

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155751	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/24/2014
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NAME OF PROVIDER OR SUPPLIER MEADOW LAKES	STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEADOW LAKE DR MOORESVILLE, IN 46158
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey Dates: November 10, 12, 13, 14, 17, 18, 19, 20, 21, and 24, 2014.</p> <p>Facility number: 004831 Provider number: 155751 AIM number: 200809750</p> <p>Survey team: Angela Patterson, RN-TC (11/10, 11/12, 11/13, 11/14, 11/18, 11/19, 11/20, 11/21, and 11/24, 2014) Cheryl Mabry, RN Patti Allen, LSW (11/14, 11/17, 11/18, 11/19, 11/20, 11/21, and 11/24, 2014)</p> <p>Census bed type: SNF: 17 SNF/NF: 107 Residential: 43 Total: 167</p> <p>Census payer type:</p>	F 000	<p>Meadow Lakes is respectfully requesting a paper compliance review for the federal and state citings for the survey which ended November 24, 2014. Please review the plan of correction submitted, with supporting documentation, to establish substantial compliance has been met and maintained as of December 19, 2014. Thank you, in advance, for your attention to this very serious matter.</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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F 241 SS=D Bldg. 00	<p>Medicare: 22 Medicaid: 74 Other: 28 Total: 124</p> <p>Residential sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December 05, 2014; by Kimberly Perigo, RN.</p> <p>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 or her individuality. Based on observation, interview, and record review, the facility failed to ensure privacy was provided while a resident was in the bathroom in that the room door and bathroom door were left open during care for 1 randomly observed resident. (Resident #6) (Certified Nursing Assistant-CNA #4) Findings include:</p>	F 241	F-241 SS=D It is the intention of Meadow Lakes to 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 or her individuality. What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice- Education was provided to CNA #4. Resident #6 was	12/19/2014	

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	<p>On 11/19/14 at 8:50 a.m., observed Resident #6's room door open and bathroom door open while Resident #6 was on the toilet and CNA #4 was standing inside the bathroom with Resident #6. While knocking on the room door CNA #4 stepped out of the bathroom. When asked was that proper protocol (leaving the doors open while resident was on toilet), CNA #4 indicated, " No." When asked what should she have done, CNA #4 indicated, "Close both doors." When asked if doors are not closed what right does that violate, "Their privacy."</p> <p>On 11/19/14 at 9:00 a.m., interview with LPN #2 indicated, when asked if a resident is on the toilet should the room door and bathroom door be left open by the CNA, " No."</p> <p>Resident #6's clinical record was reviewed on 11/18/14 at 2:58 p.m. Diagnosis included but were not limited to: hypertension, depressive disorder, diabetes, chronic airway obstruction, chronic pain, esophageal reflux and kidney disease. The current Minimum Data Set (MDS) assessment dated 9/23/14, indicated a Brief Interview Mental Status (BIMS) score of 15 when 8-15. A score of 15 indicated cognitively intact and interviewable.</p>		<p>questioned and stated that she has no issue with privacy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken- All residents who have had care provided by CNA #4 had the potential to be affected by this practice prior to November 20, 2014. Education was provided to CNA #4. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur- Direct care staff was provided education on resident rights specific to maintaining privacy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE, what quality assurance program will be put into place- A daily survey checklist was implemented on each shift for the nurse to monitor for privacy and dignity. The facility will complete a Continuous Quality Improvement Tool titled: 'Quality Indicator: Dignity and Privacy', weekly for 4 weeks, then monthly for 3 months. The tool will continue weekly until substantial compliance is met and maintained. Substantial compliance is defined as a score at or above 95% By what date the systemic changes will be completed- 12/19/2014</p>	

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F 242 SS=E Bldg. 00	<p>On 11/20/14 at 9:15 a.m., the Director of Nursing provided policy "Resident Rights" revision date 1/2006 and indicated that was the current policy used by the facility. The policy indicated, "... All staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well being, and proper delivery of care. ..."</p> <p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure that residents were able to schedule how many times a week they take a shower and what time to get up in the morning according to their preference for 3 of 3 residents who met the criteria for review of choices. (Resident #6, Resident #55, Resident #93)</p> <p>Findings include:</p>	F 242	<p>F-242 SS=E</p> <p>It is the intention of Meadow Lakes to allow the resident to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p>	12/19/2014

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	<p>1.) On 11/12/14 at 3:49 p.m., interview with Resident #6 indicated when asked, do you choose how many times a week you take a bath or shower? "No, would like shower once a week but get twice a week. It's not comfortable. It's too cold."</p> <p>Resident #6's clinical record was reviewed on 11/18/14 at 2:58 p.m. Diagnosis included but were not limited to: hypertension, depressive disorder, diabetes, chronic airway obstruction, chronic pain, esophageal reflux and kidney disease.</p> <p>The current Minimum Data Set (MDS) assessment dated 9/23/14, indicated a Brief Interview Mental Status (BIMS) score of 15. A score of 15 indicated cognitively intact and interviewable. Resident #6 needed physical help in part of bathing care and setup.</p> <p>On 11/19/14 at 10:46 a.m., the Activity Director provided Preferences for Daily Customary Routines dated 6/20/14, and indicated that was the current preference sheet for Resident #6. The preference sheet indicated, "Do you have a preference as to what time or how often you bathe? Yes, ... preferred time/frequency to bathe: 2x wk/evening, ...What type of bathing are you used to ,</p>		<p>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice-</p> <p>Resident #6, #55 and #93, had a QIS interview conducted with a facility staff member to address preferences. The plan of care and profile for each resident was updated to reflect the stated preferences.</p> <ul style="list-style-type: none"> · Resident #6 was interviewed and preferences for bathing and care plan was updated. Resident is receiving bathing per preference. · Resident #55 was interviewed and for preference for time to awake and care plan was updated · Resident #93 was interviewed and preferences for bathing and care plan was updated <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken-</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice · Activity Director/designee will interview their assigned residents or families utilizing the 'Preferences for Daily Customary Routines' worksheet to evaluate for choice · Once preferences are identified by the Activity Director/designee, appropriate departments will be notified and care plans and resident care sheets/profiles will be updated 	

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	<p>...sponge bath, ..."</p> <p>There had been no preference for daily customary routines updated since 6/20/14.</p> <p>On 11/19/14 at 11:17 a.m., the Director of Nursing provided Resident Profile dated 10/10/13, indicated "...Provide shower two times per week on mon/thurs day shift, partial bath in between, ..."</p> <p>This had not been updated since 10/10/13.</p> <p>On 11/18/14 at 3:24 p.m., interview with the Clinical Educator (CE) indicated, when asked when are resident preference done? "We do comprehensive assessment and ask preferences on admission." When asked if that was the only time preferences completed, CE indicated, "Yes, It's just done on admission. We usually care plan if there is a preference."</p> <p>On 11/18/14 at 3:45 p.m., interview with the Director of Nursing indicated when asked how do you know residents preference? "We ask on admission and the Activity Director ask quarterly." How do you know when preferences change? " The resident will let us know."</p> <p>2). On 11/14/14 at 10:07 a.m., interview</p>		<p>accordingly to ensure resident preferences/choices are honored</p> <ul style="list-style-type: none"> ·In-service will be conducted on December 16, 2014 on Preferences for Daily Routines including resident choices by the Corporate Nurse Consultant <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur-</p> <ul style="list-style-type: none"> ·Activity Director/designee will interview their assigned residents or families utilizing the 'Preferences for Daily Customary Routines' worksheet to evaluate for choice annually, quarterly and with a significant change of condition. ·Once preferences are identified by the Activity Director/designee, appropriate departments will be notified and care plans and resident care sheets/profiles will be updated accordingly to ensure resident preferences/choices are honored ·In-service will be conducted on December 16, 2014 on Preferences for Daily Routines including resident choices by the Corporate Nurse Consultant ·Customer care representative will follow up with residents and/or families monthly to ensure preferences are honored and the Interdisciplinary Team will update resident care plans and care sheets accordingly <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE, what quality assurance program will be</p>	

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	<p>with Resident #55 indicated when asked, Do you choose when to get up in the morning? "No, they get me up at 7:00. I prefer to get up around 9:00." When asked does staff ask you what time you would like to get up, Resident #55 indicated, "No, they don't ask me if I want to get up. They just start working on me around 6:30 a.m."</p> <p>Resident #55's clinical record was reviewed on 11/18/14 at 9:32 a.m. Diagnosis included but were not limited to: depressive disorder, hypertension, asthma, constipation and osteoarthritis. The current Minimum Data Set (MDS) assessment dated 10/16/14, indicated a Brief Interview Mental Status (BIMS) score of 15. Which indicated cognitively intact and interviewable. The MDS did not address a time Resident #55 wanted to wake up in the morning.</p> <p>Review of resident profile dated 11/19/14, indicated "...Help resident in rising at 6:30 or 7, if res [resident] is willing. ..."</p> <p>On 11/18/14 at 3:24 p.m., interview with the Clinical Educator indicated when asked when are resident preference done? "We do comprehensive assessment and ask preferences on admission." Is that the only time preference sheets were</p>		<p>put into place-</p> <ul style="list-style-type: none"> Activities and Accommodation of Needs CQI tool will be completed by Activity Director or designee weekly x 4 weeks, monthly x 5months, and quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance <p>By what date the systemic changes will be completed- 12/19/2014</p>	

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	<p>completed? "Yes, It's just done on admission. We usually care plan if there is a preference."</p> <p>There were no care plan's provided with Resident #55's preference on getting up in the morning.</p> <p>On 11/19/14 at 9:49 interview with the Activity Director (AD) indicated, When asked how do you do preference sheet, "With new admit, quarterly, significant change and annual." When asked what questions do you ask? AD indicated, "We ask them activity preference, religion, shower bath, a.m. or p.m. on the form. It's very generic, not a.m. or p.m." When asked how is this information relayed to the CNA's, AD indicated, "It's put on the computer and checked off for the CNA's to know." When asked If her forms are generic how do you individualize it, The AD indicated, "I wouldn't say it was generic but it's very basic any pertinent information I would put in a careplan." When asked if there was no significant change how do you know if the preference changes, the AD indicated, "We do our daily round. My staff go up and down the hall we invite the residents to activity."</p> <p>On 11/19/14 at 10:46 a.m., the Activity Director provided Preferences for Daily</p>			

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	<p>Customary Routines dated 7/24/14, and indicated that was the current preference sheet for Resident #55. The preference sheet indicated, "Do you have a preference as to what time you get up? yes, ...resident's preferred up time: 9:00 [this was scratched out] 6:30 or 7:00 ..." When asked why 9:00 was scratched out if that was Resident #55's preference and whom changed the time, the AD indicated, "I can only assume the resident preferred a different time."</p> <p>There had been no updated Preferences for Daily Customary Routines since 7/24/14 indicating Resident#55 preference on getting up in the morning.</p> <p>On 11/21/14 at 8:45 a.m., observed Resident #55 up in wheelchair in her room. Resident #55 indicated that she was awoken by staff around 6:45 a.m. and dressed by 7:30." When asked if she wanted to be awoken at that time, Resident #55 indicated, "No, but I don't want them to make any exceptions for me."</p> <p>On 11/20/14 at 9:15 a.m., the Director of Nursing provided policy "Resident Rights" revision date 1/2006 and indicated that was the current policy used by the facility. The policy indicated, "... All staff members recognize the rights of</p>			

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	<p>residents at all times and residents assume their responsibilities to enable personal dignity, well being, and proper delivery of care. ..."</p> <p>3). 11/12/2014 11:09 a.m., an interview with Resident #93 indicated the resident wants to have a shower daily, and has told the facility in the past but nothing changed.</p> <p>Resident #93's clinical record was reviewed on 11/18/2014 at 3:50 p.m. Diagnoses included but, were not limited to congestive heart failure, hypothyroidism, chronic kidney disease, esophageal reflux, chronic obstructive pulmonary disease, ischemic heart disease, depressive disorder, hypertension, anemia and anxiety. The significant change MDS (Minimum Data Set) assessment dated 8/25/2014, assessed Resident #93 BIMS score as a 15. A score of 8-15 indicated the resident was interviewable and cognitively intact.</p> <p>On 11/20/2014 at 2:00 p.m., an interview with Resident #93 indicated that no one including her customer care representative has asked her how many showers she wants.</p> <p>On 11/19/2014 at 10:35 a.m., the</p>				

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F 257 SS=D Bldg. 00	<p>Activities Director provided the facilities Preferences for Daily customary Routines and indicated the form was the one the Activity Director currently used to assess preferences. The form dated 5/2013, for Resident #93 indicated the bathing routines the resident preferred was a shower in the a.m. but the form lacked documentation of how many showers weekly the resident preferred. The Activity Director indicated the form did not assess how many showers or baths the resident preferred to have only the type of bathing preferred.</p> <p>On 11/19/2014 at 11:18 a.m., the Director of Nursing provided the resident profile for Resident #93. The profile care plan approaches dated 2/6/2013, included but were not limited to showers on Wednesday and Saturday day shift, partial bath in between.</p> <p>Review of the facilities shower sheets provided by the Director of Nursing on 11/21/2014 at 3:00 p.m., indicated Resident #93 had two showers weekly for the month of November 2014.</p> <p>3.1-3(u)(3)</p> <p>483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and</p>			

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	<p>safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received showers in a comfortable environment in that the shower rooms temperature were not kept warm for resident comfort. (Resident #6)</p> <p>Findings include:</p> <p>On 11/12/2014 3:52 p.m., interview with Resident #6 indicated when asked, Do staff treat you with respect and dignity? "No, they don't respect me with shower being cold. I don't want to take any showers." When asked, do you choose how many times a week you take a bath or shower? "No, would like shower once a week but get twice a week. Its not comfortable. Its too cold."</p> <p>Resident #6's clinical record was reviewed on 11/18/14 at 2:58 p.m. Diagnosis included, but were not limited to: hypertension, depressive disorder, diabetes, chronic airway obstruction, chronic pain, esophageal reflux and kidney disease. The current Minimum Data Set (MDS) assessment dated 9/23/14 indicated a Brief Interview Mental Status (BIMS) score of 15. A score of 15 indicated cognitively intact</p>	F 257	<p>F-257 SS=D It is the intention of Meadow Lakes to provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990, must maintain a temperature range of 71-81 degrees fahrenheit. What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice-</p> <p>Resident #6 receives a shower in a room with comfortable temperature level · Facility has installed additional heating system in all community shower rooms How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken-</p> <p>All resident that receive bathing services in the community shower rooms have the potential to be affected by the alleged deficient practice · Facility will install thermometers in all community shower rooms and staff will check to make sure that temperature is in between 71-81 degrees F prior to providing bathing · Nursing staff will be in-serviced by the Clinical Education Coordinator/designee on safe and comfortable temperature levels for bathing including making sure that</p>	12/19/2014	

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	<p>and interviewable.</p> <p>On 11/18/14 at 3:58 p.m., interview with CNA #5 indicated, when asked what is the protocol for giving residents a shower. "I put on heat lamps [in the shower rooms] every time I go into the shower room." When you bring residents into the shower room is it [shower room] already warm. "Yes." When asked if Resident #6 ever refused a shower because it was to cold. "No."</p> <p>On 11/18/14 at 4:17 p.m., interview with CNA #3 indicated, when asked if the shower rooms are cold when Resident #6 gets a shower. "I turn on the heat lamp before I get resident." When asked if Resident #6 ever refused a shower because it was to cold, CNA #3 indicated, " No, not from me."</p> <p>On 11/19/14 at 9:00 a.m., observed the back hall shower room to be cold while a CNA was giving a resident a shower. The heat lamp was observed on over the shower stall, but the shower room was still cold. There were no heat lamps observed anywhere else in the shower room.</p> <p>On 11/19/14 at 9:15 a.m., observation of both shower rooms on the 100 hall with the Clinical Educator present indicated</p>		<p>shower room temperature is in between 71-81 degrees F prior to providing bathing by December 19, 2014. Thermostats have been installed in each shower room that register the temperature of that bathing area. The temperature can be raised or lowered to distribute the heat source maintained within 71-81 degrees at the time a resident would be showered. The new heat source now allows for individual control. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur- · Facility will install thermometers in all community shower rooms and staff will check to make sure that temperature is in between 71-81 degrees F prior to providing bathing · Nursing staff will be in-serviced by the Clinical Education Coordinator/designee on safe and comfortable temperature levels for bathing including making sure that shower room temperature is in between 71-81 degrees F prior to providing bathing by December 19, 2014 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE, what quality assurance program will be put into place- · Dignity and Privacy CQI tool will be completed weekly x 4 weeks, monthly x 5 months and then quarterly for one year with results reported to the</p>	

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	<p>the shower room was cold outside the shower stall. There were heat lamps over the shower stall, but nothing to warm the shower room. The Clinical Educator indicated the CNA's should come in before shower and cut the heat lamps on. The Clinical Educator indicated "But I could see how residents would be cold when exiting the shower."</p> <p>On 11/19/14 at 10:35 a.m., observation of the 100 hall shower room with the Maintenance Supervisor (MS) present indicated temperature of 69 degrees Fahrenheit on the front hall shower room and 71 degrees Fahrenheit on the back 100 hall shower room. When asked if that is a comfortable temperature for residents getting in and out of the shower, the MS indicated, "For me yes, for the resident I don't know." When asked if there were heat registered in the shower room, the MS indicated, "Yes, but it is based on the thermostat outside in the hall. It is set at 75 degrees [Fahrenheit] and will shut off if the hallway reaches that temperature. So the shower room won't get heated because the heat from the residents rooms come into the hall and the temp reaches 75 degrees [Fahrenheit] and it don't matter what the temperature is in the shower room."</p> <p>There was no policy provided indicating</p>		<p>Continuous Quality Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance By what date the systemic changes will be completed- 12/19/2014</p>		

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F 279 SS=D Bldg. 00	<p>comfortable temperature in the facility.</p> <p>3.1-19(h)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to ensure that careplans were developed after assessment for residents with dental problems which included non fitting dentures and missing teeth for 1 of 1 resident reviewed for dental care plan. (Resident #170)</p> <p>Findings include:</p>	F 279	<p>Meadow Lakes is requesting an informal dispute resolution for this citing as the facility does not agree with the information. Thank you for your consideration.</p> <p>F-279 SS=D</p> <p>It is the intention of Meadow Lakes to use the results of the assessment to develop, review and revise the residents comprehensive plan of care.</p>	12/19/2014			

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	<p>Resident #170's clinical record was reviewed on 11/18/14 at 10:13 a.m. Diagnosis included but were not limited to: depressive disorder, dementia, symptoms adult failure to thrive dysphagia, and esophageal reflux. The admission Minimum Data Set (MDS) assessment dated 8/29/14, indicated Resident #170 needed extensive assistance of 1 staff member for dressing, eating and personal hygiene. The 9/3/14 MDS indicated, ... Dental ... Z. None of the above were present (broken or loosely fitting full or partial denture). The current MDS dated 10/19/14, indicated a Brief Interview Mental Status (BIMS) score of 3. Which indicated not cognitively intact nor interviewable. Resident #170 needed extensive assist of 1 staff member for dressing, eating and personal hygiene.</p> <p>Physician order dated 8/24/14 indicated, " May be seen by Podiatrist, Dentist, ..."</p> <p>On 11/21/14 at 9:00 a.m., interview with Certified Nursing Assistant #6 (CNA) indicated Resident #170 refuses to let staff put dentures in. When he admitted his dentures would hang out of his mouth. I do offer to put them in but he refuses."</p> <p>Care plan dated 8/24/14 indicated "Self</p>		<p>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice-</p> <ul style="list-style-type: none"> · Resident #170 has a dental care plan <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken-</p> <ul style="list-style-type: none"> · All residents with dental problems have the potential to be affected by the alleged deficient practice · The MDS Coordinator/designee reviewed all clinical records to identify residents who have dental problems and care plan will be developed · The Interdisciplinary Team will review the facility activity report and nursing admission assessment, and weekly summaries to identify those residents with dental problems in the clinical meeting and care plan will be developed. · Staff will be in-serviced on assessment and reporting of dental problems by the Clinical Education Coordinator by December 19, 2014 	

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	<p>care deficit related to: weakness and debility, recent hosp [hospital] stay, ...Goal... Resident will not further decline in current ADL [activity of daily living] ability, ...Provide oral care at least two times daily, ...Set up hygiene/grooming equipment in easy reach, ...upper dentures, ..."</p> <p>On 11/24/14 at 11:47 a.m., interview with the Director of Nursing (DON) indicated when asked if there was a care plan indicating Resident #170 refuses to wear his denture. "We don't have another care plan stating that [indicating Resident #170 refuses to wear dentures]." When asked if there was documentation Resident#170 was refusing to wear his denture, the DON indicated, "No, I don't think documentation like that exist."</p> <p>There were no care plans indicating Resident #170 refuses to wear his upper denture provided. There were no progress notes provided indicating that a dentist referral had been completed.</p> <p>3.1-35(a)</p>		<p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur-</p> <ul style="list-style-type: none"> · The MDS Coordinator/designee reviewed all clinical records to identify residents who have dental problems and care plan will be developed · The Interdisciplinary Team will review the facility activity report and nursing admission assessment, and weekly summaries to identify those residents with dental problems in the in the clinical meeting and care plan will be developed. · Staff will be in-serviced on assessment and reporting of dental problems by the Clinical Education Coordinator by December 19, 2014 <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE, what quality assurance program will be put into place-</p> <ul style="list-style-type: none"> · Care Plan Updating CQI tool will be utilized weekly x 4, monthly x 5, and quarterly thereafter for one year. Data will be submitted to the CQI 		

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F 328 SS=E Bldg. 00	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were provided a oxygen tank with oxygen while in the dining room in that 4 of 4 randomly observed resident oxygen tanks were empty. (Resident #3, Resident #45, Resident #131, Resident #185) (LPN #1, CNA #1, CNA#2)</p> <p>Findings include:</p> <p>1). On 11/12/14 at 12:45 p.m., Resident #3 was observed in the 100 hall dining room with a nasal cannula positioned in the nostrils and an empty oxygen tank. Interview with LPN #1 indicated the</p>	F 328	<p>committee for follow up.</p> <ul style="list-style-type: none"> If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. <p>By what date the systemic changes will be completed- 12/19/2014</p> <p>F-328 SS=E It is the intention of Meadow Lakes to ensure that residents receive proper care and treatment and care for the following special services.</p> <p>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice-</p> <ul style="list-style-type: none"> Resident #3's oxygen tank was filled and monitored every two hours by the CNA to ensure the tanks are not empty. Resident #45's oxygen tank was filled and monitored every two hours by the CNA to ensure the 	12/19/2014	

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	<p>oxygen tank was empty and was observed to remove Resident #3 from the dining room at that time. Resident #3 was returned to the 100 hall dining room with a full oxygen tank.</p> <p>Resident #3's clinical record was reviewed on 11/17/14 at 9:38 a.m. Diagnosis included but were not limited to: CHF [Congestive Heart Failure], total occlusion coronary artery, and chronic airway obstruction. The current Minimum Data Set (MDS) assessment dated 9/12/14, indicated a Brief Interview Mental Status (BIMS) score of 15. Which indicated cognitively intact and interviewable.</p> <p>Physician's order dated 9/9/14 indicated, "Oxygen at 2 liters per nasal cannula every shift."</p> <p>Care plan dated 6/26/14, indicated "Problem: Resident has potential for impaired gas exchange related to : CHF [Congestive Heart Failure] ... Goal: Resident will have adequate respiratory functions ... improved oximetry results, ...Approach: oxygen at 2 L[liter]per n/c [nasal cannula]"</p> <p>2). On 11/12/14 at 12:45 p.m., observed Resident #185 sitting in the 100 hall dining room with a nasal cannula on, but</p>		<p>tanks are not empty.</p> <ul style="list-style-type: none"> Resident #131's oxygen tank was filled and monitored every two hours by the CNA to ensure the tanks are not empty. Resident #185's oxygen tank was filled and monitored every two hours by the CNA to ensure the tanks are not empty. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken-</p> <ul style="list-style-type: none"> All residents who receive oxygen per portable oxygen tank have the potential to be affected by the alleged deficient practice All nursing staff will be in-serviced by the Clinical Education Coordinator/ designee on Oxygen Therapy including how to test and fill a portable oxygen tank by December 19, 2014 DNS/designee will conduct rounds on all shifts and complete an audit tool to ensure that all portable oxygen tanks are not empty and filled appropriately <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur-</p> <ul style="list-style-type: none"> All nursing staff will be in-serviced by the Clinical Education Coordinator/ designee on Oxygen Therapy including how to test and fill a portable oxygen tank by December 19, 2014 DNS/designee will conduct 	

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	<p>the oxygen tank was empty. LPN #1 was observed to check the oxygen tank at that time and indicated it was empty.</p> <p>Observed LPN #1 to remove Resident #185 from the dining room. Resident #185 was returned to the 100 dining room with a full oxygen tank.</p> <p>Resident #185's clinical record was reviewed on 11/17/14 at 10:15 a.m. Diagnosis included but were not limited to: chronic airway obstruction, esophageal stricture, and bronchus/lung cancer. The current Minimum Data Set (MDS) assessment dated 9/11/14, indicated a Brief Interview Mental Status (BIMS) score of 11. A score of 11 indicated cognitively intact and interviewable.</p> <p>Physician's order dated 11/6/14, indicated "Oxygen at 2 liter per nasal cannula, as resident allows, Every Shift, ..."</p> <p>Care plan dated 5/12/14, indicated "PROBLEM: Resident has potential for impaired gas exchange related to: new dx[diagnoses] lung CA [cancer] and has COPD [chronic obstructive pulmonary disease], routine oxygen use, ... APPROACH: Administer oxygen at 1 liter per n/c [nasal cannula] as ordered, ..."</p>		<p>rounds on all shifts and complete an audit tool to ensure that all portable oxygen tanks are not empty and filled appropriately</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE, what quality assurance program will be put into place-</p> <ul style="list-style-type: none"> · An Oxygen Therapy CQI tool will be completed weekly x 4 weeks, monthly x 5 months, and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance <p>By what date the systemic changes will be completed- 12/19/2014</p>	

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	<p>3). On 11/12/14 at 1:02 p.m., Resident #131 was observed in the 100 hall dining room with a nasal cannula on but the oxygen tank read empty. CNA #1 was observed to check the oxygen tank and indicated it was empty. "I won't lie to you it is empty." CNA #1 was observed to remove the oxygen tank and take to fill.</p> <p>Resident #131's clinical record was reviewed on 11/17/14 at 9:57 a.m. Diagnosis included but were not limited to: Idiopathic pulmonary fibrosis (a disease in which tissue deep in your lungs becomes thick and stiff, or scarred, over time. The formation of scar tissue is called fibrosis.). The current Minimum Data Set (MDS) assessment dated 9/18/14, indicated a Brief Interview Mental Status (BIMS) score of 7. A score of 7 indicated not cognitively intact nor interviewable.</p> <p>Physician's order dated 11/6/14, indicated "Oxygen at 2 lpm [liters per minute] per nasal cannula as resident allows, ...Every Shift, ..."</p> <p>Care plan dated 9/12/14, indicated, " PROBLEM: Resident has potential for impaired gas exchange related to : pulmonary fibrosis chronic cough, ... APPROACH: Administer oxygen as</p>			

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	<p>ordered"</p> <p>4). On 11/12/14 at 12:40 p.m., Resident #45 was observed eating in the moving forward dining room with a nasal cannula on, but the oxygen tank was empty. Observed CNA #2 to check oxygen tank and indicated it was empty. CNA #2 was observed to remove the oxygen tank from Resident #45's wheelchair and take to fill. CNA #2 returned with a full oxygen tank.</p> <p>Resident #45's clinical record was reviewed on 11/17/14 at 10:31 a.m. Diagnosis included but were not limited to: chronic ischemic heart disease.</p> <p>The current Minimum Data Set (MDS) assessment dated 9/11/14, indicated a Brief Interview Mental Status (BIMS) score of 7. A score of 7 indicated not cognitively intact nor interviewable.</p> <p>Physician's order dated 7/15/14, indicated " Oxygen at 1 liter per nasal cannula. Humidified to keep, ... greater than 90%, ...Every Shift, ..."</p> <p>Care plan dated 5/17/14, PROBLEM: Resident is at risk for alteration in breathing pattern, ...APPROACH dated 5/21/14,: oxygen as ordered, ..."</p> <p>On 11/12/14 at 1:10 p.m., interview with</p>			

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F 371 SS=F Bldg. 00	<p>the Director of Nursing (DON) indicated when asked who was responsible for filling residents oxygen tank, "CNA's [Certified Nursing Assistants], they are responsible to fill at night. There is always 2 oxygen tanks in the room." When asked when should the tanks be checked the DON indicated, "They [C.N.A.'s] should check tanks before getting the resident up." How often should the tanks be checked? "Well they don't last that long."</p> <p>3.1-47(a)(6)</p> <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 cold food was stored at the proper temperature, in that cold food temperatures were measured at 51-55 degrees Fahrenheit, and failed to ensure staff used proper handwashing in the kitchen, in that the staff was observed not to wash their hands as indicated by facility policy, the Center for Disease</p>	F 371	Meadow Lakes is requesting an informal dispute resolution for this citation. The facility does not agree with the information. Thank you for your consideration. F-371 SS=F It is the intention of Meadow Lakes to store, prepare and distribute food under sanitary conditions. What corrective action(s) will be accomplished for those residents found to be affected	12/19/2014

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	<p>Control and the 410 IAC 7-24 Retail Food Establishment Sanitation Requirements. This deficient practice had the potential to affect 124 of 124 residents served from the kitchen. (DA #1 and Cook #1)</p> <p>Findings include:</p> <p>1. On 11/10/14 at 10:40 a.m., observed the temperature in the milk cooler in the kitchen to be 42 degrees Fahrenheit. Inside the cooler were 56 cartons of skim milk and 41 cartons of chocolate milk.</p> <p>The Dietary Manager (DM) was observed to take the temperature of two cartons of milk. A skim milk temperature measured 51 degrees Fahrenheit and the temperature of a chocolate milk carton measured 55 degrees Fahrenheit. The DM was observed to have Dietary Aide #4 to discard all the milk at that time. The Maintenance Supervisor removed the cooler from the kitchen.</p> <p>2. On 11/10/14 at 11:10 a.m., observed Cook #1 walk to the trash and threw something in, put her hands in her uniform pocket, and walked over to the prep counter. Cook #1 wrote on a label for the tea containers, walked over to a cart and placed the lid on the container. She than walked over to the prep table</p>		<p>by the deficient practice- 1. No residents were affected by the improper temperature of the cooler. The contents of the entire cooler were discarded. The milk cooler was repaired. Following the repair, the milk was proper temperature. 2. Cook #1 was educated on the appropriate circumstances to hand wash. Cook #1 was educated on the hand washing policy, including a return demonstration. 3. Dietary staff was educated to remove the utensils from a pan when not in use and place on a clean surface. There is no requirement that there cannot be a utensil in a pan. This did not affect any resident. 4. Dietary Aide #1 was educated on proper storage of ice scoop and ice machine technique. The ice was removed and sanitized. There were no residents served this ice. 5. There was no negative outcome for this resident. She was given a new yogurt. The temperature of the yogurt was 45 degrees. There is no requirement for specific temperature at the point of service. The food item was on a room tray. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken- 1. All residents had the potential to be effected yet no other residents were affected as the cooler was emptied and repaired 2. Cook #1</p>	

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	<p>and crossed her arms. She then walked over picked up a plastic container filled with water and made lemonade. No handwashing was observed. When asked when should handwashing be done Cook #1 indicated, "When you come into the kitchen, when you touch something like your face, when you leave the kitchen." When asked if that was done, Cook #1 indicated, " No, did I touch something. I didn't touch the trash." When informed that she put her hands in her pocket and crossed her arms. Cook #1 indicated, "You're right, you're right. It is what it is."</p> <p>3. On 11/17/14 at 11:15 a.m., observed Dietary Aide #1 (DA) to get a metal bucket from a cart in the kitchen, walk over to the ice machine and dip the bucket into the ice machine to get ice. She then walked over and place the bucket on the cart. DA #1 got another bucket from the cart, walk over to the ice machine and dip the bucket in to get ice. DA #1 placed the bucket on the cart and got a 3rd bucket to fill with ice. At that time the Dietary Manager stopped DA #1 and indicated to her, she could not dip the bucket into the ice machine and to use the ice scoop.</p> <p>On 11/17/14 at 11:40 a.m., the Dietary Manager indicated, "We have removed</p>		<p>was educated on the appropriate circumstances to hand wash. Cook #1 was educated on the hand washing policy, including a return demonstration. Staff was educated on proper hand washing procedure, including a return demonstration. 3. No residents are affected by this. 4. No residents were affected by the breach in sanitation. The ice machine was emptied and sanitized. Education was presented to the dietary staff on the proper utilization and storage of the ice scoop. 5. Food temperatures are taken prior to meal service. The cooler temperature is checked and recorded daily. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur- 1. The temperature of the milk is recorded daily, by a dietary staff member, at each meal prior to and following each meal. The milk cooler temperature is checked and recorded three times daily. 2. Staff was educated on proper hand washing procedure, including a return demonstration. 3. Utensils are removed from pans when not in use. 4. Registered dietitian or designee will review on the monthly sanitation review to ensure compliance is maintained. 5. Food temperatures are taken prior to meal service. The cooler</p>		

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	<p>all the ice from the ice machine, because she [indicating DA #1] stuck the buckets in there."</p> <p>4. On 11/8/2014 at 12:47 p.m., the Infection Control Nurse brought Resident #93's lunch tray to the room. The breakfast tray was still present on the bedside table. The Dietary Supervisor measured the temperatures of the food on the tray, the yogurt measured 45 degrees Fahrenheit. The Dietary Supervisor indicated the temperature should be 40 degrees or below and removed it from the residents tray and replaced it.</p> <p>On 11/25/14 at 4:03 p.m., review of the 410 IAC 7-24-187 dated November 13, 2004, indicated "Potentially hazardous food; hot and cold holding, ...[a] Except during preparation, cooking, or cooling, ...potentially hazardous food shall be maintained as follows: ...[2] At a temperature specified in the following: [A] At forty-one [41] degrees Fahrenheit or less. ..."</p> <p>On 11/12/14 at 4:05 p.m., the Director of Nursing provided policy "DIETARY/FOOD SERVICES" revised date 2/2012, and indicated that was the policy currently used by the facility. The policy indicated, "...PURPOSE: To ensure safe and sanitary food preparation</p>		<p>temperature is checked and recorded daily. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE, what quality assurance program will be put into place-</p> <p>1. The temperature logs will be reviewed daily by the Dietary manager or designee. The logs are kept up to date during open kitchen hours-7 days per week. The logs will be presented to the Continuous Quality Improvement committee monthly for 6 months.</p> <p>2. The nursing staff is completing a daily survey checklist on all shifts in all departments. The facility will complete a Continuous Quality Improvement Tool titled: 'Quality Indicator: Infection Control Review' , weekly for 4 weeks, then monthly for 5 months. The tool will continue weekly until substantial compliance is met and maintained. Substantial compliance is defined as a score at or above 95% 3. The dietary manager or designee will ensure the utensils are not stored in the pots, 7 days per week. There is a checklist in place. Registered dietitian or designee will review on the monthly sanitation review to ensure compliance is maintained. The results will be reviewed at the Continuous Quality Improvement Review meeting monthly for 6 months to establish a pattern of compliance. 4. The dietary</p>	

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	<p>and operation to prevent foodborne illnesses. ...2. Dietary Staff Requirements: ... d. Practice proper food handling procedures, including but not limited to handwashing, ..."</p> <p>On 11/13/14 at 8:35 a.m., the Administrator provided policy "AMERICAN SENIOR COMMUNITIES FOOD HANDLING" dated 1/2014, and indicated that was the policy currently used by the facility. The policy indicated "... b. After touching bare human body parts other than clean hands and clean exposed portions of arms; ...d. After handling soiled surfaces, equipment or utensils; e. ... when changing tasks, ...g. After engaging in other activities that contaminate the hands [... touching ...uniform]."</p> <p>On 11/25/14, review of Center for Disease Control at www.cdc.gov/handwashing/, dated December 16, 2013 indicated, " When should you wash your hands? Before, during, and after preparing food ... After touching garbage How should you wash your hands? Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. Scrub your hands for at least 20 seconds. ..."</p>		<p>manager or designee will ensure the ice scoop is stored properly daily, seven days per week. Registered dietitian or designee will review on the monthly sanitation review to ensure compliance is maintained. The results will be reviewed at the Continuous Quality Improvement Review meeting monthly for 6 months to establish a pattern of compliance. 5. The temp logs are completed each day, seven days per week, during open kitchen hours. Registered dietitian or designee will review on the monthly sanitation review to ensure compliance is maintained. The results will be reviewed at the Continuous Quality Improvement Review meeting monthly for 6 months to establish a pattern of compliance. By what date the systemic changes will be completed- 1. 12/19/2014 2. 12/19/2014 3. 12/19/2014 4. 12/19/2014 5. 12/19/2014</p>	

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F 372 SS=C Bldg. 00	<p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. Based on observation and interview, the facility failed to ensure proper disposal of garbage for 1 of 1 outdoors waste receptacles.</p> <p>Findings include:</p> <p>On 11/20/14 at 2:22 p.m. with the Dietary Consultant and Dietary Manager (DM) present observed the outside dumpster lids to be open, side door open and a trash bag slightly hanging out. When asked if the lids and door should be open, the DM indicated, "No, it should be closed and closed tight, the lid should be shut." Observed the DM close the lid and shut the door to the dumpster at that time.</p> <p>On 11/12/14 at 4:05 p.m., the Director of Nursing provided policy "DIETARY/FOOD SERVICES" revised date 2/2012, and indicated that was the one currently used by the facility. The</p>	F 372	<p>Meadow Lakes is requesting an informal dispute resolution for this citing as the facility does not agree with the information. Thank you for your consideration.</p> <p>F-372 SS=D</p> <p>It is the intention of Meadow Lakes to dispose of garbage and refuse properly.</p> <p>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice-</p> <ul style="list-style-type: none"> No residents were identified as being affected by the alleged deficient practice. A new trash receptacle was ordered and will be placed on or before December 19, 2014. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken-</p> <ul style="list-style-type: none"> All residents residing in the facility have the potential to be 	12/25/2014

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	<p>policy indicated, "...PURPOSE: To ensure safe and sanitary food preparation and operation to prevent foodborne illnesses. ...2. Dietary Staff Requirements: ...6. Dietary waste management include: ... c. Outside holding areas (dumpster, compactor, or cans) ...ii. Dumpster lids are closed, ..."</p> <p>3.1-21(i)(5)</p>		<p>affected by the alleged deficient practice.</p> <ul style="list-style-type: none"> · A new trash receptacle was ordered and will be placed by December 19, 2014 by Republic Trash Services. · The ED/designee in-serviced the maintenance supervisor on ensuring the facility trash containers have an appropriate closing lid on or before December 19, 2014 · Facility staff will be in-serviced on ensuring the facility trash bins have the lids closed at all times. This education will be provided by the Clinical Education Coordinator or designee by December 19, 2014 <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur-</p> <ul style="list-style-type: none"> · The ED/designee in serviced the maintenance supervisor on ensuring the facility trash containers have an appropriate closing lid on or before December 19, 2014 · Facility staff will be in-serviced on ensuring the facility trash bins have the lids closed at all times. This education will be provided by the Clinical Education Coordinator designee by December 19, 2014 · The maintenance supervisor or house supervisor will check the trash bins daily to ensure the lids are closed and have an appropriately fitting lid 	

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R 000 Bldg. 00	The following state findings are cited in accordance with 410 IAC 16.2-5.	R 000	<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE, what quality assurance program will be put into place-</p> <ul style="list-style-type: none"> · Executive Director or Designee will monitor the trash bins 3x daily 5 days/week for 4 weeks then 5x/week for 5 months, then weekly x2 months to ensure compliance. o Data will be given to QA committee monthly to ensure compliance for 6 months after which the CQI team will re-evaluate the continued need for the audit. If a 100% threshold is not achieved an action plan will be developed. <p>By what date the systemic changes will be completed- 12/19/2014</p>	
R 273	410 IAC 16.2-5-5.1(f)		<p>Meadow Lakes is respectfully requesting a paper compliance review for the federal and state citations for the survey which ended November 24, 2014. Please review the plan of correction submitted, with supporting documentation, to establish substantial compliance has been met and maintained as of December 19, 2014. Thank you, in advance, for your attention to this very serious matter.</p>	

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Bldg. 00	<p>Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper handwashing was completed in the Residential kitchen as indicated by facility policy and Center for Disease Control and ice machine maintained in clean operation status. This deficient practice had the potential to affect 43 of 43 residents being served out of the kitchen. (DA #2 (Dietary Aide))</p> <p>Findings include:</p> <p>On 11/20/14 at 2:10 p.m., with the DM present observed the Residential ice machine to have thick white substance on and in the drain pan. The container around the water spout was dirty. There was a chunk of yellowish chalk-like substance in the drain pan. When asked what was that substance, the DM indicated, "Lime, from that hard water." Observed the DM at that time tell DA #2 to remove and go get [Name of the Assistant Dietary Manager]. The DM was observed to removed the container from round the water spout and ice dispenser.</p> <p>On 11/20/14 at 2:15 p.m. observed DA</p>	R 273	<p>Meadow Lakes is respectfully requesting a face to face informal dispute resolution for this citing. State finding R-273</p> <p>It is the intention of Meadow Lakes to ensure that all food preparation and serving areas are maintained in accordance with state and local sanitation and safe food handling standards.</p> <p>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice-</p> <ol style="list-style-type: none"> The ice machine was cleaned and de-limed on the date identified during the survey Dietary aide #2 was educated on the proper times and procedure for hand washing. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken-</p> <ol style="list-style-type: none"> The ice machine was cleaned and de-limed on the date identified during the survey. There was no negative outcome for any clients. The dietary staff will clean according to policy. Dietary aide #2 was educated 	12/19/2014			

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	<p>#2 to enter the Residential kitchen and handwash for 12 seconds. She walked over to a cart in the kitchen, place something on the cart. She exited the kitchen to go get the Assistant Dietary Manager. DA #2 was observed to enter the Residential kitchen. She walked over to the prep table and started rolling utensil in napkins. When asked how when should she handwash, DA #2 indicated, "Every time I touch something, every time I go out of the kitchen." When asked how long should she handwash, DA #2 indicated, "Twenty seconds." When asked if that was done, DA #2 indicated, "Yes I'm sure it was 20 seconds."</p> <p>On 11/24/14 at 1:48 p.m., the Administrator provided "...Cleaning Ice Machine and Scoop" revision date 5/2006, and indicated that was the policy currently used by the facility. The policy indicated, " The ice machine equipment ... will be cleaned on a regular basis to maintain a clean, sanitary condition. ...Wash interior thoroughly using detergent solution. ...Sanitize... Note: If self-dispensing ice machine, wash and clean only the outside of the machine. Sanitize the ice dispensing mechanism and drain area. Maintenance will clean and maintain the interior."</p>		<p>on the proper times and procedure for hand washing</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur-</p> <ol style="list-style-type: none"> The deep cleaning will be conducted monthly by the dietary staff to ensure the lime is addressed per the facility procedure. The ice machine was added to the Assisted Living daily cleaning tasks. There is a checklist that is signed off daily. The dietary staff was educated on proper hand washing procedure. This included the appropriate times to wash hands. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE, what quality assurance program will be put into place-</p> <ol style="list-style-type: none"> Registered dietitian or designee will review on the monthly sanitation review to ensure compliance is maintained. The results will be reviewed at the Continuous Quality Improvement Review meeting monthly for 3 months to establish a pattern of compliance. The Registered Dietitian or designee will conduct sanitation rounds. This includes hand washing. The results will be turned in and reviewed by the Continuous Quality Improvement review team. This will be reviewed for a period of three months to establish compliance. 	

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	<p>On 11/12/14 at 4:05 p.m., the Director of Nursing provided policy "DIETARY/FOOD SERVICES" revised date 2/2012, and indicated that was the one currently used by the facility. The policy indicated, "...PURPOSE: To ensure safe and sanitary food preparation and operation to prevent foodborne illnesses. ...2. Dietary Staff Requirements: ... d. Practice proper food handling procedures, including but not limited to handwashing, ..."</p> <p>On 11/13/14 at 8:35 a.m., the Administrator provided policy "AMERICAN SENIOR COMMUNITIES FOOD HANDLING" dated 1/2014, and indicated that was the one currently used by the facility. The policy indicated "... b. After touching bare human body parts other than clean hands and clean exposed portions of arms; ...d. After handling soiled surfaces, equipment or utensils; e. ... when changing tasks, ...g. After engaging in other activities that contaminate the hands [... touching ...uniform]."</p> <p>On 11/25/14, review of Center for Disease Control at www.cdc.gov/handwashing/, dated December 16, 2013 indicated, " When should you wash your hands? Before, during, and after preparing food</p>		<p>By what date the systemic changes will be completed-</p> <p>1. 12/19/2014</p>				

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	... How should you wash your hands? Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice. ... "				