, and indicated the form was the one currently being used by the facility. The form indicated, "...Once approved...submit background check information, New Hire Form and the approval to hire from...The facility will receive e-mail from payroll acknowledging background check being ran...Extend a job offer contingent on the employee passing			

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	a post-offer physical examination and favorable background check result...Candidate may start orientation once confirmation has been received that the LCHC has been submitted...If it has been 72 hours and you have not heard back from payroll regarding the results of the requested LCHC, candidate may start on the floor. However, continued employment will be contingent upon a favorable background check result..."			