

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155387	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/12/2013
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NAME OF PROVIDER OR SUPPLIER CAROLETON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 IOWA AVE CONNERSVILLE, IN 47331
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 4, 5, 6, 7, 8 & 12, 2013</p> <p>Facility number: 000318 Provider number: 155387 AIM number: 100266550</p> <p>Survey team: Leslie Parrett RN TC Angel Tomlinson RN Barbara Gray RN</p> <p>Census bed type: SNF/NF: 44 Total: 44</p> <p>Census payor type: Medicare: 1 Medicaid: 33 Other: 10 Total: 44</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on 11/19/13 by Suzanne Williams, RN</p>	F000000		

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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F000164 SS=E	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and interview, the facility failed to maintain residents' names and physician information in a confidential manner for 5 residents randomly observed during 1 of 2 observations of the north and south hall medication carts (Residents #7, #1, #5, #58, & #33).</p>	F000164	Preparation and submission of this plan of correction by Caroleton Manor of Connerville, LLC, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and	12/12/2013	

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	<p>Findings include:</p> <p>During observation on 11-7-13 at 10:45 a.m. in the north hall of the facility, a medication cart with an attached trash can was sitting in the hallway. The trash can had empty medication cards laying on top of the container, with black magic marker marked through the resident's name and medication. During observation of five of the empty medication cards, Residents #7, #1, #5, #58, & #33's names and personal physician's name were legible. Interview with RN #1 at this time indicated it was normal practice to throw residents' empty medication cards in the medication cart trash can. RN #1 indicated she tried to throw them away in the trash can located at the nursing station because it was deeper and hard to reach down in. But, if she was going down the resident hallway passing medications, she would throw the empty medication cards in the medication cart trash.</p> <p>During observation on 11-7-13 at 10:47 a.m. in the south hall of the facility, a medication cart with an attached trash can was sitting in the hallway. The trash can had empty resident medication cards in it.</p>		<p>submitted solely pursuant to the requirements under state and federal laws. F164 1. Resident #7's medication card was removed from the trash can and placed in the Shred-It box on 11/7/13 by licensed nurse. Resident #1's medication card was removed from the trash can and placed in the Shred-It box on 11/7/13 by licensed nurse. Resident #5's medication card was removed from the trash can and placed in the Shred-It box on 11/7/13 by licensed nurse. Resident #58's medication card was removed from the trash can and placed in the Shred-It box on 11/7/13 by licensed nurse. Resident #33's medication card was removed from the trash can and placed in the Shred-It box on 11/7/13 by licensed nurse. RN #1 was re-educated by RN Supervisor on 11/13/13 related to the requirements of discarding medication cards to maintain confidentiality. LPN#2 was re-educated by RN Supervisor on 11/13/13 related to the requirements of discarding medication cards to maintain confidentiality. 2. An audit of trash cans was conducted on the evening of 11/7/13 and on 11/27/13 by the Director of Nursing to make sure medications cards were discarded as required. 3. Re-education of licensed nurses was completed on 11/12/13 by the RN supervisor related to</p>				

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	<p>Interview with LPN #2 at this time indicated it was normal practice to throw empty resident medication cards in the medication cart trash. LPN #2 indicated she marked through resident names prior to putting them in the trash can.</p> <p>3.1-3(o)</p>		<p>ensuring medications cards are discarded in the Shred-IT box to ensure residents records remain confidential. 4. The Director of Nursing or the Administrator will conduct random audits of the trash cans weekly for 4 weeks and monthly for 2 months to ensure medication cards continue to be discarded as required to maintain confidentiality. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and follow-up. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months and the audits will continue until the facility reaches 95% compliance. Date of Compliance: December 12, 2013</p>		

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F000246 SS=D	<p>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.</p> <p>Based on observation and interview, the facility failed to position a resident at a comfortable height at the dining table, for 1 of 4 residents observed and interviewed for comfortable positioning in the dining room. (Resident #27)</p> <p>Findings include:</p> <p>On 11/4/13 at 11:42 A.M., Resident #27 was observed seated in her wheelchair at a dining table with two of her peers. She was seated on a thick wheelchair seat cushion and her feet were flat on the floor. She was eating and drinking independently. The table top was at the level of her upper chest. At that time, Resident #27 indicated the table was too high and it was uncomfortable for her to eat. She indicated she had mentioned to the staff several times the height of the table was uncomfortable.</p> <p>On 11/4/13 at 1:21 P.M., Resident</p>	F000246	<p>F246 1. Resident #27 was screened by therapy on 11/5/13 for positioning needs. An adjustable table was ordered by the Administrator on 11/27/13 to accommodate the resident's needs for dining. 2. An observation audit of residents that eat in the dining room was conducted on 11/25/13 by the Director of Nursing and Director of Therapy to ensure residents maintain the comfortable positioning during meals and the table is at a comfortable height. 3. The nursing staff will be re-educated by the Director of Nursing on or before 12/5/13 related to requirements of ensuring residents are positioned comfortable during meals and the dining table is at a comfortable height for the resident. 4. The Administrator or the Director of Nursing will conduct audits weekly for 4 weeks, and monthly for 2 months to ensure residents continue to be positioned at a comfortable height at the dining table. The Administrator will submit a report to Quality Assurance Committee monthly for 3 months. The Administrator</p>	12/12/2013

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	<p>#45, who sat at the same table as Resident #27 in the dining room, indicated she had heard Resident #27 mention to staff several times that the table was too high. She indicated Resident #27 had stated to her "it's like scooping the food off the table into her mouth." She indicated Resident #27 was not normally a complainer.</p> <p>On 11/4/13 at 1:50 P.M., Resident #27 indicated again that the dining table height was uncomfortable but "I manage to eat that way." She stated "maybe I'm just too particular."</p> <p>On 11/6/13 at 11:43 A.M., Resident #27 was observed seated at the dining table with peers. She was seated on a thick wheelchair cushion. Her feet were flat on the floor. She was eating and drinking independently. She was slightly bent forward at the shoulders and her neck was slightly flexed to the left. The Director of Nursing (DON) asked her if she would like to sit in a dining chair instead of her wheelchair. Resident #27 indicated she preferred to sit in her wheelchair. The table top was at the height of her upper chest.</p> <p>On 11/6/13 at 12:13 P.M., the DON indicated the facility team and</p>		<p>will be responsible for monitoring and follow up. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months and the audits will continue until the facility reaches 95% compliance. Date of Compliance: December 12, 2013</p>		

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	<p>Administrator had addressed Resident #27's positioning at the dining table on 11/5/13. She indicated they had placed her in a dining chair for lunch and supper. She indicated Resident #27 indicated she preferred to sit in her wheelchair for lunch on 11/6/13. She indicated Resident #27 had scoliosis. She indicated the dining tables were standard height and Resident #27 was seated at the lowest table they had available. She indicated residents were seated at the dining table according to their preference of peers they preferred to sit with. She indicated no resident had ever complained about the height of the dining tables. She indicated a resident's wheelchair height was adjusted to allow them to propel themselves about the facility.</p> <p>3.1-3(v)(1)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to provide a nutritional supplement according to the resident's physician order and plan of care and failed to provide a bowel stimulant according to the resident's plan of care, for 2 of 23 residents reviewed for physician's orders and care plans. (Resident #6 and #58)</p> <p>Findings include:</p> <p>1.) Resident #6's record was reviewed on 11/6/13 at 1:36 P.M. Diagnoses included, but were not limited to, dementia without behavior disturbances and debility.</p> <p>An admission Minimum Data Set (MDS) assessment for Resident #6 dated 10/4/13, indicated the following: She was understood and she understood others. She scored 3 on her Brief Interview for Mental Status (BIMS) exam, indicating she was severely impaired for her cognitive decision making. She required extensive assistance of one person to</p>	F000282	<p>F282 1. Resident #6's med Pass order was added to the medication record on 11/7/13 by Charge Nurse. The physician and responsible party were notified by the licensed nurse on 11/7/13 Med Pass was given to the resident by the licensed nurse on 11/7/13 Resident #58's was given a laxative by the licensed nurse and documented results in the medical record 11/6/13. 2. An audit was completed on 11/6/13 and 11/27/13 by Director of Nursing to ensure residents had a bowel movement within the past 3 days and medications given as ordered related to bowel movements. An audit of resident orders and medication records was completed on 11/6/13 and 11/27/13 by Director of Nursing and Medical Records Nurse to ensure medication and supplements are administered as ordered by physician. 3. Licensed Nurses will be re-educated by the Director of Nursing on or before 12/5/13 related to the requirements of monitoring bowel movements every 3 days, ensuring residents receive a bowel stimulant as ordered by the physician and related to the requirements of</p>	12/12/2013

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	<p>eat. She had no limitation in her range of motion.</p> <p>A physician's order for Resident #6 dated 10/25/13, indicated the following: Resident #6 would receive Med Pass 90 milliliters (ml) everyday.</p> <p>A Care Plan for Resident #6, updated 11/6/13, indicated the following: Problem-She was at risk for weight loss related to her advancing dementia, low albumin level, her need for cueing, and 1 assist with meals. Approaches-She would be provided with nutritional supplements as ordered. She would be provided the diet ordered by her physician. She would receive Med Pass 90 ml by mouth everyday.</p> <p>A review of Resident #6's medication documentation indicated she had not been receiving her Med Pass since 10/31/13.</p> <p>On 11/6/13 at 2:58 P.M., RN #1 indicated the last day Resident #6 received her Med Pass was 10/30/13.</p> <p>On 11/6/13 at 3:52 P.M., RN #1 indicated there was no order to discontinue Resident #6's Med Pass.</p>		<p>transcribing and checking medications orders. 4. The Director of Nursing or RN supervisor will conduct audits weekly for 4 weeks and monthly for 2 months to ensure residents bowel movements continue to be monitored, bowel stimulants continue to be administered per physician's order and medication orders are transcribed on the medication records per physician's order. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and follow-up. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months and the audits will continue until the facility reaches 95% compliance. Date of Compliance: December 12, 2013</p>		

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	<p>2.) Resident #58's record was reviewed on 11/7/13 at 9:53 A.M. Diagnoses included but were not limited to, senile dementia, muscle weakness, chronic pain, and constipation.</p> <p>Resident #58's admission Minimum Data Set (MDS) assessment dated 10/2/13, indicated the following: Resident #58 was understood and usually understood others. She scored 12 on her Brief Interview for Mental Status (BIMS) exam, indicating she was moderately impaired for daily decision making. She required extensive assistance of one person for bed mobility, transferring, toileting, dressing, and personal hygiene. She had impaired range of motion to one side of her upper and lower extremities. She was continent of bowel, and her bowel pattern indicated constipation was present.</p> <p>A November 2013, physician's recapitulation order for Resident #58, indicated the following: 9/25/13-Colace 100 milligram (mg) capsule by mouth everyday as needed (PRN) for constipation. Dulcolax 10 mg rectal suppository everyday PRN for constipation.</p>			

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	<p>A Plan of Care for Resident #58 dated 9/25/13, indicated the following: Problem-She had a high bowel impaction risk related to medication use, decreased mobility, and appetite. Goal-She would have a soft formed stool every 2 days and verbalize or indicate freedom from discomfort over the next 92 days. Approach-She would receive Colace 100 mg capsule everyday PRN for constipation. She would receive dulcolax 10 mg rectal suppository everyday PRN for constipation. Routine bowel habits would be encouraged. Her bowel movements (BM) would be monitored daily to ensure at least a 3 day BM was maintained.</p> <p>A review of Resident #58's BM records and medication records indicated the following: Resident #58 did not have a BM on 10/8/13, 10/9/13, 10/10/13, or 10/11/13. She received Colace 100 mg capsule on 10/8/13, and 10/9/13. No other bowel stimulants were documented as given on those days. She did not have a BM on 10/17/13, 10/18/13, or 10/19/13. She did not receive a bowel stimulant any of those days. She did not have a BM on 10/22/13, 10/23/13, 10/24/13, or 10/25/13. She did not receive a bowel stimulant any of those days. She did not have a</p>						

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	<p>BM on 10/28/13, 10/29/13, or 10/30/13. She did not receive a bowel stimulant any of those days.</p> <p>On 11/17/13 at 10:26 A.M., LPN #4 indicated the facility protocol for a resident with no BM included giving an ordered PRN bowel stimulant on the third day of no bowel movement. Then if the resident still had no BM, the nurse would administer a more aggressive PRN bowel stimulant. She indicated Resident #58 had not had a BM documented on 10/8/13, 10/9/13, 10/10/13, or 10/11/13. She indicated Resident #58 had a Colace 100 mg capsule documented as given on 10/9/13. She indicated no other PRN stimulants were documented as given on 10/10/13, or 10/11/13. She indicated Resident #58 had no BM documented on 10/17/13, 10/18/13, or 10/19/13. She indicated no PRN bowel stimulant was documented as given on 10/19/13. She indicated Resident #58 had no BM documented on 10/22/13, 10/23/13, 10/24/13, or 10/25/13. She indicated no PRN bowel stimulant was documented as given on 10/24/13, or 10/25/13. She indicated no BM was documented on 10/28/13, 10/29/13, or 10/30/13. She indicated no PRN bowel stimulant was documented as given on 10/30/13.</p>						

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	<p>On 11/11/13 at 8:17 A.M., the Director of Nursing indicated the facility nursing staff documented a resident's bowel status on a BM record daily. She indicated if a resident had no BM marked on the BM record by the third day, the evening shift nurse administered a PRN bowel stimulant. If the resident had not had a BM by the 4th day, the day or evening shift nurse administered a rectal suppository. She indicated Resident #58's plan of care where it stated "monitor BM daily to ensure at least 3 days is maintained" meant the resident should have a bowel movement by the 3rd day, and if not, she would be given a PRN stimulant. She indicated the bowel protocol starts on the third day of no BM.</p> <p>3.1-35(g)(2)</p>			

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, interview, and record review, the facility failed to follow the Registered Dietician's recommendation and physician's order for a nutritional supplement to increase the residents albumin level and improve her overall nutritional status, for 1 of 3 residents reviewed for nutrition, of 5 who met the criteria for nutrition. (Resident #6)</p> <p>Findings include:</p> <p>On 11/6/13 at 11:55 A.M., Resident #6 was observed seated at the assisted dining table in the main dining room with her peers. CNA #3 was observed cutting Resident's #6's roast beef. CNA #3 placed food on Resident #6's fork and handed it to her. Resident #6 put the food in her mouth and began to eat independently. Resident #6 continued to feed herself. No</p>	F000325	<p>F325 1. Resident #6's Med Pass order was placed on the medication record on 11/7/13 by the licensed nurse The physician and responsible party were notified by the licensed nurse on 11/7/13. Med pass was given to the resident as order by the licensed nurse on 11/7/13. 2. An audit of resident physician orders and medication records was completed on 11/27/13 by Director of Nursing and Medical Records Nurse to ensure medication and supplements are given per physician's orders. 3. The licensed nurses will be re-educated by the Director of Nursing on or before 12/5/13 related to the requirements of transcribing medication orders to ensure no orders are omitted from the medication administration record. 4. Director of Nursing will conduct audits weekly for 4 weeks and monthly for 2 months to ensure medications and supplements continue to be administered per</p>	12/12/2013

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NAME OF PROVIDER OR SUPPLIER CAROLETON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 IOWA AVE CONNERSVILLE, IN 47331
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	<p>chewing or swallowing difficulty was observed. She drank approximately 600 milliliters (ml) of fluids independently.</p> <p>On 11/6/13 at 1:00 P.M., CNA #3 indicated Resident #6 sat at the assisted dining table because she sometimes needed prompted and encouraged to eat, or needed food placed on her fork or spoon. She indicated Resident #6 had a fair appetite and would sometimes eat all of her meal, but sometimes she would not be hungry.</p> <p>Resident #6's record was reviewed on 11/6/13 at 1:36 P.M. Diagnoses included, but were not limited to, dementia without behavior disturbances and debility.</p> <p>An admission Minimum Data Set (MDS) assessment for Resident #6 dated 10/4/13, indicated the following: She was understood and she understood others. She scored 3 on her Brief Interview for Mental (BIMS) exam, indicating she was severely impaired for her cognitive decision making. She required extensive assistance of one person to eat. She had no limitation in her range of motion.</p>		<p>physician's orders. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and follow-up. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months and the audits will continue until the facility reaches 95% compliance. Date of Compliance: December 12, 2013</p>	

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	<p>A Comprehensive Nutritional Assessment for Resident #6 dated 10/8/13, indicated the following recommendation: Resident #6 would receive 90 ml of Med Pass everyday on a 1 week trial to provide 7.5 grams of protein and 180 kilocalorie's, due to a low albumin level of 2.7.</p> <p>A physician's order for Resident #6 dated 10/18/13, indicated the following: Resident #6 would receive Med Pass 2.0 - 90 ml every day as a one week trail. The Med Pass could be discontinued if Resident #6 refused.</p> <p>A nurses note for Resident #6 dated 10/25/13 at 7:30 A.M., indicated the following. The physician examined the resident. An order was received for Med Pass 90 ml everyday. The physician was updated that the resident had been accepting 100% of her Med Pass while she had been on the trial basis.</p> <p>A physician's order for Resident #6 dated 10/25/13, indicated the following: Resident #6 would receive Med Pass 90 ml everyday. Her laboratory levels would be re-checked on a Comprehensive Metabolic Profile on 11/8/13.</p>			

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	<p>A Care Plan for Resident #6, updated 11/6/13, indicated the following: Problem-She was at risk for weight loss related to her advancing dementia, low albumin level, her need for cueing, and 1 assist with meals. Approaches-She would be provided with nutritional supplements as ordered. She would be provided the diet ordered by her physician. She would receive Med Pass 90 ml by mouth everyday.</p> <p>A review of Resident #6's medication documentation indicated she had not been receiving her Med Pass since 10/31/13.</p> <p>On 11/6/13 at 2:58 P.M., RN #1 indicated the last day Resident #6 received her Med Pass was 10/30/13.</p> <p>On 11/6/13 at 3:52 P.M., RN #1 indicated there was no order to discontinue Resident #6's Med Pass.</p> <p>A Comprehensive Metabolic Profile was completed for Resident #6 on 11/7/13. The laboratory value indicated her albumin level remained low at 3.1.</p> <p>3.1-46(a)(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 provide a range hood free of peeling paint and the Dietary Manager failed to wear a hair covering in the kitchen, for 1 of 1 kitchen observed for sanitary practices. This had the potential to affect all 44 residents served from the kitchen.</p> <p>Findings include:</p> <p>During an observation of food service in the kitchen on 11/6/13 at 10:42 A.M., the range hood was observed to have peeling paint. The peeling was more prominent on both ends of the range hood. One end of the range hood was above the coffee pot and clean coffee cups. The other end of the range hood was above clean plates that were being used by Cook #5 to place food on from the steam table. The steam table was approximately 4 feet away from the range hood. The Dietary Manager was observed not to wear any hair</p>	F000371	F371 1. Hair covering was applied by the certified dietary manager immediately on the day of observation 11/6/13. The facility has secured a quote to replace the range hood by the Maintenance Director on 11/26/13. The new range hood will be installed by 12/11/13 by an outside contractor. 2. An audit of dietary staff was completed on 11/26/13 by Administrator to make sure dietary staffs were wearing a hair net The Certified Dietary Manager will do a kitchen audit on 11/27/13 to make sure that are no peeling paint from other equipment. 3. The Certified Dietary Manager was re-educated by the Administrator on 11/6/13 and 11/27/13 related to the requirements of wearing a hair net. Re-education of dietary employees will be conducted by the registered dietician on or before 12/4/13 related to wearing a hair net and reporting to supervisor of any equipment with peeling paint. 4. The Administrator will conduct audits weekly for 4 weeks and monthly for 2 months to ensure dietary staff continue to wear hair nets	12/12/2013

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	<p>covering on his head. His hair was approximately 1/8 to 1/4 inches long.</p> <p>On 11/6/13 at 11:14 A.M., the Dietary Manager said the range hood had silver paint peeling on both ends of the hood. He indicated the coffee pot and clean coffee cups were underneath one end of the hood and clean plates were underneath the other end of the hood. He indicated the range hood was above the range where food was prepared and the steam table was approximately 4 feet across from the range. He indicated the dietary staff cleaned the range hood exterior at least weekly and daily if needed. He indicated the range hood needed re-painted. He indicated he normally didn't have any hair on his head, but currently he did, and it was approximately 1/8 to 1/4 inches long.</p> <p>An "Employee Cleanliness" policy provided by RN Supervisor #6 on 11/12/13 at 2:42 P.M., indicated the following: "Policy: All Dietary Department employees will dress appropriately and practice good hygiene. Procedure: ...6.) Wear a hairnet or bouffant disposable cap that covers hair completely...."</p> <p>3.1-21(i)(3)</p>		<p>and the kitchen remains free of peeling paint. A report will be submitted to the Quality Assurance Committee monthly for 3 months. The Quality Assurance Committee will re-evaluate the need for further monitoring after 3 months and the audits will continue until the facility reaches 95% compliance. The Administrator is responsible for monitoring and follow-up. Date of Compliance: December 12, 2013</p>	

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