

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2013
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NAME OF PROVIDER OR SUPPLIER CLOVERLEAF OF KNIGHTSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: February 17, 18, 19, 20, 21, & 22, 2013</p> <p>Facility Number: 000296 Provider Number: 155542 AIM Number: 100467820</p> <p>Survey Team: Mary Weyls RN TC Teresa Buske RN Laura Brashear RN</p> <p>Census Bed Type: SNF/NF: 90 Total: 90</p> <p>Census Payor Type: Medicare: 18 Medicaid: 45 Other: 27 Total: 90</p> <p>These deficiencies also reflect State Findings in accordance with 410 IAC 16.2.</p> <p>Quality Review was compiled on 03/01/2013 by Brenda Nunan, RN.</p>	F000000	<p>This plan of correction is to serve as Cloverleaf of Knightsville's credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute an admission by Cloverleaf of Knightsville or it's management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</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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F000159 SS=D	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that</p>			

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	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review, the facility failed to ensure residents had access to personal funds in a reasonable time frame for 1 of 2 residents who met the criteria for personal funds and 21 additional residents [Resident #'s 93, 72, 102, 10, 6, 15, 32, 43, 16, 13, 17, 5, 4, 1, 12, 73, 117, 69, 29, 76, 127, 62].</p> <p>Finding includes:</p> <p>On 2/18/13 at 10:11 a.m., Resident #93 was interviewed. The resident indicated he could not withdraw personal money from his account on weekends.</p> <p>On 2/22/13 at 3:00 p.m., the Human Resource Director was interviewed. The staff member indicated she maintained resident funds in a locked cabinet in her office. The staff member indicated the office is locked when she is not there [including weekends] and she and the Administrator were the only staff with</p>	F000159	<p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:F159 I. The Policy on Residents Personal Funds Availability has been created and distributed to all Residents who access Resident trust.II. All residents who utilize Resident trust have the potential to be affected. III. The Policy on Residents Personal Funds Availability has been created and discussed with Resident Trust Manager and after hour Supervisor. Residents were informed during Resident council meeting on 3/5/13 of their rights regarding withdrawal of money on the weekends and whom they are to receive this money from. IV. The Administrator or her designee will follow up with after hour Supervisor and Residents during Resident Council monthly for next 6 months to assure money is assessible on weekends. COMPLIANCE DATE: 03/24/2013</p>	03/24/2013

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	<p>access to the residents' funds.</p> <p>On 2/22/13 at 4:18 p.m., the business office manager provided a list of residents who maintained funds in an account in the facility. The list included names of 22 residents.</p> <p>The Administrator was interviewed on 2/22/13 at 3:34 p.m. The Administrator indicated the facility did not have a policy which addressed maintaining resident funds and did not have a system to provide funds on weekends.</p> <p>3.1-6(f)(1)</p>						

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F000364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview, and record review the facility failed to provide food that was palatable and/or at proper temperature for 7 of 19 residents that met criteria for concerns with food quality and 1 of 1 random interview of resident regarding food temperature (Residents #12, #4, #105, #78, #127, #93, #20, #83).</p> <p>Findings include:</p> <p>1. During initial dining observation on 2/17/13 at 12:05 p.m., the resident rooms trays were observed to be contained on a non-heated food cart. In dining room A, the resident trays were observed to be served from a non-heated food cart and a non-heated thermal cart.</p> <p>2. Upon interview of Resident #93 on 2/18/13 at 10:13 a.m., the resident indicated that the food in the dining room was "always cold."</p> <p>Upon review of the clinical record of</p>	F000364	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F364 Nutritive Value/Appear , Palatable/Prefer Templ.) Residents #12, #4, #105, # 78,#93, #20 and #83 are recieving meals at appropriate temperature. Resident #127 has been discharged home. II.) All residents have the potential to be affected. III.)All meals on A wing and C wing will now be served from a heated holding device. Room trays will also be served off of heated holding device from dining rooms and served at intervals instead of coming from kitchen. An enclosed delivering cart will be used to deliver room trays. Food service Director met with Resident Council regarding plan to resolve cold food complaints and the proposed plan met with approval. IV.) Food Service Director is to follow up with Resident Council to see if</p>	03/24/2013

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	<p>Resident #93 on 2/18/13 at 3 p.m., the documentation indicated the most recent Minimum Data Set (MDS) assessment was completed 1/7/13. The assessment identified the resident was independent in cognitive decision making skills.</p> <p>3. Upon interview of Resident #12 on 2/22/13 at 8:40 a.m., the resident indicated the evening food was usually cold. The resident also indicated the steam table was not used during the evening meal and that she ate in dining room A routinely.</p> <p>Upon review of the clinical record of Resident #12 on 2/22/13 at 11 a.m., the documentation indicated the most recent Minimum Data Set (MDS) assessment was completed 2/1/13. The assessment identified the resident was independent in cognitive decision making skills.</p> <p>4. Upon interview of Resident #4 on 2/20/13 at 10:11 a.m., the resident indicated the food at meals was always warm but not hot and that she had never asked the staff to warm up the food.</p> <p>Upon review of the clinical record of Resident #4 on 2/21/13 at 2 p.m., the</p>		<p>issue is resolved when new plan is implemented. Food Service director will test temp trays three times weekly for 30 days; then weekly for 30 days; then monthly for 6 months. Residents will be routinely interviewed as part of QA/QI. 5 weekly interviews will be conducted rotating on various wings at various meals for 1 month weeks. Then 2 weekly interviews will be conducted on various wings/meals for 1 month and then 1 interview will be conducted on various wings/meals weekly for 4 months. We will be using a questionnaire about food temperature, food quality and food presentation. Food Service Director will obtain audits and questionnaires and provide to Administrator. Administrator to monitor all responses for 6 months.3/24/2013</p>		

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	<p>documentation indicated the most recent Minimum Data Set (MDS) assessment was completed 11/17/12. The assessment identified the resident was moderately independent in cognitive decision making skills. A dietary note dated 2/17/13 identified the resident ate in dining room A and was alert and oriented to person, place, and time.</p> <p>5. Upon interview of Resident #105 on 2/18/13 at 11:07 a.m., the resident indicated that the food was "cold sometimes."</p> <p>Upon review of the clinical record of Resident #105 on 2/22/13 at 11:15 a.m., the documentation indicated the most recent Minimum Data Set (MDS) assessment was completed 1/10/13. The assessment identified the resident as moderately impaired in cognitive decision making skills. A dietary note, dated 1/10/13, indicated the resident ate meals in dining room A.</p> <p>6. Upon interview of Resident #78 on 2/18/13 at 2:17 p.m., the resident indicated the food temperature was cold, especially at supper.</p> <p>Upon review of the clinical record of Resident #78 on 2/22/13 at 1 p.m.,</p>			

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	<p>the documentation indicated the most recent Minimum Data Set (MDS) assessment was completed on 11/15/12. The assessment identified the resident as independent in cognitive decision making skills. A dietary note dated 2/15/13 identified the resident ate meals in dining room A.</p> <p>7. Upon interview of Resident #127 on 2/18/13 at 2:01 p.m., the resident indicated the food was not at proper temperature and that she ate meals in her room. On 2/22/13 at 8:30 a.m., the resident indicated her breakfast was cold this a.m. The resident also indicated all meals were cold and that once staff deliver the tray "they don't come back in" when asked if she had requested staff to warm food. Upon interview of the resident on 2/22/13 at 12:05 p.m., the resident indicated the food was warm but not hot.</p> <p>Upon review of the clinical record of Resident #127 on 2/22/13 at 2 p.m., the documentation indicated the most recent Minimum Data Set (MDS) assessment was completed on 1/20/13. The assessment identified the resident as independent in cognitive decision making skills.</p> <p>8. During interview of resident #83 on</p>			

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	<p>2/21/13 at 2:30 p.m., the resident indicated the food was not always warm enough when delivered to her room.</p> <p>During interview with resident #83, on 2/22/13 at 12:25 p.m., while resident was eating lunch meal in the resident room, the resident stated "not very hot."</p> <p>Resident #83's clinical record was reviewed on 2/22/13 at 3 p.m. An admission assessment dated 12/22/12, indicated the resident independent for cognitive decision making skills.</p> <p>9. During interview of resident #20 on 2/18/13 at 11:02 a.m., the resident indicated food was sometime cold. The resident indicated meals were eaten in the resident's room.</p> <p>Resident #20's clinical record was reviewed on 2/21/13 2 p.m. An admission assessment dated, 2/7/13, indicated the resident was moderately impaired for cognitive decision making.</p> <p>10. On 2/22/13 at 11:49 a.m., the first set of resident room trays were observed to be delivered to Unit C on a non-heated food cart. The food</p>				

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	<p>temperatures of the last tray to be served from the food cart were obtained. The temperatures were as follows: Fish- 109.7 degrees Fahrenheit; Potato wedges- 115 degrees Fahrenheit; Green beans- 113.4 degrees Fahrenheit. The food was tasted and the food temperatures were noted to warm but not hot.</p> <p>11. Upon review of the Resident Council Minutes on 2/21/13 at 3:20 p.m., the minutes were noted with concerns of food temperature on 9/14/12 and 2/5/13. The minutes for 9/14/12 indicated concerns with cold food on hall trays for Unit B. The minutes for 2/5/13 indicated concerns with cold spaghetti over the weekend.</p> <p>During interview of the Food Service Supervisor (FSS) on 2/21/13 at 3:20 p.m., the FSS indicated in September 2012 she discussed timing of the delivery of hall trays and that she had not had any further concerns. The FSS indicated regarding the concerns on 2/5/13 that she had completed test trays on the halls as well as the dining room and concerns had not been identified. The FSS indicated the facility utilized thermal top and bottoms for each resident plate.</p>			

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	3.1-21(a)(2)			

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to store, prepare and serve food under sanitary conditions for 1 of 2 kitchen observations. This had the potential to affect 2 of 90 residents of the facility.</p> <p>Findings include:</p> <p>On 2/17/13 at 11:45 a.m., the kitchen was observed. The handwashing sink was noted with soiled dark and pink substances covering the interior and exterior surfaces. The paper towel dispenser attached to the wall above the sink had dried substances on the exterior. A two drawer plastic storage container on bottom shelf of a counter with mixers, toaster, and puree machine on top had a heavily soiled exterior. The exterior of the stove had a heavy buildup of spillage. The top of the 'Southbend' oven had a heavy accumulation of debris on the top of the oven. A metal counter adjacent to the steam table had a</p>	F000371	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 371 Food Procure, Store/prepare/serve-SanitaryI.) Handwashing sink, paper towel dispenser, two drawyer plastic container, exterior of stove, top of southbend oven metal counter shelf on bottm and drawer with scoops have all been thoroughly cleaned and inspected. Dietary aides and cooks have been reeducated on proper glove use, proper handling of dinnerware, temperatures and proper storage of dishes.II.) All Residents have the potential to be affected. III.)All food service personnel have been re-educated regarding preparing and serving foods, cleaning schedules and expectations of the cleaning schedules. An updated</p>	03/24/2013			

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	<p>green plastic matt on the bottom shelf. Crumbs and spillage were observed on the matt. Large cooking pots were stored upside down on the matt. A drawer containing serving scoops was open and had an accumulation of crumbs on the interior.</p> <p>On 2/22/13 at 4:55 p.m., the Dietary Manager indicated the drawer that contained the scoops was broken and needed work done so it would open and close correctly.</p> <p>A dietary aide was observed serving meals from the steam table. The aide was observed to touch the interior plate surfaces with bare hands and to touch uniform and other surfaces without washing hands or utilizing gloves. Three divided plates on the steam table shelf utilized for meal service were observed with wet interiors.</p> <p>The floor of the walk in freezer was observed covered with packages of food. The Dietary Manager indicated staff were in the process of doing the inventory. A package of food was opened and spilling on to the floor. The Dietary Manager indicated it was pancakes and would be discarded. The Manager removed the bag and</p>		<p>cleaning list has been created to increase the frequency of cleaning. IV.) The Food Service Director or her designee is completing a quality improvement audit of the cleanliness, serving techniques and proper storage of dinnerware three times weekly for 30 days;then weekly for 30 days;then monthly for 6 months. Results of all audits are being reviewed monthly by the facility's quality assurance committee for additional recommendations as necessary.Completion Date:3/24/2013</p>		

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	discarded it. On 2/22/13 at 4:55 p.m. the Dietary Manager provided a log of the cleaning schedule. The silverware drawer, and shelving were on the weekly schedule and were documented as done on 2/17/13. The top of the oven was also on the weekly schedule and was documented as done on 2/18/13. 3.1-(i)(3)				

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on observation, record review and interview the facility failed to ensure resident medication regimens were reviewed at least monthly by a licensed pharmacy for 2 of 6 residents, reviewed for unnecessary medication use (Resident #'s 99 and 67).</p> <p>Findings include:</p> <p>1. Resident # 99's clinical record was reviewed on 2/21/13 at 10 a.m. An admission date was noted of 1/15/13. Documentation of a pharmacist review of the resident's drug regimen was not noted.</p> <p>During interview of the Director of Nursing (DON) on 2/22/13 at 3:34 p.m., the DON indicated she spoke with the pharmacist responsible for reviewing the resident's medication regimen. The DON indicated the pharmacist reviewed the residents residing on Unit C (including resident</p>	F000428	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F-428-Drug Regimen Review, Report Irregular, Act On Residents #67 and #99 were promptly assessed for unnecessary medications in regards to medication regimen review by consultant pharmacist on 2/28/2013. At that time, all resident medication regimens were reviewed as well, and compared to resident roster of all current residents at Cloverleaf facility. No additional irregularities were found, and all current residents at Cloverleaf facility have medication regimen reviews in place per policy. In addition, consultant pharmacist was re-educated regarding policy entitled "Medication Regimen Review (monthly report)". Pharmacy consultant is now</p>	03/24/2013			

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	<p>of Resident #67 on 2/22/13 at 2:30 p.m., documentation indicated the resident was admitted to the facility on 10/22/12 and readmitted on 12/20/12. The physician order sheets for January 2013 and February 2013 were lacking documentation of pharmacist review of medications.</p> <p>Upon interview of the Director of Nursing (DON) on 2/22/13 at 3:36 p.m., the DON indicated she had spoken with the facility pharmacist and the pharmacist indicated the resident's medications had been reviewed as follows: 11/14/12- reviewed with no recommendations; 12/2012- the resident was not reviewed as returned to facility after pharmacist visit; 1/24/13- the resident was not reviewed due to chart was not available; and 2/20/13- to be reviewed in the upcoming week.</p> <p>During review of an undated facility policy titled, "Unnecessary Drugs-Monitoring" received on 2/22/13 at 5:40 p.m. from the Director of Nursing (DON)documentation indicated, "...The Pharmacist is responsible for reviewing the resident's medication regimen monthly to help identify and report irregularities associated with the use of medications...."</p>			

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	3.1-25(h)				

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (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 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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to</p>	F000441	Preparation and/or execution of this plan does not constitute	03/24/2013	

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	<p>ensure proper sanitation of a multiple resident use blood glucose accucheck meter for 1 of 3 random observations of checking residents' blood glucose levels [Resident #69].</p> <p>Finding includes:</p> <p>On 2/21/13 at 11:00 a.m., RN #1 was observed to perform a blood glucose test for Resident #69. The RN entered the resident's room with a plastic basket containing finger stick lancets, alcohol swabs, and a glucometer placed on top of the supplies in the basket. The RN removed the meter, wiped it with an alcohol swab, and placed it on the resident's over the bed table. The RN donned gloves, swabbed the resident's finger with another alcohol swab, wiped the puncture site with a tissue, picked up the meter with the test strip inserted into the meter, and placed a drop of blood from the resident on to the strip. The RN held the tissue on the puncture site. With the same gloves on the RN wiped the meter with another alcohol swab, placed the meter back into the basket on top of the lancets, removed gloves, exited the room, returned to the medication cart and put the basket in a drawer of the cart.</p>		<p>admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F-441-INFECTIO CONTROL, PREVENT SPREAD, LINENS I.) Resident #69 has been reassessed with no negative outcomes from the alleged deficient practice. RN #1 has had one on one re-education/coaching on proper glucometer use and cleaning practices. II.) Facility resident's records audit was completed to identify those residents receiving glucose monitoring. IDT reviewed those residents for possible negative outcomes. None were found. Policy for "Use, cleaning, storage of Microdot meter" has been updated to provide more clarification for staff as to process. DON/designee will provide in-service education to licensed staff on all aspects of use/best practice in glucometer use, as well as proper handling, cleaning and storage of glucose meters. III.) Regional Director of Clinical Operations updated and revised policy on "Use, cleaning and storage of Microdot meter". Updated policy reviewed with DON/Administrator for staff education. The clinical staff will be in-serviced on updated policy/procedure. IV.) The Director of Nursing/designee will</p>	

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	<p>During interview of the Director of Nursing (DON) on 2/22/13 at 11:00 a.m., the DON indicated RN #1 was responsible for the blood glucose testing on B west. The DON indicated three residents required blood glucose testing on B west. The DON indicated the RN that performed an incorrect cleansing of the glucometer was a PRN (as needed) employee.</p> <p>A facility policy titled "Use, Cleaning and Storage of Microdot Meter," [no date], provided by the Director of Nursing {DON} on, 2/22/13 at 3:30 p.m., included, but was not limited to, "Proper use, cleaning and storage of Microdot Meter is imperative in spreading the spread of infection within the facility. Policy Interpretation and Implementation 1. The Microdot Meter is kept in clean, disinfected conditions in its storage bag inside the med [medication] cart when not in use...3. When performing glucose testing, take meter to the resident bedside, never lay the meter in the bed or anywhere on the resident when in use. Instead, lay paper towel or other clean barrier on the bedside table, and place meter on clean barrier. 4. After obtaining glucose reading, the unit should be wiped clean with antiseptic wipe, air dried,</p>		<p>audit/observe at least three clinical staff performing glucose monitoring daily (to include all three shifts) x 5days/week for 4 weeks, then weekly for 4 weeks, then monthly x 4 months. Any staff found/observed will be further educated until staff compliance achieved. Thereafter, will be monitored quarterly and results will be reported and reviewed per QA meeting process. Date of compliance: 3/24/2013</p>		

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	<p>and replaced back into the storage bag and placed in med cart..."</p> <p>On 2/22/13 at 4:35 p.m., the DON was interviewed. The DON indicated the facility utilizes the disinfecting product "Sani-Cloth" to cleanse the meters. Information on the product's label indicated the product was for cleaning and decontamination against HIV-1, [Human Immunodeficiency Virus], Hepatitis B Virus, [HBV], Hepatitis C Virus [HCV] of surfaces/objects soiled with blood/body fluids. "Cleaning procedure: All blood and other body fluids must be thoroughly cleaned from surfaces and objects before disinfection by the germicidal wipe. Open, unfold and use first germicidal wipe to remove heavy soil. ..Contact time: Use germicidal wipe to thoroughly wet surface. Allow to remain wet two (2) minutes, let air dry. although efficacy at a two (2) minute contact time has been shown to be adequate against HIV-1, HBV, and HCV this time is not sufficient for the other organisms listed on this label. Therefore a three (3) minute wet contact time must be used for other listed organisms, five (5) minutes for TB [tuberculoses.]</p> <p>3.1-18(l)</p>			

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F000458 SS=D	<p>483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.</p> <p>Based on interview the facility failed to provide at least 80 square feet (sq ft) per resident in a multiple resident room. This was evidenced in 1 of 50 rooms in the facility. Room #14.</p> <p>Finding includes.</p> <p>Resident room #14 was observed during finial tour on 02/17/13 at 11:30 a.m. The room was identified as having a waiver for room variance by the Administrator during a phone interview on 02/25/2013 at 1 p.m.</p> <p>Room measurements provided by the Maintenance Supervisor on 2/22/13 at 2 p.m. and identified as unchanged from the previous measure date of 12/17/10 at 11:10 a.m., indicated resident room #14 had 3 beds in 225 square feet with 75 square foot per resident.</p> <p>3.1-19(l)(2)</p>	F000458	<p>F458 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQUARE FEET/RESIDENT</p> <p>It is the policy of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done.</p> <p>SNF/NF Room 14, three resident bed, 216 square feet, equaled 71.5 sq feet per resident No other rooms are identified.</p> <p>A letter for room waiver was provided on 3/21/13 Completion date: 03/24/2013</p>	03/24/2013

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