STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155291		05/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE VALLEY MEADOWS	3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 11,12,13,14, & 15, 2015. Facility number: 000188 Provider number: 155291 AIM number: 100266310 Census bed type: SNF/NF: 101 Total: 101 Census payor type: Medicare: 7 Medicaid: 78 Private: 10 Other: 6 Total: 101 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider is requesting a paper IDR for F371 and F456 as the facility disagrees with the scope and severity of the deficiencies. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey Revisit on or after June 5, 2015.	
F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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			

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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	or her individuality. Based on observation and interview, the facility failed to ensure a dignified experience for participation in meetings for 1 of 2 residents reviewed for dignity (Resident #39 and #16). Findings include: During an observation on 5/15/15 at 1:28 p.m., with the Activity Director present, Resident #39 was observed seated in the main dining in a large Broda chair. This chair was wider than the standard size entry way of the fine dining room. During an observation on 5/15/15 at 1:42 p.m., with the Activity Director present, the fine dining room was observed. The dining room had two doorways in which residents could enter the room.. The doorways were standard size doorways. During an interview on 5/15/15 at 1:43 p.m., Resident #39 indicated she used to attend the council meetings however she had stopped participating because her "wheel chair would not fit in the door." She indicated she could hear what the council discussed from the hallway however she could not participate due to having to sit outside the doorway. She indicted she would like to attend the meetings if the facility would provide a	F 0241	**F241 – Dignity andRespect of Individuality** It is the intent of this provider to promote care for allresidents in a manner and in an environment that maintains or enhances eachresident's dignity and respect in full recognition of his or her individuality. **What correctiveaction(s) will be accomplished for those residents found to have been affectedby the alleged deficient practice?** The resident council meeting was moved to the main dining room. The wheelchairs of resident #39and #16 fit into the doorways of this space. **How will you identifyother residents having the potential to be affected by the same allegeddeficient practice and what corrective action will be taken** Residents with extra-wide wheelchairs have the potential tobe affected by the same alleged deficient practice. All residents with extra-wide wheelchairshave been informed of the new location of resident meetings by the Activity Director. All scheduled activities and meetings for residents will be held in areas that all residents can access. **What measures will beput into place or what systemic changes you will make to ensure that thealleged deficient practice does not recur** All scheduled activities and meetings for residents will beheld in areas that	06/05/2015

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	room that accommodated her chair. During an interview on 5/15/15 at 2:51 p.m., the Executive Director indicated the Activity Director had not informed her of the concern. She indicated the facility did have a room available to accommodate all residents. 2. On 5/15/15 at 1:50 p.m., Resident #16 indicated she attended the council meetings. She indicated she had to "sit outside in the hallway" because her wheel chair was a wide wheel chair and would not "fit through the door." She indicated she preferred to be inside the room at the table with the other residents instead of having to sit outside the door in the hallway. On 5/15/15 at 1:50 p.m., Resident #16's wheel chair was observed in her room. The wheel chair was an oversized, wide wheelchair. This wheel chair was wider than the entry way of the fine dining room. During an interview on 5/15/15 at 1:40 p.m., the Activity Director indicated the facility provided the fine dining room for residents to conduct the council meetings. She indicated Resident #16 had to sit in the hallway outside the doors of the fine dining room because her chair would not		all residents can access. The Activity Director and activity staff was provided education onresident rights. The Activity Director will review the activity calendar monthly to ensure that the schedule is compatible with all residents' wheelchairs. The Executive Director will review the activity calendar monthly to ensure activities and resident meetings are held in spaces that all residents can access. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place** The Activity Director/designee is responsible for completing the Activities CQI tool weekly x four, bi-monthly x two months, and quarterlythereafter for six months. The resultsof these audits will be reviewed by the CQI committee overseen by the ED. Ifthreshold of 95% is not achieved, an action plan will be developed to ensurecompliance. **Compliance date: June5, 2015**	

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	fit through the doorways. She indicated the facility had other rooms which would accommodate residents and allow for privacy. During an interview on 5/15/15 at 2:51 p.m., the Executive Director indicated the Activity Director had not informed her of the concern. She indicated the facility did have a room available to accommodate all residents. 3.1-3(t)			
F 0243 SS=D Bldg. 00	483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings. Based on observation, interview, and record review, the facility failed to ensure a private location for resident groups to meet for 2 of 2 residents (Resident # 39 and #16) reviewed for private meeting space. This deficient practice had the potential to affect all residents who	F 0243	**F243 – Right toParticipate in Resident/Family Group** It is the intent of this facility to allow all residents toorganize and participate in resident groups in the facility; a resident'sfamily has the right to meet in the facility with the families of otherresidents in the facility; the facility must	06/05/2015

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	participated in group meetings. Findings include: 1. During an observation on 5/15/15 at 1:28 p.m., with the Activity Director present, Resident #39 was observed seated in the main dining in a large Broda chair. This chair was wider than the standard size entry way of the fine dining room. During an observation on 5/15/15 at 1:42 p.m., with the Activity Director present, the fine dining room was observed. The dining room had two doorways in which residents could enter the room.. The doorways were standard size doorways. During an interview on 5/15/15 at 1:43 p.m., Resident #39 indicated she used to attend the council meetings however she had stopped participating because her "wheel chair would not fit in the door." She indicated she could hear what the council discussed from the hallway however she could not participate due to having to sit outside the doorway. She indicted she would like to attend the meetings if the facility would provide a room that accommodated her chair. During an interview on 5/15/15 at 2:51 p.m., the Executive Director indicated the		provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings atthe group's invitation; and the facility must provide a designated staff personresponsible for providing assistance and responding to written requests thatresult from group meetings. **What correctiveaction(s) will be accomplished for those residents found to have been affectedby the alleged deficient practice?** The resident council meeting was moved to the main diningroom. The wheelchairs of resident #39and #16 fit into the doorways of this space. **How will you identifyother residents having the potential to be affected by the same allegeddeficient practice and what corrective action will be taken** Residents with extra-wide wheelchairs have the potential tobe affected by the same alleged deficient practice. All residents with extra-wide wheelchairshave been informed of the new location of resident meetings by the Activity Director. All scheduled activities and meetings for residents will be held in areas that all residents can access. **What measures will beput into place or what systemic changes you will make to ensure that thealleged deficient practice does not recur** The Activity Director and activity staff was	

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	Activity Director had not informed her of the concern. She indicated the facility did have a room available to accommodate all residents. 2. On 5/15/15 at 1:50 p.m., Resident #16 indicated she attended the council meetings. She indicated she had to "sit outside in the hallway" because her wheel chair was a wide wheel chair and would not "fit through the door." She indicated she preferred to be inside the room at the table with the other residents instead of having to sit outside the door in the hallway. On 5/15/15 at 1:50 p.m., Resident #16's wheel chair was observed in her room. The wheel chair was an oversized, wide wheelchair. This wheel chair was wider than the entry way of the fine dining room. During an interview on 5/15/15 at 1:40 p.m., the Activity Director indicated the facility provided the fine dining room for residents to conduct the council meetings. She indicated Resident #16 had to sit in the hallway outside the doors of the fine dining room because her chair would not fit through the doorways. She indicated the facility had other rooms which would accommodate residents and allow for privacy.		provided education on resident rights. The Activity Director will ensure the resident council meeting is held in a private space that all residents can access. The Executive Director will review the activity calendar monthly to ensure activities and resident meetings are held in spaces that all residents canaccess. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place** The Activity Director/designee is responsible for completing the Activities CQI tool weekly x four, bi-monthly x two months, and quarterlythereafter for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	During an interview on 5/15/15 at 2:51 p.m., the Executive Director indicated the Activity Director had not informed her of the concern. She indicated the facility did have a room available to accommodate all residents. A policy titled "Resident Council" identified as current by the Executive Director on 5/15/15 at 2:51 p.m., indicated, "...The facility will promote and support the residents' right to participate and organize resident council... Resident Council meetings will be held in a private space...." 3.1.3(i)			
F 0246 SS=D Bldg. 00	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation and interview, the facility failed to ensure a physical environment that accommodated entrance into a meeting location with an over sized wheelchair for 2 of 2 residents reviewed for accommodation of needs (Residents #39 and #16).	F 0246	**F246 ReasonableAccommodation of needs/preferences** It is the intent of this facility to ensure all residents resideand receive services in the facility with reasonable accommodations of individualneeds and preferences, except when the health or safety	06/05/2015

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	Findings include: 1. During an observation on 5/15/15 at 1:28 p.m., with the Activity Director present, Resident #39 was observed seated in the main dining in a large Broda chair. This chair was wider than the standard size entry way of the fine dining room. During an observation on 5/15/15 at 1:42 p.m., with the Activity Director present, the fine dining room was observed. The dining room had two doorways in which residents could enter the room.. The doorways were standard size doorways. During an interview on 5/15/15 at 1:43 p.m., Resident #39 indicated she used to attend the council meetings however she had stopped participating because her "wheel chair would not fit in the door." She indicated she could hear what the council discussed from the hallway however she could not participate due to having to sit outside the doorway. She indicted she would like to attend the meetings if the facility would provide a room that accommodated her chair. During an interview on 5/15/15 at 2:51 p.m., the Executive Director indicated the Activity Director had not informed her of		of the individual orother residents would be endangered. **What correctiveaction(s) will be accomplished for those residents found to have been affectedby the alleged deficient practice?** The resident council meeting location was changed to themain dining room. The wheelchairs of resident#39 and #16 will fit into this space. **How will you identifyother residents having the potential to be affected by the same allegeddeficient practice and what corrective action will be taken** Residents with extra-wide wheelchairs have the potential to be affected by the same alleged deficient practice. All residents with extra-wide wheelchairs have been informed of the new location of resident meetings by the Activity Director. All scheduled activities and meetings for residents will be held in areas that all residents can access. **What measures will beput into place or what systemic changes you will make to ensure that thealleged deficient practice does not recur** The Activity Director and activity staff was provided education on resident rights. The Activity Director will review the activity calendar monthly to ensure that the schedule is compatible with all residents' wheelchairs. The Executive Director will review the activity calendar monthly to	

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	the concern. She indicated the facility did have a room available to accommodate all residents. 2. On 5/15/15 at 1:50 p.m., Resident #16 indicated she attended the council meetings. She indicated she had to "sit outside in the hallway" because her wheel chair was a wide wheel chair and would not "fit through the door." She indicated she preferred to be inside the room at the table with the other residents instead of having to sit outside the door in the hallway. On 5/15/15 at 1:50 p.m., Resident #16's wheel chair was observed in her room. The wheel chair was an oversized, wide wheelchair. This wheel chair was wider than the entry way of the fine dining room. During an interview on 5/15/15 at 1:40 p.m., the Activity Director indicated the facility provided the fine dining room for residents to conduct the council meetings. She indicated Resident #16 had to sit in the hallway outside the doors of the fine dining room because her chair would not fit through the doorways. She indicated the facility had other rooms which would accommodate residents and allow for privacy.		ensure activities and resident meetings are held in spaces that all residents can access. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place** The Executive Director/designee is responsible forcompleting the Accommodation of Needs CQI tool weekly x four, bi-monthly x twomonths, and quarterly thereafter for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved,an action plan will be developed to ensure compliance. **Compliance date: June 5, 2015**	

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	During an interview on 5/15/15 at 2:51 p.m., the Executive Director indicated the Activity Director had not informed her of the concern. She indicated the facility did have a room available to accommodate all residents. The Executive Director indicated a policy regarding accommodation of needs was not available, but indicated it was the facility's practice to accommodate all residents. 3.1-3(v)(1)			
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure adequate hand sanitation for 2 of 2 dining observations. This deficiency had the potential to affect 20 of 20 residents residing on the memory care unit. Findings include: 1. During observations in the memory care dining room on 5/11/15 beginning at 12:43 p.m. and ending at 1:02 p.m., the	F 0371	**F371 –Food Procure, Store/Prepare/Serve – Sanitary** This provider is requesting a paper review IDR because the facility disagrees with the scope of the deficiency. It is the intent of this provider to procure food from sources approved or considered satisfactory by Federal, State or local authorities and to store, prepare, distribute and serve food under sanitary conditions. **Whatcorrective action(s) will be accomplished for those residents found to**	06/05/2015

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	following was observed: Unit Manager (UM) #1 washed her hands for 5 seconds and then delivered a food tray to Resident #102. UM #1 picked up a folding chair and sat next to Resident #4. Next, UM #1 picked up the resident's juice and assisted Resident #4 to drink. Then, UM #1 picked up the resident's fork and assisted the resident to eat. UM #1 was not observed performing adequate hand sanitation during this observation. Certified Nursing Assistant (CNA) #2 washed her hands for 14 seconds and turned off the water with her bare right hand. CNA #2 delivered a food tray to Resident #133, then touched the top of an empty chair next to Resident #133. CNA #2 removed the top bun from the resident's sandwich with her bare hand and added condiments to the sandwich. She returned the top bun to the sandwich with her bare hand. CNA #2 opened a straw and placed it into Resident #133's water. CNA #2 carried a folding chair to Resident #133's table and sat next to Resident #133. She began feeding Resident #133. CNA #2 did not wash her hands between touching items and feeding the resident. Memory Care Facilitator (MCF) washed her hands for 8 seconds. MCF dropped a		**havebeen affected by the deficient practice:** Employees on the memory care unit were educated on hand washing and completed skills validation check off for hand hygiene by the Clinical Education Coordinator. A dining room manager will be assigned to observe dining room service and complete the dining room manager observation checklist. **How other residents having the potential to be affected by the samedeficient practice will be identified and what corrective action(s) will betaken:** Residents residing on the memory care unit have the potential to be affected by this alleged deficient practice. All staff will receive education on hand washing and proper dining room service and complete the hand washing skills validation check off with by the Clinical Education Coordinator. **What measures will be put into place or what systemic changes will bemade to ensure that the deficient practice does not recur:** All staff will receive education on hand washing and proper dining room service and complete the hand washing skills validation check off with the Clinical Education Coordinator. A dining room manager will be assigned to observe dining room service and complete the dining room manager observation checklist for all dining rooms.	

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	cup, picked it up, and placed it by the sink. She picked up a clean cup, filled it with coffee, and gave the cup to Resident #71. Next, she picked up a glass, filled it with orange juice, and gave it to Resident #71. Then, she took Resident #38 to his room. MCF did not wash her hands between touching the contaminated cup and assisting the resident. CNA #2 washed her hands for 17 seconds. CNA #2 sat next to Resident #133 and picked up Resident #133's water glass. CNA #2 did not wash her hands again during this observation. 2. During observations in the memory care dining room on 5/12/15 beginning at 12:19 p.m. and ending at 12:30 p.m., the following was observed: CNA #2 washed her hands for 10 seconds. Then she opened a hot chocolate packet, poured the hot chocolate packet into a cup, poured hot water into the cup, and took the cup to Resident #133. CNA #2 touched the back of Resident #133's chair with her left hand while she held the cup of hot chocolate up to the resident's mouth with her right hand. CNA #2 picked up two dirty cups and a paper plate. She disposed of the plate and placed the dirty cups by the sink. CNA #2 washed her		Any concerns will be corrected immediately and re-education provided. **How the corrective action(s) will be monitored to ensure the deficientpractice will not recur, i.e., what quality assurance program will be put inplace:** The Clinical Education Coordinator/designee is responsible for completing the Infection Control Review CQI tool weekly x four, bi-monthly xtwo months, and quarterly thereafter for six months. The Directorof Nursing/designee will complete the Meal Service Observation CQI weekly x four,bi-monthly x two months, and quarterly thereafter. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **ComplianceDate:** June 5, 2015	

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(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
	hands for 10 seconds. She touched the handle to a rolling kitchen cart with right hand. Next, she picked up a tray and delivered it to Resident #74. CNA #2 touched the plate, and removed the plastic wrap from two cups on the tray. CNA #2 removed the lid to a sippy cup, poured the water from the cup into the sippy cup, and placed the lid back onto the sippy cup. Then, CNA #2 picked up the packets of mayo and mustard and placed them on the resident's plate next to her sandwich. Then, she picked up the empty tray and lid, and placed them on the counter next to the sink. CNA #2 washed her hands for 7 seconds. During an interview on 5/14/15 at 3:50 p.m., UM #1 indicated she knew when to wash her hands and the proper technique for hand washing. During an interview on 5/15/15 at 1:24 p.m., the MCF indicated she knew when to wash her hands and the proper technique for hand washing. On 5/15/15 at 10:45 a.m., the Administrator provided the current hand washing policy, dated 11/14. The policy indicated employees were to wash their hands after touching bare skin, handling soiled surfaces or equipment, and after engaging in other activities that may			

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	contaminate their hands. The policy indicated staff was to scrub their hands with soap and water with friction for a minimum of 20 seconds. The policy indicated employees were to dry their hands with paper towels and to turn off the faucet with a paper towel. 3.1-21(i)(3)			
F 0456 SS=F Bldg. 00	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview, and record review, the facility failed to ensure the kitchen's dishwasher maintained the manufacturer's safe wash cycle temperatures while operated for 2 of 2 wash cycles observed. This deficient practice had the potential to affect 101 of 101 residents. During the initial observation of the kitchen on 5/11/2015 at 9:24 a.m., with the Dietary manager present, Dietary Staff #11 was observed washing a rack of dirty dessert bowls via the high temperature dishwasher. The temperature reached 142 degrees Fahrenheit (F) during the wash cycle.	F 0456	**F456 –Essential Equipment, Safe Operating Condition** This provider is requesting paper review IDR because the facility disagrees with the scope and severity of the deficiency. It is the intent of this provider to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. **Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:** The booster was turned on by staff. The machine did each the appropriate temperature but would not maintain temperature. The machine was immediately shut down at that time. The Maintenance Director was	06/05/2015

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	After the dessert bowls finished the wash/rinse cycle, Dietary Staff #12 was observed removing the dessert dishes and storing them on the drying rack. During an observation on 5 /11/2015 at 9:30 a.m., with the Dietary Manger present, Dietary Staff #11 was observed washing a rack of dirty silverware via the high temperature dishwasher. The temperature reached 146 degrees Fahrenheit during the wash cycle. After the silverware finished the wash/rinse cycle, Dietary Staff #12 was observed removing the silverware and placing them in clean storage containers. During an interview on 5/11/15 at 9:35 a.m., with the Dietary Manager present, Dietary Staff #11 indicated the wash cycle should reach 160 degree Fahrenheit. He further indicated it frequently did not reach 160 degrees Fahrenheit and he would not inform the dietary staff who was responsible for removing and storing the dishes. He indicated "she wouldn't know" however, after it failed to reach the necessary temperatures "a few times" he would inform the Maintenance Director. During an interview on 5/11/2015 at 9:38 a.m., the Dietary Manager indicated the manufacturer instructions for the		notified. SafeCare came in and inspected the machine on 5/12/15 due to the machine not maintaining appropriate temperature. Repairs were made to the machine. The residents were served on paper products until the machine had been repaired. All dishes were re-washed once the machine reached and maintained the appropriate temperature. **How other residents having the potential to be affected by the samedeficient practice will be identified and what corrective action(s) will betaken:** All residents have the potential to be affected by this alleged deficient practice. All dietary staff was educated by the Dietary Manager on the high temperature dish machine and the recording of dish machine temperatures. **What measures will be put into place or what systemic changes will bemade to ensure that the deficient practice does not recur:** All dietary staff was educated by theDietary Manager on the high temperature dish machine and the recording of dishmachine temperatures. The Dietary Manager/designee will check the temperature log during the wash cycle to ensure the temperatures are appropriate. The dietary staff will stop washing immediately if the temperature is incorrect and notify the Dietary Manager and Maintenance if services are needed. The dishes	

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	dishwasher indicated the wash cycle should have reached a temperature of 160 degrees Fahrenheit, which had been printed on the side of the dishwashing machine. She indicated she was unable to manually take a temperature of the wash cycle water temperature. During an interview on 5/11/2015 at 9:45 a.m., the Maintenance Director indicated the heat booster had not been turned on. He further indicated the wash temperatures would not reach the appropriate temperature without it turned on. and it was the responsibility of the dietary staff to turn it on each morning. During an interview on 5/11/15 at 9:47 a.m., the Dietary Manager indicated the dietary staff should have monitored wash cycle temperatures prior to washing dirty dishes after each meal. The DM indicated dietary staff should have informed the Maintenance Director when the dishwasher did not reach the correct wash cycle temperature. A Temperature Chart, dated May 2015, was provided by the Dietary Manager on 5/15/15 at 2:51 p.m. This document indicated wash cycles temperatures for the dishwasher had not been monitored prior to staff washing the dirty breakfast dishes on 5/11/15.		will not be used until properly washed and sanitized. **How the corrective action(s) will be monitored to ensure the deficientpractice will not recur, i.e., what quality assurance program will be put inplace:** The Dietary Manager/designee is responsible for completing the Kitchen Sanitation/Environmental Review tool weekly x four, bi-monthly x two months, and quarterly thereafter for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved,an action plan will be developed to ensure compliance. **ComplianceDate:** June 5, 2015	

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	On 5/15/2015 at 2:51 p.m., the Executive Director provided a policy titled "Recording Dish Machine Temperature/Sanitizer." The policy indicated, "...Dishwashing staff will monitor and record dish machine temperatures and/or sanitizer concentration to assure proper sanitizing of dishes....Staff will be trained to record dish machine temperatures for the wash wash and rinse cycles and the sanitizer concentration (if appropriate) at each meal...." Manufactures instructions for the facility's dishwashing machine were provided by the Executive Director on 5/15/2015 at 3:01 p.m. The instructions indicated, "Hot water sanitizing wash temperature 160 F (71 C [Celsius] min. [minimum]...." 3.1-19(bb)			