

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/05/2016
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NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00197474.</p> <p>Complaint IN00197474 - Unsubstantiated due to lack of sufficient evidence.</p> <p>Survey dates: April 26, 27, 28, 29, May 2, 4, and 5, 2016</p> <p>Facility Number: 000128 Provider Number: 155223 AIM Number: 100289650</p> <p>Census bed type: SNF/NF: 90 Total: 90</p> <p>Census payor type: Medicare: 15 Medicaid: 52 Other: 23 Total: 90</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 5/9/2016 by</p>	F 0000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider or any conclusion set forth in the statement of deficiencies, or any violation of regulation. Provider desires that the 2567 plan of correction be considered the letter of credible compliance and request a desk review certification of compliance on or after 5/25/2016 Fay Pruitt, HFA</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 0272 SS=D Bldg. 00	29479. 483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. Based on observation, record review, and	F 0272	It is the policy of the facility to conduct initial and periodic	05/25/2016	

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	<p>interview, the facility failed to ensure an accurate comprehensive nursing bladder assessment was completed for a resident admitted with a urinary catheter for 1 of 1 resident reviewed for a urinary catheter. (Resident #35)</p> <p>Finding includes:</p> <p>On 4/27/16 at 10:35 a.m., Resident #35 was observed in his room, sitting in his wheelchair watching TV. The resident had an indwelling urinary catheter.</p> <p>The medical record for Resident #35 was reviewed on 4/28/16 at 1:28 p.m. The record indicated the resident was admitted on 4/18/16 and diagnosis included, but was not limited to, retention of urine, unspecified.</p> <p>Resident #35's Hospital Discharge Report dated 4/18/16, indicated a urinary catheter was present upon discharge from the hospital.</p> <p>A Bowel and Bladder Incontinence Screener dated 4/19/16, indicated the resident never voided appropriately. The document did not indicated the resident had a urinary catheter.</p> <p>The 5-day Medicare Minimum Data Set (MDS) assessment was completed on</p>		<p>assessments as required by regulation to establish the functional capacity of each resident. Resident #35 has had his catheter removed as according to assessment, he did not have a medical need to support the use of an indwelling catheter. Any resident who resides in the facility and who has an indwelling catheter has the potential to be affected by this finding. A facility wide audit was conducted to ensure that no resident residing in the facility who has an indwelling catheter lacks proper assessment/criteria to support the use of the catheter. Any concerns were addressed as discovered. The DON/Designee will monitor all new admissions to be certain that as part of the admission process, any resident admitted with an indwelling catheter has a comprehensive assessment completed to verify that the resident's condition and urinary elimination status meets the regulatory criteria for the placement of the catheter. If it does not, the physician will be notified and a plan for bladder management will be discussed. This monitoring will be part of the agenda of the daily CQI meetings and it will be ongoing. The concern will remain on the daily CQI agenda until resolved for each admission or readmission. This process will be ongoing. At an in-service held for the</p>	

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	<p>4/25/16. The assessment indicated the resident had a urinary catheter.</p> <p>During an interview with the ADON (Assistant Director of Nursing) on 5/2/16 at 3:05 p.m., she indicated the admission bladder assessment indicated the resident did not have a urinary catheter.</p> <p>On 5/2/16 at 3: 09 p.m., the Vice President of Clinical Services indicated Resident #35's urinary catheter should have been identified by the nurse on the admission bladder assessment.</p> <p>A policy and procedure titled, "Resident Admission/Re-Admission Assessment," dated 7/1/11 and identified as current, was received from the ADON on 5/4/16 at 11:40 a.m. The policy indicated, "...Guideline: All resident's are to be assessed upon admission or readmission...."</p> <p>A policy, dated 7/1/11, and identified as current, titled, "Incontinence," provided by the DON (Director of Nursing) on 5/4/16 at 11:40 a.m., indicated, "...Procedure-Assessment/Evaluation:...2. Complete the Bladder Assessment Form...Obtaining admission information regarding urinary continence status...."</p> <p>3.1-31(c)(1)</p>		<p>nursing staff 5/11/2016, the following was reviewed: A.) Bowel/Bladder Assessments—What? When? Who? B.) Catheter Use--Criteria/Diagnosis for indwelling catheter C.) Care of a catheter/tubing/urinary drainage bag--as related to both infection control and dignity D.) Incontinence Care E.) Toileting Programs F.) Questions/Answers Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings, the monitoring by the DON/Designee as related to admission and readmission assessments for residents with indwelling catheters will be reviewed. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored weekly by the Administrator until resolved.</p>		

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F 0278 SS=D Bldg. 00	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure the accuracy of the skin assessment used for the coding of the Admission Minimum Data</p>	F 0278	It is the policy of the facility to ensure that resident assessments are an accurate reflection of the resident's status and functional capacity. The MDS coding for	05/25/2016

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	<p>Set for 1 of 3 residents reviewed with pressure ulcers (Resident #107).</p> <p>Finding includes:</p> <p>A review, on 4/29/16 at 2:19 p.m., of Resident #107's 14-day scheduled Minimum Data Set (MDS) Assessment, dated 2/26/16, Section M (M0210), titled Unhealed Pressure Ulcer(s) indicated a code of 0-no unhealed pressure ulcer(s) at Stage 1 or higher.</p> <p>The Weekly Skin Wound Assessment, dated 4/12/16, indicated Resident #107 had developed a Stage II pressure ulcer on her right heel. The Weekly Skin Wound Assessment, dated 4/20/16, indicated Resident #107 had developed a Stage II pressure ulcer on her right buttocks.</p> <p>The MDS Coordinator, on 5/4/16 at 12:59 p.m., indicated the MDS assessment, dated 2/25/16, indicated no pressure ulcers, because they told me it was shearing on her right buttocks. I was not told Resident #107 had 2 pressure ulcers, so an MDS Significant Change Assessment had not been completed, but should have been done on 4/20/16, when the Resident's second wound was changed from a skin tear to a pressure ulcer.</p>		<p>Resident #107 is an accurate reflection their status and functional capacity. Any resident who resides in the facility has the potential to be affected by this finding. A 30 day "look back" audit was conducted to ensure that no resident had experienced a "Significant Change In Condition" which would prompt the need for a "Significant Change In Status Assessment" to be completed as per MDS RAI guidelines. Had any been discovered, the appropriate assessment would have been completed. At the morning CQI meetings, the MDS Coordinator will receive information contained in the progress notes, orders and IDT discussion that have taken place since the prior CQI meeting. If any resident meets criteria for a Significant Change In Status assessment, the MDS Coordinator will initiate it and complete it timely. The DON/Designee and the MDS Coordinator will review weekly any residents who have had a change of condition to ensure that if that change of condition meets the requirements for an MDS Significant Change In Status Assessment that one has been completed. This monitoring will continue weekly until 4 consecutive weeks of zero negative findings is achieved. Then, the monitoring will continue every 2 weeks for a period of not less than 6 months to ensure</p>	

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F 0315 SS=D Bldg. 00	<p>The Administrator, on 5/4/16 at 2:45 p.m., indicated the facility policy was to follow the Center for Medicare Services (CMS) Resident Assessment Instrument (RAI), Version 3.0 Manual MDS assessment guidelines for every resident MDS Assessment.</p> <p>The MDS Coordinator provided a copy of the Center for Medicare Services (CMS) Resident Assessment Instrument (RAI), Version 3.0 Manual, on 5/5/16 at 10:50 a.m., which included but was not limited to, "...03. Significant Change In Status Assessment (SCSA) (A0310A=04) ...A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not 'self-limiting' (for declines only); 2. Impacts more than one area of the resident's health status...."</p> <p>3.1-31(d)(3)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a</p>		<p>ongoing compliance. After that, random monitoring will occur. Note: Any concerns will be addressed as found. At an in-service by the MDS Consultant held for the IDT team and in the presence of the Administrator and the DON/ADON on 5/23/2016, the criteria necessary for an MDS Significant Change In Status Assessment was reviewed including their individual roles in completion of their input. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings, the results of the monitoring of the Significant Change In Status Assessment MDSs will be reviewed. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any Action Plans will be monitored weekly by the Administrator until resolution.</p>		

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	<p>resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interview, the facility failed to ensure services were provided to prevent possible urinary tract infections and medical justification for a urinary catheter for 1 of 1 resident reviewed with a urinary catheter (Resident #35).</p> <p>Findings include:</p> <p>On 4/27/16 at 10:35 a.m., Resident #35 was observed in his room, sitting in his wheelchair watching TV. The resident had an indwelling urinary catheter.</p> <p>On 4/27/16 at 10:51 a.m., Resident #35 was observed sitting in his wheelchair in his room. The resident's urinary catheter drainage bag was observed lying on the floor next to his wheelchair.</p> <p>The medical record for Resident #35 was reviewed on 4/28/16 at 1:28 p.m. The record indicated the resident was admitted on 4/18/16 and diagnosis included, but was not limited to, retention of urine, unspecified.</p>	F 0315	<p>It is the policy of the facility to ensure that residents who enter the facility without a catheter do not receive one unless their clinical condition indicates that a catheter is indicated. Further, residents who reside in the facility and who are incontinent, receive the appropriate care and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Resident # 35 has had his catheter removed as per according to assessment he did not have a medical reason to support the use of an indwelling catheter. (See responses to F-272 as they are inclusive for F-315 for "like residents" identification, monitoring, education and Quality Assurance ongoing) In addition, the DON/Designee will monitor all indwelling catheters 5 days weekly on various shifts and to include some weekend days to ensure that all catheters/tubings are properly positioned and that the urinary drainage bags not touching the floor. This monitoring will continue until 4 consecutive weeks of zero</p>	05/25/2016

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	<p>A care plan dated 4/24/16, indicated the resident had a urinary catheter related to a diagnosis of urinary retention.</p> <p>The 5-day Medicare Minimum Data Set (MDS) assessment was completed on 4/25/16. The assessment indicated the resident had a urinary catheter.</p> <p>Review of the physician's orders indicated there were no orders pertaining to the resident's urinary catheter.</p> <p>During an interview on 5/2/16 at 1:15 p.m., LPN #1 indicated the resident had a urinary catheter due to urinary retention.</p> <p>During an interview on 5/2/16 at 1:37 p.m., MDS (Minimum Data Set) Coordinator #2 indicated the resident had a urinary catheter due to a diagnosis of urinary retention. She indicated urinary retention was not a justified diagnosis unless it was related to another medical condition. At 1:42 p.m., MDS Coordinator #2 indicated a related diagnosis was not identified for the resident's urinary catheter. She indicated the urinary catheter had been placed when the resident was in the hospital and he had been admitted back to the facility with the urinary catheter.</p>		<p>negative findings is achieved. Then the monitoring will continue weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. Note: Any concerns will be corrected as found. At the monthly QA meetings, the results of the catheters/tubings/urinary drainage bags will be reviewed for any patterns, however any findings will have been addressed and corrected as found.</p>	

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	<p>During an interview on 5/2/16 at 2:09 p.m., CNA #3 indicated the resident's urinary catheter drainage bag should never touch the floor.</p> <p>During an interview on 5/2/16 at 2:56 p.m., LPN #1 indicated there were no orders for the resident's urinary catheter in the MAR (Medication Administration Record).</p> <p>During an interview on 5/2/16 at 3:05 p.m., the ADON (Assistant Director of Nursing) indicated there was not an order or a justified diagnosis for the resident's urinary catheter. She indicated the nurse failed to identify the urinary catheter at admission and no follow-up call for catheter orders was made to the physician.</p> <p>During an interview on 5/2/16 at 3:09 p.m., the Vice President of Clinical Services indicated the nurse should have identified the urinary catheter during the admission assessment and contacted the physician for orders.</p> <p>During an interview on 5/4/16 at 12:18 p.m., the DON (Director of Nursing) indicated it was an infection control risk for a urinary catheter drainage bag to touch the floor. She indicated a urinary catheter drainage bag should never touch</p>			

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	<p>the floor.</p> <p>A policy, dated 7/1/11 and identified as current, titled, "Incontinence," provided by the DON (Director of Nursing) on 5/4/16 at 11:40 a.m., indicated, "...Procedure-Assessment/Evaluation:...2. Complete the Bladder Assessment Form...Obtaining admission information regarding urinary continence status...Catheters: Use the Indwelling Catheter Justification/Decision Diagram to assist with evaluation of indwelling catheters."</p> <p>A copy of a document, dated 7/1/11 and identified as current, titled, "Indwelling Catheter Justification/Decision Diagram," provided by the DON on 5/4/16 at 11:40 a.m., indicated, "Review Admission Paperwork and Physician Orders...Enter Physician order for the Indwelling catheter..."</p> <p>On 5/5/16 at 10:40 a.m., the DON provided a copy of the Lippincott Nursing Manual, ninth edition, identified it as a current policy for management of indwelling catheters, titled, "Management of the Patient with an Indwelling (Self-Retaining) Catheter and Closed Drainage System...Maintaining a closed drainage system...2...c. Keep the bag off the floor...3...c. Avoid letting the</p>			

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F 0364 SS=D Bldg. 00	<p>drainage bag touch the floor...."</p> <p>3.1-41(a)(1) 3.1-41(a)(2)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview, and record review the facility failed to ensure food was served at the proper temperature for 2 of 2 test trays reviewed for food temperatures.</p> <p>Finding Includes:</p> <p>On 5/4/16 at 1:57 p.m., two test trays were obtained from the kitchen for the ICF (Intermediate Care Facility) unit. The food temperatures were as follows:</p> <p>a). Mechanical soft chicken sandwich was 101.3 degrees Fahrenheit.</p>	F 0364	<p>It is the policy of the facility to ensure that food is served at the proper temperature as per regulation and guidelines. Mechanical soft chicken sandwiches, mashed potatoes, baked potatoes, squash and mechanical squash are all served at appropriate temps. Resident #108 is satisfied with the temperature of her food/meals as served. Any residents who receive a meal tray or food prepared and served from the dietary department have the potential to be affected by this finding. The Dietary Manager/Designee will temp food prior to it being served to the residents. This is to ensure that</p>	05/25/2016	

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	<p>b). Mashed Potatoes was 125.6 degrees Fahrenheit.</p> <p>c.) Baked Potatoes was 134.0 degrees Fahrenheit.</p> <p>d). Squash was 124.6 degrees Fahrenheit.</p> <p>e). Mechanical soft squash was 123.1 degrees Fahrenheit.</p> <p>On 4/27/16 at 11:54 a.m., Resident # 108's daughter and POA (power of attorney) indicated, her mother often complained her food was cold when she received a hall tray from the kitchen.</p> <p>On 5/4/16 at 2:35 p.m., the administrator indicated all the foods served on the trays should have been at least 135.0 degrees Fahrenheit.</p> <p>On 5/5/16 at 1:15 p.m., the administrator and acting dietary manager indicated she had not monitored the hall trays weekly for food temperatures per policy.</p> <p>A policy dated 2010, identified as current, titled, "Serving Food and Beverages", provided by the Administrator on 5/4/16 at 9:00 a.m., included but not limited to, "...1. Foods shall be served at the following temperatures to ensure a safe and</p>		<p>the foods "temp" within acceptable parameters before served. Any concerns will be addressed as found. This process will be ongoing. Further, there will be a test tray sent to each unit where trays are served as well as the main dining room. It will be the last tray on the cart (after resident trays have been served). The temps will be recorded. Any concerns will be addressed a found. This will be done until 4 consecutive weeks of zero negative findings is achieved. After that, a test tray will be sent weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random test trays will be sent.</p> <p>Further, the Dietary Manager/Designee will interview 10 residents 3 days weekly from various dining areas and at various meals and days (including some weekend days) to ensure satisfaction with meal/food temps. Any concerns will be addressed as found. This monitoring will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, the monitoring of 10 residents will occur once weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. At an in-service held for Dietary staff 5/23/2016, the following was reviewed: A.) Food temps—parameters/maintaining</p>		

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F 0371 SS=E Bldg. 00	<p>appetizing dining experience: Meat, casseroles 135.0 degrees to 170 degrees Fahrenheit and Vegetables, Potatoes 135 degrees to 170 degrees Fahrenheit...8. Food temperatures for trays delivered to elder rooms or hall area will be monitored weekly by the Food Service Manager...."</p> <p>3.1-21(a)(2)</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</p>		<p>B.) Temping food prior to serving C.) Recording food temps D.) Test trays E.) What to do if food is found to be unacceptable F.) Questions/Answers At an in-service held for all staff who assist in tray delivery held 5/23/2016, the following was reviewed: A.) Why timely tray delivery? B.) Why have test trays? C.) What do I do if a resident complains about the food temp? D.) Resident Rights/Dignity—related to the Dining Experience E.) Infection Control practices as trays are delivered and/or food is served F.) Questions/Answers Any staff who fail to comply with the points of the in-service will be further educated and progressively disciplined as indicated. At the monthly QA meetings the results of the monitoring of the food trays and the resident interviews will be reviewed. Any patterns will have been identified. If necessary, an Action Plan will be written by the committee to address any patterns. The Administrator will monitor any Action Plan weekly until resolution. Note: Any concerns will have been addressed as found.</p>		

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	<p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was prepared under sanitary conditions for 1 of 2 kitchen observations and failed to ensure food was served under sanitary conditions to 7 of 60 residents served in the main dining room (Residents #83, #1, #61, #120, #27, #127, #51, #36, and #6).</p> <p>Findings include:</p> <p>1). During an initial kitchen tour on 4/26/16 at 10:24 a.m. the following were observed:</p> <p>a). Dried food particles, fresh food items and small pieces of paper debris, including paper straw wrappers, cracker wrappers, and paper towel pieces, were observed on the soiled and dingy kitchen floor, including the area in front of the food preparation table.</p> <p>b). A yellow-brown greasy build-up was present on the front and down the sides of the stove and ovens.</p> <p>c). The steam table was observed with lime build-up and soiled with food debris and bread crumbs.</p>	F 0371	<p>It is the policy of the facility to see that food is stored and prepared in a sanitary environment. The entire dietary department floor has been thoroughly cleaned and this cleanliness will be maintained. The stoves/ovens have been thoroughly cleaned and this cleanliness will be maintained. The steam table has been thoroughly cleaned and this cleanliness will be maintained. All opened bread is dated when opened. All items in the refrigerator and/or freezer are labeled and dated properly. Any outdated foods are thrown away. Foods even in containers are not placed directly onto the floor. A protective barrier is in place. This includes the back hallway. Foods are not stored closer than 18 inches from a ceiling. There is a detailed cleaning schedule that covers cleaning of the entire kitchen and its equipment. All equipment is stored clean and in a clean acceptable space prior to use. All meals are served under sanitary conditions. Those serving food do not touch their face, hair or glasses or any other unclean surface while passing food trays. Staff do not touch food including buttering bread, with their bare hands. All residents who eat food stored/prepared by the facility and served by staff have the potential to be affected by this finding. The</p>	05/25/2016

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	<p>d). An opened and undated loaf of bread in a bag was observed on the kitchen counter.</p> <p>e). In the front kitchen refrigerator, 2 trays containing 14-4 ounce cups with a red liquid were observed unlabeled and undated, a bag of salad and 2 gallon jars of pickles were observed opened and undated.</p> <p>f). In the back kitchen refrigerator, 2 large scoops were observed lying on a rack in the refrigerator.</p> <p>g). In the Kitchen's back hallway by the walk-in refrigerator, a new shipment of food which contained, 2-20.57 lb. (pound) boxes of Flat Buffet Ham, a box of frozen potato rounds, a boxed case of vanilla shakes, and a boxed case of 1/2" (inch) Crinkle Oven Frozen Potatoes was observed placed directly onto the soiled and sticky floor without a protective barrier. Five, plastic, canister, cereal containers were observed undated and unlabeled in the back hallway also.</p> <p>h). In the walk-in refrigerator, a large bag of celery and a large bag of coleslaw were observed opened and undated.</p> <p>i). In the walk-in freezer, an opened and undated 20 lb. box of frozen broccoli was</p>		<p>Administrator/Designee will monitor 5 days weekly (at various shifts and times to include some weekend days/times) in the dietary department to see that the following occurs: 1.) All food in the refrigerators/freezers/dry storage is properly labeled and dated 2.) The dietary department is clean including floors/stoves/ovens/equipment/steam table and equipment 3.) Cleaning schedules are being followed 4.) No food is delivered and placed directly on a floor (even in a container) without a protective barrier 5.) No foods are stored closer than 18" from any ceiling The DON/Designee will monitor 5 days weekly (at various meals and times to include some weekend days/meals and in various dining areas) to ensure that staff practice proper technique in regards to infection control while serving resident food trays. This monitoring by both the Administrator/Designee and the DON/Designee will continue until 4 consecutive weeks of zero negative findings has been achieved. After wards, the monitoring will occur weekly by both for a period of not less than 6 months to ensure ongoing compliance, after that, random monitoring will occur. Note: Any concerns will be addressed immediately as found. At an in-service held for the dietary staff on 5/23/2016, the following was reviewed: A.) Dating and labeling</p>	

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	<p>observed touching the top of the freezer ceiling, along with several other boxes of frozen foods just a couple of inches from the top the freezer ceiling.</p> <p>On 4/26/16 at 10:56 a.m., Cook #10 indicated, there used to be a cleaning schedule for the kitchen, but the kitchen staff did not currently have a cleaning schedule, since the DM (Dietary Manager) had left approximately a month ago. The kitchen staff were informed approximately 2 weeks ago to start deep cleaning the kitchen and the kitchen staff have not got the kitchen put back together since. The air vents were cleaned first, which caused all the dust and dirt throughout and the kitchen has been turned upside ever since. The Cook further indicated, food should be dated when opened, drinks should be labeled and dated when prepared, scoops are to be stored in the scoop holder on the wall not left on the refrigerator racks, new deliveries of food should not be set directly onto the floor, but have a protective barrier, and food in the freezer should be at least 12 inches away from the ceiling for circulation.</p> <p>On 4/29/16 at 2:47 p.m. the ADM (Administrator) indicated the kitchen had been without a DM for about a month, when the previous DM left without</p>		<p>food in dry storage/refrigerators/freezers B.) When should a food be discarded? C.) Cleaning requirements and cleaning schedules in dietary D.) Protective floor barrier maintained for food delivery to the Dietary Department E.) Storing food away from the ceiling and/or sprinklers F.) Questions/Answers Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the results of the monitoring will be reviewed, however any concerns will have been immediately addressed and corrected as discovered.</p>				

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	<p>notice. Staff were told a couple of weeks ago to deep clean the kitchen. The kitchen does have a cleaning schedule, shipments of food should not be put directly onto the floor, opened food items should have opened dates, and all prepared food items should be labeled and dated.</p> <p>On 5/4/16 at 9:00 a.m., the ADM provided a blank copy of the kitchen cleaning schedule. She was not able to provide a completed kitchen cleaning schedule form.</p> <p>The ADM, on 5/4/16 at 9:00 a.m., provided a policy, titled "Date Marking," identified as current and dated 2010, which included but was not limited to, "Policy: All foods stored for more than 24 hours will be properly identified and marked according to the following guidelines ...Procedure: ...2. Date marking for refrigerated storage food items ...Once opened, all ready to eat, potentially hazardous food will be re-dated with the date the item was opened ...3. Date marking for freezer storage food items ...Once a package is opened, it will be redated with the date the item was opened...."</p> <p>The policy, titled Cleaning Rotation, dated 2010 and identified as current by</p>			

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	<p>the ADM was proved on 5/4/16 at 9:00 a.m., which included but was not limited to, "Guideline: Equipment and utensils will be cleaned according to the following guidelines, or manufacturer ' s instructions ...2. Items cleaned daily: Stove top, Grill, Kitchen and dining room floors, Steam table, Exterior of large appliances ...3. Items cleaned weekly: ...Ovens"</p> <p>2). On 4/26/16 during the noon meal service in the main dining room the following was observed:</p> <p>a). At 12:12 p.m., CNA (Certified Nursing Assistant) #8 was observed with her bare hands to retrieve a slice of bread out of a plastic wrapper and then proceeded to butter the bread for Resident #83. CNA #8 was then observed to scratch her head, adjust her eye glasses and push her hair behind her ear before she proceeded to assist Resident #83 with eating her lunch. CNA #8 was not observed to perform hand hygiene.</p> <p>b). At 12:19 p.m., CNA #8 was observed to wiped her nose with the back of her hand and then grabbed a fork and assisted Resident #1 with eating her lunch. CNA #8 was not observed to perform hand hygiene.</p>			

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	<p>c). At 12:33 p.m., CNA #8 was observed to scratch her nose, grab a fork and assisted Resident #61 with her lunch meal. CNA #8 was not observed to perform hand hygiene.</p> <p>On 4/29/16 at 2:50 p.m., the ADM (Administrator) indicated staff should not touch food with their bare hands and should sanitize their hands prior to assisting residents with their meals.</p> <p>3). On 4/26/16 during the noon meal service in the main dinning room the following was observed:</p> <p>a). At 12:15 p.m., CNA # 5 touched Resident # 120's slice of bread with her bare hands as she took the bread out of the plastic wrap.</p> <p>b). At 12:18 p.m., LPN # 7 touched Resident # 27's slice of bread with her bare fingers while she buttered the bread.</p> <p>c). At 12:19 p.m., CNA # 5 touched Resident # 127's slice of bread with her bare hands as she pulled the bread out of the plastic wrap.</p> <p>d). At 12:21 p.m., CNA # 5 touched Resident # 51's slice of bread with her bare hands as she pulled the bread out of the plastic wrap.</p>			

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	<p>e). At 12:39 p.m., CNA # 8 touched Resident # 36's slice of bread with her bare hands as she pulled the bread out of the plastic wrap.</p> <p>During an interview on 5/4/16 at 11:42 a.m., CNA # 6 indicated staff shouldn't be touching food items with their bare hands when they are serving residents their meals.</p> <p>A policy dated 08/11/11, identified as current, titled, "Policy and Procedure Meal Service", provided by the ADON on 5/4/16 at 11:40 a.m., included but not limited to, "...6. There is no bare hand contact with ready to eat foods...."</p> <p>3.1-21(i)(3)</p>			