

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2014
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NAME OF PROVIDER OR SUPPLIER RURAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN 46218
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 10, 11, 12, 13, and 14, 2014</p> <p>Facility number: 000388 Provider number: 155807 AIM number: 100454140</p> <p>Survey Team: Tom Stauss, RN-TC Beth Walsh, RN Karina Gates, Medical Surveyor Courtney Mujic, RN (March 12, 13, and 14, 2014)</p> <p>Census bed type: SNF/NF: 45 Total: 45</p> <p>Census payor type: Medicare: 3 Medicaid: 41 Other: 1 Total: 45</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March</p>	F000000	<p>This plan of correction is to serve as Rural Health Care Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Rural Health Care Center or its 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>	
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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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	24, 2014; by Kimberly Perigo, RN.			

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to revise residents' care plans to the current interventions for a contracture, impaired mobility, fall risk and hospice services. This affected 2 of 15 residents reviewed for care plans. (Resident #11 and #34)</p> <p>Findings include:</p> <p>1a. The clinical record for Resident #11 was reviewed 3/13/14 at 11:00 a.m. The diagnoses for Resident #11 included, but were not limited to, right hemiplegia (paralysis) and multiple orthopedic problems.</p>	F000280	<p>I. Resident #11 and #34's care plans have been reviewed and revised to reflect current interventions.II. All residents' MDS, fall risk assessments and POS were reviewed to identify those with impaired mobility, those at risk for contractures and/or falls and those with hospice orders. Those identified are at risk to be affected.III. All identified residents' care plans were reviewed and revised to reflect current interventions. All care plans were reviewed and revised to reflect current interventions. The MDS/Care Plan Coordinator will be reeducated on proper revision of care plans to assure</p>	04/11/2014			

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	<p>A contracture (permanent shortening of muscle/joint) care plan, with a revision date of 2/11/14 and remained current at time of review, indicated an intervention of, "provide ROM [range of motion] exercises [exercises done to preserve flexibility and mobility] to the affected extremities [sic] q [each] shift [sic] 3 sets of 10 reps [repetitions]." The intervention was dated 8/6/12.</p> <p>A document titled, Restorative Care Plan and Charting, dated 2/1/14 to 2/28/14, indicated a goal of tolerating, "...PROM [passive range of motion-movement of the joint with no effort from resident] to Rt [right] arm without c/o [complaint of] pain 2 times a day..." The document also was dated for each day of the month with initials of the CNAs that performed PROM on day and evening shift. Night shift was not listed on the document.</p> <p>During an interview with the Restorative CNA #7, on 3/13/14 at 10:32 a.m., she indicated Resident #11 was only getting PROM twice a day according to the document above.</p> <p>On 3/13/14, at 10:49 a.m., the ADoN</p>		<p>each care plan reflects current interventions.VI. The DON or designee will review care plans during daily IDT meetings to assure new orders or interventions are appropriately updated in each resident's care plan. The Don or designee will review completed care plans following MDS assessments to assure completed care plans accurately reflect current interventions. Don or designee will report to QA monthly for 3 months or until 100% compliance is achieved.</p>	
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	<p>(Assistant Director of Nursing) indicated he was unable to locate documentation that ROM exercises were done each shift. He also indicated the care plan was not updated to reflect the PROM/ROM were being done, as written, for Resident #11.</p> <p>At 11:50 a.m., on 3/13/14, the MDS Coordinator indicated it was an oversight and the care plan had not updated.</p> <p>1b. A review of a impaired mobility care plan, with a revision date of 2/11/14 and remained current during review, indicated an intervention of, "apply splint to Rt. wrist/hand per OT [occupational therapy] dly [daily]." The intervention was dated 8/6/12.</p> <p>During an interview with the Restorative CNA #7, on 3/13/14 at 10:32 a.m., she indicated Resident #11 had not worn his splint for a really long time. She further indicated Resident #11 refused to wear the splint and would hide it, so he wouldn't have to wear it.</p> <p>During the following observations, Resident #11 was not wearing a splint: 3/13/14 at 12:10 p.m.</p>						

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	<p>3/13/14 at 1:42 p.m. 3/13/14 at 2:54 p.m.</p> <p>The MDS Coordinator indicated, on 3/13/14 at 11:50 a.m., she knew Resident #11 was not wearing his splint and it was an oversight on revising the care plan, with an intervention indicating the Resident's refusal to wear the splint.</p> <p>2a. The clinical record for Resident #34 was reviewed 3/13/14 at 11:30 a.m. The diagnoses for Resident #34 included, but were not limited to, dementia with behavior disturbance, schizophrenia, history of hip fracture, malnutrition, and osteoporosis.</p> <p>A current fall care plan had the following interventions: "Make sure the water pitcher is close to the bedside and within the resident's reach...Remove w/c [wheelchair] from room when the resident is in bed...personal items within reach..." All interventions were dated 8/3/12 and remained current at time of the review.</p> <p>During an interview with the DoN (Director Nursing), on 3/13/14 at 2:56 p.m., she indicated she does not know why the intervention with water was on the care plan, because</p>				

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	<p>Resident #34 only drinks grape juice. She also indicated she doesn't know why the wheelchair intervention was on the care plan either, because the Resident does not try to transfer himself to his wheelchair. The Resident does not have any personal items that he would like next to him, so that intervention should not be on the care plan. The Fall Care Plan needed to be revised to reflect current interventions needed for the Resident.</p> <p>A policy titled Fall Prevention and Assessment, dated 9/12, was received from the DoN on 3/13/14 at 10:20 a.m. The policy indicated, "...3. If interventions have been successful in preventing falling, the staff will continue with current approaches or reconsider whether these measures are still needed..."</p>			

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>2b. Physician's orders, dated 2/26/2014, indicated an order for Hospice services to evaluate and treat Resident #34. A care plan, dated 12/10/13, indicated Southern Hospice care is providing current hospice services to resident #34.</p> <p>On 3/13/2014 at 10:52 a.m., during an interview, the DON (Director of Nursing) indicated Resident #34's care plans were "not specific enough" in regard to hospice services provided to Resident #34. She indicated the facility care plan should list how many times a week skilled nursing and/or CNA (certified nursing</p>	F000280	<p>I. Resident #11 and #34's care plans have been reviewed and revised to reflect current interventions.II. All residents' MDS, fall risk assessments and POS were reviewed to identify those with impaired mobility, those at risk for contractures and/or falls and those with hospice orders. Those identified are at risk to be affected.III. All identified residents' care plans were reviewed and revised to reflect current interventions. All care plans were reviewed and revised to reflect current interventions. The MDS/Care Plan Coordinator will be reeducated on proper revision of care plans to assure</p>	04/11/2014

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	<p>assistant) services were being provided by hospice to Resident #34.</p> <p>On 3/13/14 at 11:16 a.m., during an interview, the MDS (minimum data set) Coordinator indicated Resident #34's hospice care plan does not list how many times hospice service was being performed on a weekly basis, but she indicated the care plan should indicate the same.</p> <p>On 3/13/14 at 11:26 a.m., a hospice vendor's CNA indicated Resident #34 receives two CNA visits from hospice each week. Resident #34 receives visits from her or other hospice CNAs every Tuesday and Thursday. She indicated she completed a visit that morning with Resident #34.</p> <p>Hospice records titled, "Visit Note Report" were reviewed on 3/13/14 at 2:07 p.m. The report indicated visits by a hospice CNA were performed on multiple dates in January and February of 2014. Those dates included, but were not limited to, January 8th, 14th, 21st, 23rd, 28th, and 30th of 2014, and February 4th, 11th, 18th, 20th, 25th, and 27th of 2014.</p> <p>The record also indicated visits to Resident #34 by a hospice nurse</p>		<p>each care plan reflects current interventions.VI. The DON or designee will review care plans during daily IDT meetings to assure new orders or interventions are appropriately updated in each resident's care plan. The Don or designee will review completed care plans following MDS assessments to assure completed care plans accurately reflect current interventions. Don or designee will report to QA monthly for 3 months or until 100% compliance is achieved.</p>				

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	<p>were performed on January 10th, 17th, 24th, and 31st of 2014, and February 14th and 21st of 2014.</p> <p>An MDS assessment (minimum data set), dated 12/19/13, indicated Resident #34 was receiving hospice care while in the facility.</p> <p>3.1-35(d)(2)(B)</p>			

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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure medications and chemicals were kept out of residents' reach as indicated by the facility policy for 2 independently and cognitively impaired residents of 45 residents in the facility and failed to ensure a fall care plan intervention was in place for a resident that had a recent fall for 1 of 1 resident reviewed for falls in a sample of 1 resident who met the criteria for accidents. (Resident #10, #44, and #34)</p> <p>Findings include:</p> <p>1) A tour of the facility was conducted on 3/10/14 at 11:45 a.m. The Housekeeping/Maintenance Door was observed open. Behind this door was the Housekeeping Office, Maintenance Office, and Laundry Room. The Housekeeping Office door was wide open. Inside the top left drawer of the desk were 2 vials of insulin and 2 syringes. The following chemicals were on a</p>	F000323	<p>I. Resident #10 and #44 are navigating the facility without exposure to unsecured chemicals. Resident #34's care plans was reviewed and updated to reflect current fall interventions. II. All storage areas were inspected for proper door closure and locking. All resident fall risk assessments were reviewed to identify those at risk to be affected. All residents' MDS assessments were reviewed for cognition and mobility to identify those at risk to be affected. III. All storage area doors were inspected and found to close properly with proper locking devices in place. All staff will be reeducated on proper storage of chemicals. All care plans for those identified with fall reisk factors were updated to reflect current fall interventions. All nurses and CNAs will be reeducated on the provision of interventions according to each resident's care plan. IV. The Administrator or designee will monitor chemical storage areas daily during walking rounds and will address any identified deficiencies in practice immediately. DON or Designee</p>	04/11/2014	

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	<p>multi-shelf rack:</p> <p>3 bottles of 1 gallon bleach 1 gallon of multiuse cleaner and deodorizer Two 1.12 gallons of Pine Sol Four 12 oz. cans of Clear Vision glass cleaner Two 19 oz. cans of Raid Flying insect killer 1 gallon of Window Magic One 6.17 oz. can of Neutra Air refill</p> <p>The Administrator provided copies of the MSDS (Material Safety Data Sheets) for the above chemicals on 3/11/14 at 2:00 p.m.</p> <p>The Flying Insect Killer MSDS indicated, "Caution: Harmful if absorbed through the skin. Avoid contact with skin, eyes and clothing."</p> <p>The Lysol Neutra Air MSDS indicated, "DANGER: FLAMMABLE. HARMFUL OR FATAL IF SWALLOWED. EYE IRRITANT. May be harmful if directly inhaled..."</p> <p>The Lavender Clean Pine-Sol and the Mandarin Sunrise Pine-Sol MSDS indicated, "Eye irritant...EYE CONTACT: Immediately rinse with water for 15 minutes. If irritation persists, call a doctor. INGESTION:</p>		<p>will audit fall intervention provision weekly for 4 weeks and monthly for 2 months or until 100% compliance is achieved. The Administrator, DON or designees will report findings to QA monthly for 3 months or until 100% compliance is achieve.</p>				

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	<p>Drink a glassful of water. Call a doctor or poison control center. SKIN CONTACT: Rinse with plenty of water. If irritation persists, call a doctor. INHALATION: Move person to fresh air. If breathing problems develop, call a doctor."</p> <p>The Sunbrite Bleach MSDS indicated, "EXPOSURE/HEALTH EFFECTS: INHALATION: Respiratory tract irritant. INGESTION: Can cause corrosion of the mucous membranes. IF SWALLOWED: Call poison control center or doctor immediately for treatment advice...SKIN CONTACT: Contact with liquid can cause chemical burns...EYE CONTACT:..Call a poison control center or doctor for treatment advice."</p> <p>The Clear Vision Glass Cleaner MSDS indicated, "Eyes: Causes severe irritation, redness, tearing and blurred vision. May cause corneal inflammation. Skin: Frequent or prolonged contact may cause irritation and possibly dermatitis. May aggravate existing skin conditions. Inhalation: Inhalation of mist can cause irritation of nasal and respiratory passages. Abusive or excessive inhalation may cause</p>			

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	<p>irritation to the upper respiratory tract, dizziness, headache, nausea and other central nervous system effects. Ingestion: Can cause gastrointestinal irritation, nausea, vomiting and diarrhea. Aspiration of material into the lungs can cause pulmonary injury."</p> <p>The Maintenance Office door was closed, but unlocked. It contained two drills and a large toolbox full of small screws, nuts, and bolts.</p> <p>The Laundry Room door was open and Housekeeper #1 was present, folding laundry with the dryer running. An interview was conducted with Housekeeper #1 on 3/10/14 at 11:52 a.m., regarding the unlocked door. She stated, "That door is usually shut. They must have left it cracked when they left." Regarding whether she was aware anyone else was present, she stated, "No, I didn't know [anyone] was back here until [they] came and talked to me. I can't hear. The dryer is running." The dryer was running very loudly at that time.</p> <p>An interview was conducted with the Administrator on 3/11/14 at 11:48 a.m., regarding the unlocked door. He stated, "Those doors should be</p>						

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	<p>locked at all times, because we don't need anyone back there getting chemicals. The insulin belongs to one of the housekeepers. She's diabetic."</p> <p>The Administrator provided a copy of a policy entitled "Locked Door Policy" on 3/11/14 at 2:00 p.m. The policy indicated, "It is the policy of [name of facility] to keep our resident's safe at all times. Chemicals must be kept out of residents reach at all times, either on a locked cart or behind locked doors in the service hallway. All doors are to be locked and remain locked including exit doors, unoccupied staff offices, bathrooms, laundry rooms, kitchen, soiled utility rooms, therapy room and pantry. Under no circumstances can any door be propped open."</p> <p>The Administrator provided a list of cognitively impaired mobile residents in the facility. It included Resident #10 and Resident #44.</p>				

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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>2) The clinical record for Resident #34 was reviewed 3/13/14 at 11:30 a.m. The diagnoses for Resident #34 included, but were not limited to, dementia with behavior disturbance, schizophrenia, history of hip fracture, and osteoporosis. Resident #34 had a fall on 3/11/14.</p> <p>A fall care plan, dated 1/7/14 and was current at the time of review, had an intervention of, "...Place the call light within easy reach..." The intervention was dated 8/3/12.</p> <p>During the following observations, the call light was observed at the foot of the Resident's bed and was out of "easy" reach, while the Resident was in bed: 3/13/14 at 12:16 p.m. 3/13/14 at 1:43 p.m. 3/13/14 at 2:56 p.m.</p> <p>During an interview with the Director of Nursing (DoN), on 3/13/14 at 2:56 p.m., the DoN indicated the call light</p>	F000323	<p>I. Resident #10 and #44 are navigating the facility without exposure to unsecured chemicals. Resident #34's care plans was reviewed and updated to reflect current fall interventions. II. All storage areas were inspected for proper door closure and locking. All resident fall risk assessments were reviewed to identify those at risk to be affected. All residents' MDS assessments were reviewed for cognition and mobility to identify those at risk to be affected. III. All storage area doors were inspected and found to close properly with proper locking devices in place. All staff will be reeducated on proper storage of chemicals. All care plans for those identified with fall reisk factors were updated to reflect current fall interventions. All nurses and CNAs will be reeducated on the provision of interventions according to each resident's care plan. IV. The Administrator or designee will monitor chemical storage areas daily during walking rounds and will address any identified deficiencies in practice immediately. DON or Designee</p>	04/11/2014			

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	<p>should be in reach of the Resident and with the call light at the foot of the bed, the Resident was unable to reach the call light.</p> <p>On 3/14/14 at 9:40 a.m., the Resident was observed up in his wheelchair in the middle of the room. The call light was observed in the middle of the bed. The call light was not in easy reach of the resident.</p> <p>A policy titled, Fall Prevention and Assessment, dated 9/12, was received from the DoN on 3/13/14 at 10:20 a.m. The policy indicated, "...2...staff will try various relevant interventions..."</p> <p>3.1-45(a)(1) 3.1-45 (a)(2)</p>		<p>will audit fall intervention provision weekly for 4 weeks and monthly for 2 months or until 100% compliance is achieved. The Administrator, DON or designees will report findings to QA monthly for 3 months or until 100% compliance is achieve.</p>	

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F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5% for 2 of 12 residents observed during medication administration in that medications were not given according to their prescribed time. Two medication errors were observed during 25 opportunities for error, resulting in an 8% medication error rate. (Resident #'s 42, 40)</p> <p>Findings include:</p> <p>1. An MD (Medical Doctor) order for Resident #42, dated 2/16/2011, indicated, "Tramadol HCL/ Ultram [a pain relieving medication] 50 mg tablet, take two tablets [100 mg] by mouth every 8 hours...6 am, 2 pm, 10 pm."</p> <p>An observation, on 3/13/2014 at 12:11 pm, indicated QMA #1 administered two tablets of Ultram 50 mg pain reliever to Resident #42 during his lunch time meal. The pain relieving medication was given before the scheduled order time of 2 pm.</p>	F000332	<p>I. Resident #42 and #40 are receiving medications as prescribed. QMA #1 was reeducated on proper medication administration. II. All resident Physician's Orders were reviewed to identify those at risk to be affected. III. All nurses and QMAs will be reeducated on proper medication administration including but not limited to; right to administer medications. IV. The DON or designee will conduct random unannounced medication pass audits weekly for four weeks and monthly for 2 months or until 100% compliance is achieved. DON or designee will report to QA monthly x's 3 or until 100% compliance is achieved.</p>	04/11/2014			

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	<p>2. An MD order for Resident #40, dated 9/25/2013, indicated, "Hydroc/Apap/Norco [a pain relieving medication] 7.5-325 tablet, take two tablets (15/325 mg) by mouth every 8 hours scheduled...6 am, 2 pm, 10 pm."</p> <p>An observation, on 3/13/2014 at 12:03 pm, indicated, QMA #1 administered two tablets of Norco 7.5/325 mg pain reliever to Resident #40 during his lunch time meal. The pain relieving medication was given before the scheduled order time of 2 pm.</p> <p>An interview with the Director of Nursing, on 3/14/2014 at 12:35 pm, indicated it is her expectation that medications are given on time. She indicated she will have both of the medication orders updated, so the time given is changed and the resident's can continue to take the pain relieving medications at lunch.</p> <p>3.1-48(c)(1)</p>				

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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 ensure proper sanitization of dishes, cover facial hair while in the kitchen, and clean sprinklers above the stove. This affected 42 residents who eat food from the kitchen of 45 residents in the facility.</p> <p>Findings include:</p> <p>A tour of kitchen was conducted on 3/10/14 at 12:30 p.m. The DM (Dietary Manager) was present during this tour.</p> <p>The dishwasher indicated sanitization of the dishes was chemical. Regarding whether a sanitization test could be performed, the DM indicated, "We've been needing strips [sanitization test strips] for a week now, so I haven't been able to test for sanitization. The [name of dishwasher manufacturer] guy said they'd be here today or Wednesday." Regarding how proper sanitization of</p>	F000371	<p>I. Sanitizer test strips have been delivered and are being used to assure proper chemical levels are present to sanitize dishes. The stove head sprinklers have been cleaned. The Dietary Manager is wearing a beard cover at all times.II. All resident's Physician Orders were reviewed and those who receive food from the kitchen were identified as at risk.III. The Dietary Manager and all kitchen staff will be reeducated on proper testing of dish sanitizer. The Dietary Manager will be reeducated on proper covering for facial hair and proper cleaning of hood sprinklers. A dishwasher chemical test log was drafted and implemented. A kitchen cleaning schedule and log was drafted and implemented which include but is not limited to hood sprinklers.IV. The Administrator or designee will conduct random unannounced audits of dishwasher chemical testing, hair covering and hood sprinkler cleanliness weekly for 4 weeks and Monthly for 2 months or until 100% compliance is achieved. The Administrator will report to QA monthly for 3 months or until 100% compliance</p>	04/11/2014			

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	<p>dishes was ensured, the DM indicated, "I've just been making sure the lines are running right."</p> <p>The stove hood was observed with 3 sprinklers, caked with with dust, hanging directly above the stove. At that time, the DM looked at a sticker on the front of the stove hood and stated, "This gets cleaned every 6 months. It looks like November of 2013 was the last time." He stated, "Next time will be May, 2013. We haven't been cleaning the sprinklers when we do the hood. Maintenance used to, but he's gone, so I guess I'll have to start doing it."</p> <p>The DM was observed with a beard, not covered. He stated, 'I don't wear a beard protector unless I'm cooking or handling food."</p> <p>The Dietary Dishwashing Policy was provided by the Administrator on 3/11/14 at 2:00. The policy indicated, "Rinse temp- 120 degrees Fahrenheit, Sanitizer-Bleach at 50 ppm. Test strips are available through the food service supervisor."</p> <p>The Dietary Cleaning Procedure Policy was provided by the Administrator on 3/11/14 at 2:00 p.m. The policy indicated, "Equipment:</p>		is achieved.				

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	<p>HOOD...Responsible: Dietary Manager...Frequency: Weekly on Tuesday...Procedure:...Check fire sprinkler units and hood shelf for cleanliness..."</p> <p>The Dietary Personal Hygiene Policy was provided by the Administrator on 3/11/14 at 2:00 p.m. The policy indicated, "Beards are to be well trimmed and covered with an effective hair restraint."</p> <p>3.1-21(i)(3)</p>				