

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155493	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/11/2013
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NAME OF PROVIDER OR SUPPLIER SCENIC HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 311 E FIRST ST FERDINAND, IN 47532
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 2, 3, 4, 5,11, 2013</p> <p>Facility number: 000534 Provider number: 155493 AIM number: 100267220</p> <p>Survey Team: Dorothy Watts, RN TC Martha Saull, RN Terri Walters, RN Carole McDaniels, RN</p> <p>Census bed type: SNF: 28 SNF/NF: 60 Total: 88</p> <p>Census payor type: Medicare: 7 Medicaid: 44 Other: 25 Total: 76</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 13, 2013, by Jodi Meyer, RN</p>	F000000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies.</p> <p>This plan of correction is prepared and executed solely because it is required by Federal and State law.</p> <p>This plan of correction is submitted in order to respond to the allegations of noncompliance cited during annual survey review concluding on 4-11-13</p> <p>Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before 5-8-2013</p> <p>We respectfully request a desk review for compliance.</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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F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview and record review, the facility failed to ensure table height and/or food types were in place to encourage and/or accommodate resident's independent eating skills for one of one resident reviewed for dining, for 3 of 3 meals observed in the restorative dining room. Resident #46</p> <p>Findings include: On 4/2/13 at 11:55 A.M., the noon meal service was observed in the restorative dining room. Resident #46 was observed in the 400 hall dining room in her wheelchair. She was sitting at a dining room table. The resident was observed to have a kyphotic spine (posterior, protruding curvature of the spine), with her nose observed at the level of the edge of the table. The resident was served her meal, which consisted of the following: peas and carrots, chicken patty and french fries. LPN #20 cut</p>	F000246	F 246 Residents #46 suffered no ill effects from the alleged deficient practice. The campus has contacted resident #46 physician and has received an order for finger foods, sippy cups, and can eat with her fingers. The table height has been adjusted for the resident and her care plan has been updated. Completion Date 5-8-2013 All residents have the potential to be affected and therefore through alterations in provision of care and in servicing the campus will assure the resident has the right to reside and receive services in the campus with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Completion Date 5-8-2013 An in-service has been completed concerning reasonable accommodations for the dining experience with all staff. Systemic change is the campus OT will observe one meal a week to assure reasonable accommodations are made for residents during meal time. Completion Date 5-8-2013 DHS	05/08/2013			

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	<p>up the resident's food for her.</p> <p>At 12:15 P.M., LPN #20 asked the resident if she wanted chicken or not. The resident was observed at 12:18 P.M., picking pieces of meat up from her plate with her fingers.</p> <p>At 12:28 P.M., CNA #5 began poking the meat on the plate with the fork. As she did this, the resident reached out for the fork. CNA #5 tried to assist the resident to hold the fork but the resident took a piece of meat with her hands.</p> <p>At 12:42 P.M., the resident was observed with the fork in her hand and was trying to stab meat. The Resident then grabbed the meat with her fingers and took a bite.</p> <p>At 1:04 P.M., the resident was observed to have eaten all the cobbler, which she was fed by CNA #5 with a spoon, no vegetables and bites of meat.</p> <p>On 4/4/13 at 12:10 P.M., the resident was observed in the dining room in her wheelchair. The end of the resident's wheelchair arm rest was observed to be at least 2 feet from the edge of the table. The table height was observed to be at the resident's level of her clavicle (collarbone). The meal served to the resident included the following: diced red cabbage, chicken breast and</p>		<p>or designee will audit 3 random residents during meal time to assure reasonable accommodations are made during meal time 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. Completed on Date 5-8-2013</p>		

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	<p>french fries. The dessert was the mandarin oranges. At that time, the resident was unable to reach the food positioned on the back area of her plate. The resident was observed to eat her food with her fingers. LPN #5 asked the resident if she wanted to eat more. At that time, LPN #5 took the resident's plate from the table and positioned it on the resident's lap. LPN #5 is sitting with the resident. Resident #46 was observed sitting at the table with her plate on her lap and was eating her meal with her fork.</p> <p>On 4/5/13 at 12:28 P.M., the resident was observed in the dining room in her wheelchair. The resident's chin is observed below the level of the edge of the table. At that time, the resident was served her tray by the ADON (assistant director of nursing). LPN #20 then sat down beside the resident. The resident was served a submarine type sandwich on a hoagie roll, french fries and pudding. The menu posted listed the food served as cookie and cream parfait, Italian hoagie, fries and white and chocolate milk and iced tea.</p> <p>On 4/5/13 at 12:41 P.M., the DON (Director of Nursing) was made aware of the above observation. The DON observed the resident's position at the</p>				

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	<p>table with the table height being higher than the resident's chin. The DON indicated she thought the resident was care planned for finger foods. At that time, the resident's clinical record was reviewed with the DON. She indicated documentation was lacking of a plan of care for the resident to have finger foods.</p> <p>A (name of hospice) Nursing comprehensive update/visit note, dated 3/27/13 was reviewed on 4/5/13 at 1 P.M. Recorded in the record was "musculoskeletal: kyphosis."</p> <p>On 4/5/13 at 1:15 P.M., the clinical record was reviewed. Diagnoses included but were not limited to the following: adult failure to thrive, general debility, dementia, and abnormal posture. A dietary note date 1/28/13, included, but was not limited to, the following: Diet is fortified foods; eating ability, adaptive equipment; assisted.</p> <p>Nurses notes, dated 4/5/13 at 2:30 P.M., indicated the following: "Res (resident) noted at meals eating increased % (percent) of meal with finger foods and increase in ADLs (activities of daily living) with sippy cups..."</p>			

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	<p>On 4/11/13 at 9 A.M., a copy of the resident's "Nutrition/Hydration Plan of Care" was received from the DON. That form included but was not limited to the following information: "Regular diet with fortified foods; fingerfoods prn (as needed)."</p> <p>On 4/11/13 at 8:50 A.M., the DON was interviewed. She indicated they had received a physician's order for the resident to have the finger foods. The DON indicated they have provided a resident with a table more accommodating to her height in the dining room. The DON indicated the residents care plan was also updated to reflect the finger foods.</p> <p>3.1-3(v)(1)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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 the resident's plan of care addressed specific accommodations to encourage and/or accommodate resident's independent eating skills for one of one resident reviewed for dining during 3 of 3 meals observed in the restorative dining room. Resident #46</p> <p>Findings include: On 4/2/13 at 11:55 A.M., the noon meal service was observed in the</p>	F000279	<p>F 279</p> <p>Residents #46 suffered no ill effects from the alleged deficient practice. The campus has contacted resident #46 physician and has received an order for finger foods, sippy cups, and can eat with her fingers. The table height has been adjusted for the resident and her care plan has been updated. Completion Date 5-8-2013</p> <p>All residents have the potential to be affected and therefore through alterations in provision of care and in servicing the campus will</p>	05/08/2013	

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	<p>restorative dining room. Resident #46 was observed in the 400 hall dining room in her wheelchair. She was sitting at a dining room table. The resident was observed to have a kyphotic spine (posterior, protruding curvature of the spine), with her nose observed at the level of the edge of the table. The resident was served her meal, which consisted of the following: peas and carrots, chicken patty and french fries. LPN #20 cut up the resident's food for her. At 12:15 P.M., LPN #20 asked the resident if she wanted chicken or not. The resident was observed at 12:18 P.M., picking pieces of meat up from her plate with her fingers. At 12:28 P.M., CNA #5 began poking the meat on the plate with the fork. As she did this, the resident reached out for the fork. CNA #5 tried to assist the resident to hold the fork but the resident took a piece of meat with her hands. At 12:42 P.M., the resident was observed with the fork in her hand and was trying to stab meat. The Resident then grabbed the meat with her fingers and took a bite. At 1:04 P.M., the resident was observed to have eaten all the cobbler, which she was fed by CNA #5 with a spoon, no vegetables and bites of meat.</p>		<p>assure the residents' plan of care addresses specific accommodations to encourage and/ or accommodate resident's independent eating skills. Completion Date 5-8-2013</p> <p>An in-service has been completed concerning reasonable accommodations for the dining experience with all staff and documented care plan interventions. Systemic change is when there is a new specific accommodations to encourage and/or accommodate resident's independent eating skills the care plan will be updated during the Clinical Care Meeting. Completion Date 5-8-2013</p> <p>DHS or designee will audit 3 random residents care plans to assure specific accommodations are noted on the resident's care plans 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. Completion Date 5-8-2013</p>				

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	<p>On 4/4/13 at 12:10 P.M., the resident was observed in the dining room in her wheelchair. The end of the resident's wheelchair arm rest was observed to be at least 2 feet from the edge of the table. The table height was observed to be at the resident's level of her clavicle (collarbone). The meal served to the resident included the following: diced red cabbage, chicken breast and french fries. The dessert was the mandarin oranges. At that time, the resident was unable to reach the food positioned on the back area of her plate. The resident was observed to eat her food with her fingers. LPN #5 asked the resident if she wanted to eat more. At that time, LPN #5 took the resident's plate from the table and positioned it on the resident's lap. LPN #5 is sitting with the resident. Resident #46 was observed sitting at the table with her plate on her lap and was eating her meal with her fork.</p> <p>On 4/5/13 at 12:28 P.M., the resident was observed in the dining room in her wheelchair. The resident's chin is observed below the level of the edge of the table. At that time, the resident was served her tray by the ADON (assistant director of nursing). LPN #20 then sat down beside the</p>			

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	<p>resident. The resident was served a submarine type sandwich on a hoagie roll, french fries and pudding. The menu posted listed the food served as cookie and cream parfait, Italian hoagie, fries and white and chocolate milk and iced tea.</p> <p>On 4/5/13 at 12:41 P.M., the DON (Director of Nursing) was made aware of the above observation. The DON observed the resident's position at the table with the table height being higher than the resident's chin. The DON indicated she thought the resident was care planned for finger foods. At that time, the resident's clinical record was reviewed with the DON. She indicated documentation was lacking of a plan of care for the resident to have finger foods.</p> <p>On 4/5/13 at 1:15 P.M., the clinical record was reviewed. Diagnoses included but were not limited to the following: adult failure to thrive, general debility, Dementia, and abnormal posture. A dietary note date 1/28/13 included, but was not limited to, the following: Diet is fortified foods; eating ability, adaptive equipment; assisted.</p> <p>Nurses notes, dated 4/5/13 at 2:30 P.M., indicated the following: "Res</p>			

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	<p>(resident) noted at meals eating increased % (percent) of meal with finger foods and increase in ADLs (activities of daily living) with sippy cups..."</p> <p>On 4/11/13 at 9 A.M. a copy of the resident's "Nutrition/Hydration Plan of Care" was received from the DON. The record included but was not limited to the following information: "Regular diet with fortified foods; fingerfoods prn (as needed)."</p> <p>On 4/11/13 at 8:50 A.M., the DON was interviewed. She indicated they had received a physician's order for the resident to have the finger foods. The DON indicated they have provided a resident with a table more accommodating to her height in the dining room. The DON indicated the residents care plan was also updated to reflect the finger foods.</p> <p>3.1-35(b)(1)</p>			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure adequate supervision was provided to prevent falls for 1 of 3 residents reviewed for falls in stage 2. Resident #93</p> <p>Findings included:</p> <p>On 4/4/13 at 9:46 A.M., Resident #93's clinical record was reviewed. Her diagnoses included but were not limited to: Alzheimer's, hypertension, diabetes, depression, and anxiety. Her admission nursing assessment dated 12/14/12, indicated an impairment in cognition which effects safety judgement. The assessment also indicated the resident had difficulty following direction's and was non complainant in using her call light.</p> <p>Her admission physician orders dated 12/14/12, included a bed alarm. Her admission orders also included the use of a wanderguard device to be worn on the resident's right wrist.</p>	F000323	<p>F 323</p> <p>Resident #93 suffered no ill effects from the alleged deficiency. Resident #93's falls have been tracked to identify any trends and the care plan has been updated as appropriate. Completion Date 5-8-2013</p> <p>All other residents are at risk to be affected by the alleged deficiency and through alterations in processes and in servicing the campus will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Completion Date 5-8-2013</p> <p>Nursing staff have been in serviced concerning Fall/Safety Management and supervision of residents. Systemic change is all resident incidents will be tracked to identify trends. Completion Date 5-8-2013</p> <p>DHS /designee will monitor 3</p>	05/08/2013			

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	<p>Since admission on 12/14/12, Resident #93 resided on the secured 300 unit which included an area that had a open layout consisting of a lobby, living room dining, TV area, and nurses station. The secured unit also had a hallway area which included resident rooms.</p> <p>Her Minimum Data Assessment Summary (MDS) dated 12/26/12, indicated a limited assistance of 1 person to physically assist for transfer, and ambulation in her room and in the corridor.</p> <p>The extensive assistance of 1 person to physically assist was needed for toileting.</p> <p>Her cognition score was 99 (unable to complete the interview).</p> <p>The MDS dated 1/25/13 and 2/15/13, indicated extensive assistance of 2 plus persons for transfers, walking, and toilet use.</p> <p>Cognition score was documented as 99.</p> <p>A care plan initiated 12/27/12 addressed the problem of falls. Interventions initiated on 12/27/12, included but were not limited to: half rails as an enabler, call light in reach, remind resident and reinforce safety awareness, lock breaks on bed and</p>		<p>random resident at risk for falls to assure safety interventions in place as per plan of care and adequate supervision to prevent incidents 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments</p> <p>Completion Date 5-8-2013</p>				

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	<p>chair before transferring, appropriate footwear, and educate and remind resident to request assistance prior to ambulation.</p> <p>A fall circumstance, assessment and intervention form dated 1/2/13, indicated Resident #93 had fallen on the secured unit at 1:40 P.M., in the TV lounge of the unit, on that date. The documentation indicated the resident had been started on a new medication, Ativan (antianxiety) 0.5 mg four times a day and the medication dose had been adjusted that a.m. [morning]. The assessment indicated the resident had cognitive/memory impairment that effected her safety and judgement. The assessment also indicated the preventive intervention was to decrease medication dosage. A telephone order dated 1/2/13 indicated to discontinue Ativan 0.5 mg four times a day and start Ativan 0.5 mg two times a day.</p> <p>Nursing notes dated 1/31/13 at 7:45 A.M., indicated, " Res (resident) was attempting to open window in TV lounge on 300 hall when she slid out of w/c (wheelchair) onto floor. 0 (zero) injuries noted..." A fall circumstance, assessment and intervention document indicated a fall</p>			

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	<p>had occurred on 1/31/13 at 7:45 A.M., in the TV lounge area of the secured unit (300 hall). The assessment indicated a chair alarm had been initiated as a prevention intervention.</p> <p>Nursing notes dated 2/3/13 at 2:30 P.M., indicated, "Resident sitting in her w/c. Stood up sounding alarm as staff looked up she fell backward striking back of head on shelving case. Small knot felt there but she states she is ok. Neurochecks are normal alarms to bed/chair are intact et functioning correctly."</p> <p>The fall circumstance, assessment for this 2/3/13 fall indicated the fall had occurred at 2:30 P.M., in the hall/lobby area if the 300 secured unit. The prevention intervention initiated was to sit resident up to a dining table or an overbed table with activities (items for activity program) in front of her as tolerated.</p> <p>Nurses notes dated 2/13/13 at 1:50 P.M., indicated, "Staff heard alarm sounding while housekeeping was down hall running the vacuum, when vac was shut off is when alarm was heard. Staff got to room as res went down on floor..."</p> <p>The fall circumstance, assessment of</p>			

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	<p>2/13/13 fall, indicated the resident was found in her bathroom but had been in bed prior to fall, and staff had toileted shortly before the fall. Prevention intervention initiated was to have housekeeping staff to vacuum hall when residents are up in the dining room as much as possible or to use a motorless vacuum.</p> <p>Nursing notes dated 2/22/13 at 4:15 P.M., indicated, " Res is sitting on her w/c in the living room area. This nurse answered an alarm to room 305 A. Another alarm went off and this nurse investigate and found resident on the floor. Another nurse witnessed what happen and told me resident slid off from her w/c. This nurse and another nurse helped res get up and sat her back in her chair. 0 (zero) injuries noted. 0 (zero) complaint of pain. Prior to the fall, resident has been very, restless, she's been up since 6 a.m. and she's been constantly wanting to get up and walk around. Also, resident had Valium (antianxiety medication) 2 mg at 0630 (6:30 A.M.) and 1130 (11:30 A.M.)... " "... Intervention: Bring resident with the nurse wherever (sic) she go when she's restless and agitated. Never leave resident alone and keep her in sight at all times."</p>			

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	<p>The fall circumstance, assessment of the 2/22/13 fall, indicated initiation of nonskid footwear and dicem to w/c.</p> <p>A nursing note dated 3/8/13 at 10:00 A.M., indicated, " Res stood up from w/c et before staff could get to res she lost her balance et sat in floor. 0 (zero) injuries noted..." "... As intervention res w/c was modified per therapy."</p> <p>The fall circumstance, assessment dated 3/8/13, indicated Resident #93 had fallen at 9:00 A.M., in room 308 (not Resident #93's room). Prevention intervention initiated was that her w/c was modified .</p> <p>On 4/5/13 at 10:00 A.M., the Director of Nursing (DON) was interviewed regarding Resident #93's falls since admission on 12/14/12. The resident's fall care plan and fall circumstance and assessment documentation was also reviewed with the DON. The DON indicated Resident #93 had an order on admission to be up ad lib. She also indicated the resident had not been "one to be up by herself-safely." The DON was made aware of lack of supervision in regard to falls (1/2/13, 1/31/13, 2/13/13, 2/22/13) in the living room, TV, and dining area of the</p>				

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	<p>secured unit. She indicated usually staff on the unit try to keep staff up front (lobby, TV, dining area) while other staff providing care in hall/resident rooms. She indicated sometimes staff can't get to residents until the fall has happened. The DON was also made aware of lack of supervision in regard to Resident #93 falling in another resident's room on 3/8/13. She indicated the resident had fallen in another resident's room on 3/8/13.</p> <p>On 4/11/13 at 11:50 A.M., during interview with the DON, she indicated Resident #93 had an overall decline after her heart attack and hospitalization (1/11/13 thru 1/18/13). The DON was also made aware of falls dated 1/2/13, 2/3/13, and 2/13/13 had occurred between 1:40 P.M., and 2:30 P.M., (time pattern/trend). The DON was unable to provide documentation that the facility had identified a pattern/trend or had initiated an intervention to address the time trend.</p> <p>The facility policy entitled, Accident and Incident Reporting Guidelines (11/2010) was received and reviewed on 4/11/13 at 12:05 P.M. This policy included but was not limited to: "...</p>			

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	<p>13. Accident, incident and allegations of abuse occurrences shall be tracked to identify trends..."</p> <p>3.1-45(a)(2)</p>			

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview, the facility failed to ensure food preparation and service was completed with appropriate sanitizing of food contact surfaces and/or in uncontaminated Chef coats and/or without jewelry and/or using appliances and utensils which were clean and/or in good condition. This occurred during 3 of 3 food preparation and service observations with a potential to impact all residents served from the facility's single kitchen.</p> <p>Findings include:</p> <p>1. On 4/2/13 at 9:30 A.M., the initial kitchen tour began. The Director of Food Service (DFS) was asked to test a bucket of sanitation solution strength. The bucket had been used during the food preparation of the breakfast meal. The solution was cool to the touch. She began the test by dipping, redipping and swirling the paper test tape in the solution for 25</p>	F000371	<p>F 371</p> <p>All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing will ensure the campus procures food from sources approved or considered satisfactory by Federal, State, or local authorities and stores, prepares, distributes, and serves food under sanitary conditions. Completion Date 5-8-2013</p> <p>All items identified on the 2567 have been cleaned. The mentioned coffee pot and pitted pans have been removed from service. All dietary employees have been in serviced on preparing and testing sanitizing solutions, proper clearing of tables post meal, jewelry prohibition, kitchen dress code, and general cleaning schedules of the kitchen. Systemic change is the dietary manager will bring the cleaning schedule, sanitizing solution log to morning meeting and review with Executive</p>	05/08/2013			

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	<p>seconds before the first reading. She read the same tape again after 40 seconds. The test indicated there was no chemical sanitizing agent in the solution. When interviewed the DFS indicated she believed the test tape was to be read 30 seconds after the dipping.</p> <p>At 9:58 A.M., during the same tour, DA #1 (assigned to cook) was observed to be opening a can of peaches on the food preparation (prep) counter. She spilled the juice onto the food prep surface. As she wiped it up with a dry cloth she pushed approximately 1/4 puddle over the edge of the counter. The juice poured down the side into a bin of clean dry terri cloths folded for use, soiling them. She did not sanitize the food prep surface nor extract soiled terri clothes from storage but moments later took one and put it on the food prep counter for use. She was wearing a stone studded band style ring throughout the meal prep. The DFS was observed assisting in food prep tasks during the meal and was wearing a watch and wedding rings with stones.</p> <p>DA #2 was also working in the kitchen. There was a two handle large aluminum pot on the stove</p>		<p>Director that schedule complete for the previous day. All kitchen employees will complete a competency check off on Array Ultimate Sanitizer Q now and annually thereafter. Completion Date 5-8-2013</p> <p>ED/designee will complete a sanitation report in the kitchen, test sanitation solution, observe dress code, observe 3 staff to assure no cross contamination 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments Completion Date 5-8-2013</p>		

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	<p>which had a deteriorated exterior finish with an interior which was pitted and flaking metal. DA #2 indicated the pot was intended to be used to make white sauce shortly. There were 5 additional two handle aluminum pots which were stacked on a shelf and were noted to be in the same condition. A sixth pot was at the bottom of the stack and was stainless steel in adequate condition. There were 2 of 2 pans with deteriorated, buckled and chipped interior non-stick surfaces.</p> <p>Dietary Aide (DA) #1 began pouring fresh sanitizing solution for use. DA #1 then tested the solution with a test tape, indicating she believed it should be read at 15 seconds after dipping. The fresh solution test was actually read at 20 seconds and tested to have no chemical sanitizer. The DFS rearranged the chemical and water supply tubes, leading to the mixing unit above the spout, however she was still unable to mix the required strength of solution for adequate sanitizing. She indicated she would have to research the problem.</p> <p>The Manufacturer's directions, observed on the label of the container being used, were to read the test after</p>				

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	<p>dipping the test tape for 10 seconds.</p> <p>There were 3 of 3 carts, each with 2 long grooved handles, laden with dried food matter.</p> <p>The Rapid steam machine was tacky to the touch with accumulated oil and soil over all the front surfaces including the handles and hand touch surfaces.</p> <p>The microwave interior was heavily soiled with dried food matter and oily substance on the front surface. It had a sour residual odor. The exterior of the microwave and operating touch pads were heavily soiled and tacky.</p> <p>There was a coffee pot which which had a handle from which a piece of plastic had broken off, leaving a jagged edge and insulating material exposed.</p> <p>The DFS indicated it was the only pot of it's kind which they had but would remove it from use and order a new one.</p> <p>2. On 4/03 at 8:30 A.M., DA #1 was working in the kitchen area of food preparation again wearing the ornate ring with multiple stones.</p> <p>3. On 4/04/13 at 9:00 A.M. DA #2, assigned cooking duties, which she performed in a white Chef coat. The employee was observed in the dining</p>				

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	<p>room wearing the Chef coat with a pinkish stain on her left front side. She was assisting to clear tables after breakfast. She was observed working at 3 tables. At each table, she grouped and removed utensils. She collected flatware all at once from each table before removing the glassware and dishes at the table. At each table she rubbed the front of her Chef coat against the rims of soiled glassware and food waste on soiled dishes as she reached over them to retrieve items from the opposite side of the table. DA #3 had been observed wearing a black apron over her Chef coat while working in the kitchen. The Administrator also had been observed wearing a black apron in the dining room during assisting serving food residents.</p> <p>At the same time, the dishwasher, wearing a black apron was loading dishes from the window depository into dishwasher racks. She also was reaching over the soiled dishes and contaminating the front of the black apron. As she removed clean dishes from temporary air drying storage to storage for use, she was observed to hold stacks of clean items and large items against her soiled apron.</p> <p>During the noon meal food prep that</p>			
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	<p>day at 11:40 A.M., DA #2 was observed cooking in the kitchen, still with her contaminated Chef coat and the pinkish stain. She was getting bags of frozen hot dogs and onion rings and holding them against her coat. She provided the menu of the day by leaning over the food prep counter to reach it with her full upper body on the counter. She then began breaking the hotdog's apart by banging the bag on the counter. That action vibration caused a stainless steel pan to fall on the floor. She went around the counter and picked it up off the floor and put it on the food prep counter next to the onion rings temporarily. She picked it up with some other soiled bowls and utensils and took them to the dishwashing area. She returned to the prep counter and continued food prep without sanitizing the prep surface.</p> <p>On 4/11/13 at 1:00 P.M. the DFS was interviewed regarding the above. She indicated staff wear their Chef coats both in the kitchen and in the dining room because "We are not supposed to wear aprons in the dining room." She indicated she had discussed the sanitizing solution strength with the Corporate Divisional Dietary support person and he had determined the problem related to mixing the solution</p>						

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	<p>with too hot a temperature of water and then it not testing correctly, though the solution may actually be required strength when it cools down. She had not accounted for the inadequate strength of the solution which was tested after cooled. She indicated she had altered the temperature of the hot water with an adjustment at the side of the mixing unit for the sanitizing solution to change the water temperature, stating "But it won't stay that way, they will change it." She indicated the staff would have to be inserviced on the whole sanitation mixing and testing process, jewelry prohibition, and movement between clean and dirty tasks.</p> <p>The related, undated, facility policies and procedures, which were requested for all the above problems, provided by the DFS after researching them, were two.</p> <p>The first was a policy and procedure for " Manual Sanitation. Sterilization:....1. A First sanitizer bucket will be made at a.m. shift and then checked every four hours thereafter to ensure it meets the appropriate disinfectant level...</p> <p>B. 75 degrees F- 200-300 ppm (parts</p>						

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	<p>per million) room temperature (Ultimate Sanitizer)...CLEAN and SANITIZE food - contact surfaces:...anytime contamination has occurred...keep chemical SANITIZING solutions at the appropriate concentration and free from food debris and visible soil. Best practice is to change out the SANITIZING solution every 4 hours or when the SANITIZING solution becomes to (sic) saturated from continuous use and product dose does not meet the required 200-300-PPM (parts per million) when testing the test strips..."</p> <p>The second undated policy was a dining services dress code which listed "DO's and DONT'S's." DON'T's included "any jewelry that dangles" and Rings (of any kind)." The DO's included "Chef Coats."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>			