

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155729	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/12/2016
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NAME OF PROVIDER OR SUPPLIER ADAMS HERITAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 12011 WHITTERN RD MONROEVILLE, IN 46773
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 5, 6, 7, 8, 11 and 12, 2016.</p> <p>Facility number: 002549 Provider number: 155729 AIM number: 200289420</p> <p>Census bed type: SNF/NF: 46 Total: 46</p> <p>Census payor type: Medicaid: 27 Other: 19 Total: 46</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on July 14, 2016 by 17934.</p>	F 0000	<p>Preparation and execution of this plan of correction does not constitute admission or agreement by provider to the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. Adams-Heritage maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Adams-Heritage asserts that it is in substantial compliance with regulations governing the operation of long term care facilities, and this Plan of Correction in its entirety constitutes this provider's allegation of compliance and, thereby, we request resurvey to verify such as of August 11, 2016. Further, we request desk review (paper compliance) for compliance, if acceptable. Completion dates are provided for procedural processing purposes to comply with federal and state regulations, and correlate with the most recent contemplated</p>	

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 0323 SS=E Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure personal care products, personal hand sanitizer and odor control chemicals were stored securely. This deficient practice had the potential to affect 25 confused and independently mobile residents of the 46 residents who resided in the facility.</p> <p>Findings include:</p> <p>On 7/6/16 at 1:13 p.m., the 100 hall medication (med) cart was observed positioned by the nurses station. In the left side of the med cart was observed to be an open type storage area. In this unsecured, open storage area was a spray can, labeled "Odor Control" and a bottle of hand sanitizer. At 1:15 p.m., a bottle of hand sanitizer was observed on the</p>	F 0323	<p>accomplished corrective action. These do not necessarily chronologically correspond to the date that Adams Heritage is under the opinion that it was in compliance with the requirements of participation or that corrective action was necessary.</p> <p><u>F323 1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice?</u> In order to preserve the rights, privileges, and preference of our residents, a location was chosen to store personal care items within reach of wheelchair or ambulatory residents. Caddies were purchased for every resident to store these items. Caddies are stored in each of resident's closet. A letter was sent out to each resident/POA informing each individual of personal care products that will be placed in caddies purchased and provided by Adams Heritage. An explanation was given of the ISDH concern that was identified during our annual recertification survey conduction in July, 2016. Personal items such as brand</p>	08/11/2016

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	<p>unattended med cart for the 200 hall. No nurses were observed at the nurses station and residents were observed walking and self propelling in wheelchairs around the nurses station area.</p> <p>On 7/6/16 at 2:18 p.m., the bathroom in Room # 215 was observed. On the back of the toilet, a 16.9 ounce (brand name) Cream Lotion was observed. On the bedside table, the following personal care products were observed; 2 ounce (Brand Name) lotion and 20 ounce (Brand Name) Lotion. All of the above personal care products had printed on the label "Keep out of reach of children."</p> <p>On 7/6/16 at 2:29 p.m., in Room 212, a 24.5 oz bottle of (Brand Name) Lotion was observed in the bathroom on the back of the toilet. The label indicated "Keep out of reach of children." Two residents shared this bathroom.</p> <p>On 7/6/16 at 2:32 p.m., in Room 211, a tube of (Brand name) Lotion was observed at the bedside with the following observed on the label: "Keep out of reach of children." A shelf in the bathroom, which was at least 4 feet high, was observed to have the following on it: 6 ounce aerosol can of antiperspirant and an 8 ounce bottle of (Brand Name) of Peroxide mouth sore cleanser. Both</p>		<p>name lotion or anything with a label such as "keep out of reach of children" will be organized and placed in caddies inside their closets to address and correct the concern identified by the surveyors. These caddies will be within reach of residents but out of sight of residents who may choose to ingest products. Also this change was announced in Resident's Council and one of the resident stated she is displeased about the storing of personal care items and wanted to make sure it was in the minutes. The local ombudsman was notified to address the resident's concern. An assessment titled Non-Edible Item Assessment was developed and will be completed on each resident currently in house. Spray Odor Control cans and bottle of hand sanitizer from 100 hall Med cart was removed immediately from cart on 7/6/16. No resident were affected by this alleged deficient practice.</p> <p><u>2. 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?</u> Other residents that could be affected by the same alleged deficient practice would be those Identified as living at Adams Heritage. No resident were affected by the alleged deficient Practice. Every resident will have a caddy for their personal Products and will be</p>	

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	<p>products had "Keep out of reach of children" on the label.</p> <p>On 7/6/16 at 2:48 p.m. in Room 210, a 7 ounce bottle of (Brand Name) Lotion was observed on a table. The label indicated to "Keep out of reach of children."</p> <p>On 7/7/17 at 9:05 a.m., the can of "Odor Control" and bottle of hand sanitizer remained in the opened storage area on the side of the 100 hall medication cart.</p> <p>On 7/12/16 at 11:00 a.m., the bathroom in Room # 215 was observed. On the back of the toilet a 16.9 ounce (brand name) Cream Lotion was observed. On the bedside table, the following personal care products were observed; 2 ounce (Brand Name) lotion and 20 ounce (Brand Name) Lotion. All of the above personal care products had printed on the label "Keep out of reach of children."</p> <p>On 7/12/16 at 11:05 a.m., in Room 212, a 24.5 oz bottle of (Brand Name) Lotion was observed in the bathroom on the back of the toilet. The label indicated "Keep out of reach of children." Two of the residents reviewed were observed to share this bathroom.</p> <p>On 7/12/16 at 11:10 a.m., in Room 211, a tube of (Brand name) Lotion was</p>		<p>stored away in their respective closet. Spray Odor Control cans and hand sanitizer will not be in or on the med cart. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> Director of Nursing/Designee will perform audits to make sure caddies are in closet once daily hygiene is complete. Nursing staff will be educated that personal care items needs to be in caddies and stored away securely in their respective closets. Nursing staff will also be educated that no Spray Odor Control Cans and hand sanitizer will not be in the open storage of the med carts. <u>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</u> Audits will be performed daily X 3 days, then weekly for 3 weeks, then randomly for 2 months, then quarterly thereafter. Information gathered from the audits will be forwarded to QAPI committee for recommendations. <u>5. By what date the systemic changes will be completed?</u> 8/11/16</p>	

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	<p>observed at the bedside with the following observed on the label: "Keep out of reach of children." A shelf in the bathroom, which was at least 4 feet high, was observed to have the following on it: 6 ounce aerosol can of antiperspirant and an 8 ounce bottle of (Brand Name) of Peroxide mouth sore cleanser. Both products had "Keep out of reach of children" on the label.</p> <p>On 7/12/16 at 11:15 a.m. in Room 210, a 7 ounce bottle of (Brand Name) Lotion was observed on a table. The label indicated to "Keep out of reach of children."</p> <p>2. During the initial observation of the Residents' rooms the following was observed:</p> <p>An observation in room 102 on 7/5/16 at 3:10 p.m., in the bathroom, indicated two - 1.5 ounce (oz.) cans of shave cream, the label indicated "...Keep out of reach of children...." One - 3 oz. [Brand] pre-electric shave lotion, product information indicated, "...May cause eye irritation...skin irritation...harmful if swallowed in large quantities...respiratory tract irritation...."</p> <p>An observation in room 112 on 7/5/16 at 3:50 p.m., in the bathroom, indicated a</p>			

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	<p>2.6 oz. [Brand] solid antiperspirant and a 16 fluid oz. bottle of [Brand] dry skin lotion were sitting on an open shelf by the sink near the door. The shelf was about 4' from the floor. Both products were labeled with "...Keep out of reach of children...."</p> <p>An observation in room 106 on 7/6/16 at 3:36 p.m., in the bathroom, indicated one - 2.4 oz. tube of [Brand] denture adhesive was sitting on an open shelf by the sink near the door. The shelf was about 4' from the floor. The product information indicated, "...This paste may produce transient eye irritation. Ingestion of large amounts may cause nausea or vomiting. Esophageal blockage could occur in rare cases...."</p> <p>An observation in room 108 on 7/6/16 at 4:40 p.m., in the bathroom, indicated a 3 ounce (oz.) shaker bottle of antifungal powder, three - 1.5 oz. of antiperspirant and one, 2 oz. spray bottle of [Brand] odor remover were sitting on an open shelf by the sink near the doorway. The shelf was about 4 feet off the floor. Each product was labeled with "keep out of reach of children." Additional personal care products were in the bathroom and stored on tall free standing open shelving unit with 4 shelves, the following were products were observed on the open</p>			

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	<p>shelves: One -24 oz. bottle of [Brand] mouthwash, the label indicated, "...Keep out of reach of children..." One - 1.5 oz. roll on antiperspirant, the label indicated, "...Keep out of reach of children..." One - 1 fluid oz. bottle of [Brand] baby shampoo, the label indicated, "...Keep out of reach of children..." One - 14 oz. bottle of [Brand] cocoa butter lotion, the label indicated, "...Keep out of reach of children..." One box of [Brand] denture cleanser tablets, the label indicated, "Keep out of reach of children..." One can of aerosol hairspray, the label indicated, "...Keep out of reach of children..." Additional products were observed to be stored on the open shelving unit.</p> <p>An observation in room 103 on 7/7/16 at 9:36 a.m., in the bathroom, a 1.5 oz. roll-on antiperspirant was sitting on an open shelf by the sink near the doorway. The shelf was about 4 feet off the floor. The product label indicated, "...Keep out of reach of children..."</p> <p>3. Observation of Resident's rooms on 7/12/16 from 10:15 a.m. to 10:45 a.m., indicated the following:</p> <p>An observation of room 102 at 11:15 a.m., in the bathroom, indicated, one - 1.5 oz. can of shave cream, the label</p>			

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	<p>indicated "...Keep out of reach of children...." One - 4 oz. bottle of [Brand] smooth and cool fresh moisturizing body lotion with aloe, the label indicated, "...for external use only...."</p> <p>An observation of room 103 at 11:20 a.m., in the bathroom, a 1.5 oz. can of shave cream was sitting on an open shelf by the sink near the doorway. The shelf was about 4 feet off the floor. The product label indicated, "...Keep out of reach of children...." On the bedside table was sitting one - 10 fluid oz. bottle of [Brand] dry skin lotion, the label indicated, "...External use only...Do not get in eyes...Keep out of reach of children...." On the window sill was sitting one 22 oz. [Brand] baby powder, the label indicated, "...avoid inhalation...Avoid contact with eyes...."</p> <p>An observation of room 106 at 11:25 a.m., in the bathroom, a 2 oz. tube of [Brand] moisturizing body cream was sitting on an open shelf by the sink near the doorway. The shelf was about 4 feet off the floor. The product label indicated, "...Keep out of reach of children....In case of accidental ingestion seek professional assistance or Contact Poison Control Center...."</p> <p>An observation in room 108 on 7/12/16</p>			

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	<p>at 11:30 a.m., in the bathroom, indicated a 4 oz. tube of [Brand] Callazime skin protective paste, a 3 ounce (oz.) shaker bottle of antifungal powder, three - 1.5 oz. antiperspirant and one - 2 oz. spray bottle of [Brand] odor remover were sitting on an open shelf next the doorway close to the sink. The shelf was about 4 feet off the floor. Each product was labeled with "keep out of reach of children." On the back of the toilet sat a 24.5 oz. bottle of [Brand] Cocoa butter body lotion, the label indicated, "...Keep out of reach of children..." Additional products in the bathroom were stored on a 5' (foot) free standing open shelving unit with 4 shelves. The following were products were observed on the open shelves: One -24 oz. bottle of [Brand] mouthwash, the label indicated, "...Keep out of reach of children..." One 0.85 oz. tube of toothpaste, the label indicated, "...Keep out of reach of children under 6 years old...Do not swallow..." One - 1 fluid oz. bottle of [Brand] baby shampoo, the label indicated, "...Keep out of reach of children..." One box of [Brand] denture cleanser tablets, the label indicated, "Keep out of reach of children..." One 20 oz. bottle of [Brand] shampoo and conditioner, the label indicated, "...for external use only..." One - 2 oz. tube of Once a Day moisturizer body cream, the label</p>			

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	<p>indicated, "...Keep out of reach of children...." One 2.2 oz. tube of [Brand] denture adhesive cream, The product information indicated, "...This paste may produce transient eye irritation. Ingestion of large amounts may cause nausea or vomiting. Esophageal blockage could occur in rare cases...." One -12 oz. bottle [Brand] fragrance free daily moisturizing lotion, the label indicated, "...Keep out of reach of children...." One - 13.5 oz. bottle of [Brand] in-shower lotion, the label indicated, "Keep out of reach of children..." One - 8.4 oz. bottle of [Brand] mouthwash, the label indicated, "...Keep out of reach of children...."</p> <p>An observation in room 112 on 7/12/16 at 11:45 a.m., in the bathroom, indicated a 2.6 oz. [Brand] solid antiperspirant and a 16 fluid oz. bottle of [Brand] dry skin lotion were sitting on an open shelf by the sink near the door. The shelf was about 4' from the floor. The products were labeled with "...Keep out of reach of children...."</p> <p>On 7/12/16 at 10:50 a.m., the Social Service Director provided a current list of residents, who the facility indicated, were alert, confused and independently mobile. The list indicated of the 46 residents in the facility, 25 of them were considered alert, confused and mobile. After further</p>			

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	<p>review of the list provided, 6 of the residents, who the facility identified as confused and independently mobile, were observed to have personal care products unsecured in their rooms.</p> <p>On 7/12/16 at 12:49 p.m., the DON (Director of Nursing) provided the following "Safety Data Sheets" for the following products: (product name) Odor Eliminator and "Quick Care Foam Hand Sanitizer." The Safety Data Sheet for the Odor Eliminator included, but was not limited to, the following: "Hazards Identification...may cause an allergic skin reaction...may cause respiratory irritation...avoid spraying in eyes...Precautions for Safe Storage:...Keep out of reach of children...Do not inhale vapors, Avoid contact with eyes, do not ingest, observe all label precautions..." The Safety Data Sheet for the Foam Hand Sanitizer, included but was not limited to, the following: Flammable liquid and vapor and causes serious eye irritation..."</p> <p>On 7/12/16 at 12:49 p.m., the DON (Director of Nursing) provided the following policy, which was dated 10/2011: "Resident Rights." The policy included, but was not limited to, the following: "...A resident has the right to...A safe, clean...homelike</p>			

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F 0371 SS=F Bldg. 00	environment..." 3.1-45(a)(1) 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 the kitchen floor and ceiling vents were maintained in a clean and sanitary manner. The facility further failed to ensure the dishwasher rinse temperatures were maintained at the manufacture's recommended temperature for dishware sanitation. The facility further failed to ensure all milk temperatures were checked prior to meal service and foods were dated as to when they were opened. This deficient practice had the potential to affect all 46 residents in the facility.	F 0371	F371 (Section 1-Dishwasher temp and rinse temp) <u>1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice?</u> Maintenance was called immediately and he cleaned the adjustment sensor. Then Maintenance ran cycles and temperatures were in correct ranges. Hobart Professional serviced the dishwasher and made sure temperatures were compliant for the wash cycle and rinse cycle. Inservice was held 7/26/16 to review and re-educate Nutritional Services staff regarding the dishwasher	08/11/2016	

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	<p>Findings include:</p> <p>1. On 7/5/16 at 10:10 a.m., the dishwasher was observed being used. Several loads of dishes had been observed to be processed through the dishwasher. At this time, Dishwasher Staff #1 was interviewed. She indicated her job was the Dishwasher and cook. She indicated the current wash temperature of the dishwasher was 164 degrees Fahrenheit (F), as she read the dial on the machine. As the dishes progressed to the rinse stage in the dishwasher, Dishwasher Staff #1 read the temperature of the rinse cycle as "175 degrees." At this time, Dishwasher Staff #1 was interviewed as to what the temperature of the rinse cycle should be. Dishwasher Staff #1 indicated " it's just shy." A label on the dishwasher indicated "wash temp (temperature) 160 degrees" and "rinse temp 180 degrees." Dishwasher #1 indicated the dishwasher sanitized the dishes by heat. At 10:43 a.m., the Food Service Manager (FSM) was asked to run the dishwasher and check the temperatures. She ran the dishwasher and read the wash temp at 158 degrees F. She said she wanted the dishwasher temp to be 160 F and she wanted the rinse temp (temperature) to be 180 F. At this time, the FSM ran 3 loads through the dishwasher and the highest</p>		<p>Temperature polices and procedures to take if dishwasher temperatures are not correct. No residents were harmed by this alleged deficient practice. <u>2. 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?</u> None were identified. Dishwasher is located in kitchen away from residents. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> Maintenance will monitor the dishwasher on wash and rinse cycles. Dietary will keep a daily log for wash and rinse cycles and report any discrepancies immediately to Dietary Manager and Maintenance. <u>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</u> Maintenance will monitor it daily for one week, then weekly for four weeks, then bi-weekly for 2 months. Information gathered from audits will be forwarded to the QAPI committee for recommendations. Dietary will continue a daily logon temperatures. <u>5. By what date the systemic changes will be completed?</u> 7/25/16 F371 (Section 2–dating and milk temp) <u>1. What corrective action will be accomplished for those residents found to have been</u></p>	

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	<p>rinse temp was 176 F. The 4th load of dishes was read at 184 degrees by the FSM. The FSM indicated the morning cook was the staff who runs the dishwasher and logs these temps. At this time, the dishwasher temp log for July 2016 was reviewed and all of the temps documented were 160 F for wash and 180 F for rinse.</p> <p>On 7/5/16 at 10:45 a.m., Cook #1 was interviewed. She indicated she ran the dishwasher when she arrived in the morning to ensure the temperatures are within normal limits. She indicated the desired temperature for the rinse cycle was 180 F. She indicated if the temps "are off", she would then run another load through the dishwasher until the temps were up to what they were supposed to be.</p> <p>On 7/5/16 at 10:46 a.m., the FSM was interviewed. She indicated the dishwasher sanitized the dishes by heat.</p> <p>On 7/5/16 at 10:50 a.m., the FSM provided a copy of the "Appliance Temp (Temperature) Log." This form was dated July 2016 and had the following temperatures documented for the dishwasher from 7/1/16 to 7/5/16. The dishwasher's wash temperature was documented daily as 160 degree F and</p>		<p><u>affected by this alleged deficient practice?</u> An inservice was held 7/26/16 to educate Nutritional Services staff regarding the policy on proper food temperatures as well as labeling/dating procedure policy. A new milk storage method during meals will be implemented with the purchase of a new refrigerator. A new policy was written for labeling/dating. No residents were harmed by this alleged deficient practice. <u>2. 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?</u> None were identified since milk was not given to residents. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> Dietary Manager/designee will audit to make sure milk is dated. Refrigerator will be purchased to store milk during meal service(s). A thermometer will be placed in the new refrigerator and temperature will be monitored and recorded daily. <u>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</u> Dietary Manager/designee will audit dating daily for one week, then weekly for four weeks, then bi-weekly for two months. . Information gathered from audits</p>	

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	<p>the rinse temperature was 180 degrees F.</p> <p>On 7/5/16 at 10:55 a.m., the FSM was made aware of the prior dishwasher temps lower than 180 F on the rinse cycle. The FSM indicated she was not aware of the temp not being up to 180 F until this time. The FSM indicated the dishes had already been put away otherwise she would have run them through again.</p> <p>On 7/5/16 at 11:30 a.m., the FSM indicated the Maintenance Supervisor had adjusted the temperature on the dishwasher. At this time, the dishwasher was observed to have a rinse temperature of 184 degrees.</p> <p>On 7/12/16 at 12:25 p.m., the Food Service Manager (FSM) indicated when the Maintenance Man was made aware of the temperature of the rinse cycle on the dishwasher on 7/8/16 he adjusted the temperature so it would reach at least 180 degrees for the rinse cycle.</p> <p>On 7/12/15 at 12:55 p.m., the FSM provided a copy of the policy for "Dishwasher Temperature Check" with a date of 5/3/91. The policy included, but was not limited to, the following: "...If the...rinse (temperature) is not at least 180 degrees, Maintenance will be</p>		<p>will be forwarded to the QAPI committee for recommendations. Dietary Manager/designee will continue to monitor milk temperature daily. <u>5. By what date the systemic changes will be completed?</u> 8/11/16 F371 (Section 3 – Dishpan and cleaning kitchen) <u>1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice?</u> Dish pan was removed from underneath the ice machine and pipe was insulated. Complete clean of the kitchen will be performed on 7/26/16 <u>2. 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?</u> Floors, vents, and dish pan affected were located in the kitchen away from residents. No residents were identified. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> Ice machine pipe will stay insulated. Housekeeping staff will be having an inservice on the 7 steps cleaning process and proper techniques for cleaning the kitchen. Also there will be a review and implementation of a kitchen cleaning checklist. <u>4. How the corrective action(s) will be monitored to ensure</u></p>	

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	<p>notified immediately."</p> <p>2. On 7/5/16 at 10:20 a.m., a gallon of 2% milk that was observed opened in the refrigerator. The container was 3/4 empty and there was no date as to when the gallon of milk had been opened.</p> <p>On 7/8/16 at 11 a.m., Cook #1 was observed to have three separate, gallon containers of milk. Cook #1 indicated she was checking the temperature of the milk prior to service. One of the gallons of milk was full and the other two were at least 1/2 empty. Cook #1 checked the temperature of the one gallon of milk that was full, by removing the lid and placing the thermometer into the gallon of milk. She read the temperature of the milk at 47.3 degrees Fahrenheit. She did not check the temperature of the remaining two, gallon containers of milk.</p> <p>On 7/8/16 at 11:10 a.m., the FSM was made aware of the temperature of the full gallon of milk and the two other gallons of milk, which had not had the temperature checked. At this time the FSM took the full gallon of milk, shook it up and rechecked the temperature. The FSM read the temperature of the milk at 44 degrees Fahrenheit. This gallon of milk was not served. At this time, the FSM checked the temperature of the two</p>		<p><u>the deficient practice will not recur?</u> For the ice machine, Maintenance will monitor it daily for 1 week, then weekly for four weeks, then bi-weekly for 2 months. For cleaning of the kitchen, Maintenance will monitor daily for one week, then weekly for two months, then monthly thereafter. Information gathered from all audits will be forwarded to the QAPI committee for recommendations. <u>5. By what date the systemic changes will be completed?</u> For removal of dish pan from underneath ice machine and pipe to be insulated was completed on 7/26/16. For cleaning the kitchen, it will be completed on 7/26/16. Inservice and checklist will be completed by 8/1/16.</p>	

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	<p>partial gallons of milk and the FSM read the temperature at 39 degrees F. The FSM then went to the dining room to check the temperature of the gallon of milk which had been placed on a slab of ice in a pan. The FSM read the temperature of the partial gallon of milk at 45 degrees F. She indicated she would replace this gallon of milk with another after verifying the temperature was within normal range. She indicated she wanted the temperature of the milk to be below 41 degrees.</p> <p>On 7/12/16 at 12:55 p.m., the FSM was interviewed. She indicated each gallon of milk should have had the temperature checked prior to service and also each gallon of milk should be labeled as to when it was opened.</p> <p>On 7/12/16 at 3:34 p.m., the FSM (Food Service Manager) provided a current policy and procedure for "Cooling Foods." The policy and procedure was dated 4/20/09, and included but was not limited to, the following: "...Once food is at proper temperature, it is labeled, dated and stored appropriately...."</p> <p>3. On 7/5/16 at 10:40 a.m., two metal pans were observed on the floor underneath of the ice machine in the kitchen. The large oblong pan was</p>			

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	<p>observed to be entirely underneath the ice machine and was only visible from the floor. The other pan was positioned with 1/2 of the pan underneath the ice machine and the other 1/2 visible when standing at one of the two handwashing sinks, which was beside the ice machine. There was at least 4 inches of cloudy, water in the pan with a moth observed floating in the water. Also observed in the pan, was an unidentifiable substance, which appeared to be of food substance.</p> <p>On 7/8/16 at 8:35 a.m., the FSM was interviewed. She indicated the pans below the ice machine were "just drip pans for leaking water."</p> <p>On 7/8/16 at 8:40 a.m., the Maintenance Supervisor was interviewed. He indicated the pans were placed on the floor to catch the condensation from the pipes underneath the ice machine. At this time, the floor between the back of the ice machine and the wall behind were observed. The ice machine was positioned at least 3-5 inches away from the wall. The floor was covered with dark debris, in some areas with the floor surface not visible due to the amount of dark material on the floor. The dark debris on the floor was observed along the entire width of the ice machine.</p>			

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	<p>On 7/8/16 at 9:10 a.m., Housekeeper #1 was interviewed. She indicated the floor beneath and around the ice machine should be cleaned every other night after supper. She indicated usually housekeeping cleaned the floors in the kitchen and the dietary department "does the walls." Housekeeper #1 indicated there used to be a log for cleaning but that they "don't have one now." At this time, Housekeeper #1 was mopping the floor behind the ice machine. She indicated she observed dust and "black stuff" behind the ice machine. The floor behind the ice machine appeared to be clean at this time.</p> <p>On 7/8/16 at 9:12 a.m., the FSM was interviewed. She indicated the items in the kitchen are to be pulled out away from the wall every night and cleaned behind and underneath them. She also indicated "it doesn't look like the appliances have been pulled out" as there were scattered crumbs and debris throughout the edge of the floor, especially up against the wall. She indicated the debris and crumbs on the floor appeared to be from more than 1 meal service/preparation.</p> <p>On 7/8/16 at 9:50 a.m., a multi tiered shelf was observed in the kitchen in the food prep area. This shelf was moved</p>			

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	<p>when pulled with one hand. The outline of the base of the shelf was visible on the floor where dark debris residue had accumulated around the base.</p> <p>On 7/8/16 at 10:05 a.m., there was scattered debris observed under the multi shelf which housed the paper products. This was located between the walk in freezer and the walk in refrigerator. Scattered debris was also observed underneath the food prep tables in the center island area of the kitchen. On 7/8/16 at 10:18 a.m., the FSM indicated the main traffic area in the dining room floor was clean but not underneath the appliances and the food prep tables. There were crumbs and bits of food and debris scattered along the edge of the wall around the perimeter of the kitchen.</p> <p>On 7/8/16 at 10:06 a.m., the Maintenance Supervisor, provided a copy of the current policy for "Dietary Main Kitchen Area Cleaning." The policy was dated 3/1/00 and included, but was not limited to, the following: "...Purpose: To ensure monthly cleaning of the moveable and stationary cooking equipment and fire wall...Procedure:...sweep under all kitchen equipment to remove any debris...wet mop the floor under and in front of the cooking equipment..." At this time, the Maintenance Supervisor</p>			

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	<p>was interviewed. He indicated the floors were to be cleaned nightly and this included between and underneath equipment and food preparation tables and stations.</p> <p>On 7/8/16 at 10:20 a.m., the Maintenance Supervisor was made aware of the scattered dirt and debris observed on the floors, between and underneath the food preparation tables and appliances. The Maintenance Supervisor indicated at this time, "It's obvious they didn't clean under things."</p> <p>On 7/8/16 at 11:00 a.m., two ceiling vents were observed over the door to the walk in refrigerator and the walk in freezer in the kitchen. The vent over the freezer door was observed to have a thick accumulation of grayish matter on the grates in an area of at least 6 inches in circumference.</p> <p>On 7/8/16 at 11:15 a.m., the FSM was made aware of of the piece of broccoli which was at least 1 inch in length, observed on the floor underneath a food prep table. At the time, the FSM reviewed the weekly menu and indicated the last time broccoli was served from the kitchen was on 7/4/16.</p> <p>On 7/8/16 at 11:27 a.m., the Maintenance</p>			

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F 0431 SS=D Bldg. 00	<p>Supervisor was made aware of the grayish matter on the ceiling vent over the walk in freezer. At this time, he brushed his hand over the vent and the grayish matter fell from the vent. The Maintenance Supervisor was interviewed at this time and indicated the vents had been cleaned not long ago but these vents must have been missed.</p> <p>3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws,</p>			

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	<p>the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on interview and record review, the facility failed to identify inaccuracies and missing doses on controlled drug use records for 2 of 41 controlled drug use records reviewed. Further, the facility failed to identify discrepancies in the administration of narcotic medications for 2 residents (Resident #29, Resident #13).</p> <p>Findings include:</p> <p>1. On 7/8/16 at 11:00 a.m., the clinical record of Resident #29 was reviewed. Diagnoses included, but were not limited to, cancer which the resident was receiving hospice services for. The record indicated a current physician's order for morphine 2.5 mg (milligrams) every 4 hours as needed for pain/SOB (shortness of breath).</p>	F 0431	<p><u>F431 1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice?</u> No residents were identified to be affected. Resident #13 and resident #29's controlled medications were all accounted for prior to surveyor departure. Director of Nursing requested an independent audit of narcotic medication count from facility pharmacy. Audit was completed by Grandview Pharmacy and Director of Nursing gave letter from pharmacy confirming accurate count to surveyor on 7/8/16. <u>2. 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?</u> No residents were identified to be affected. 100% of current</p>	07/14/2016

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	<p>Resident #29 had two controlled drug use records for morphine 2.5 mg by mouth every 4 hours as needed for pain/SOB. Record #1 had a starting quantity of 20 doses which were signed out between 2/14/16 and 6/27/16. Record #2 had starting quantity of 8 doses which were signed out between 6/28/16 and 6/8/16 [sic].</p> <p>On 5/9, 5/15, and 5/29/16, documentation on the Medication Administration Record (MAR) indicated a morphine dose was given but did not indicate the reason for morphine use (pain/shortness of breath) nor the effectiveness of the medication after administered. Documentation was lacking in the NN (nurses notes) of the receipt and/or response to the prn (as needed) medication.</p> <p>On 5/22 and 5/28/16, Resident #29 's controlled drug use record #1 indicated morphine 2.5 mg was signed out. Documentation was lacking on the MAR of times the morphine had been administered. Documentation was lacking in the NN (nurses notes) of the receipt and/or response to the prn medication.</p> <p>On 6/26 and 6/27/16 at 12:00 p.m. and 11:00 p.m., Resident #29 ' s controlled</p>		<p>residents controlled medication accounts were verified by Grandview pharmacy representative prior to surveyor exit. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> An inservice was held on July 15,2016 by the Director of Nursing to educate the nursing staff including but not limited to: proper counting of narcotics, documentation practices, and follow up. The eight rights of medication were presented and discussed to nursing including recurrent agency LPN. <u>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</u> Narcotic count sheets will be monitored daily X 7 days, weekly X 4 weeks, then quarterly X 2 by the Director of Nursing/designee. Narcotic count sheets for each medication will be monitored formed administration during that particular week. This count sheet will be matched against the medication administration record and the actual medication blister pack card weekly X 4 weeks, then monthly X 2 by the Director of Nursing/ Designee. <u>5. By what date the systemic changes will be completed?</u> 7/14/16</p>	

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	<p>drug use record #1 indicated morphine 2.5 mg was signed out. Documentation was lacking on the MAR of times the morphine had been administered. Documentation was lacking in the NN (nurses notes) of the receipt and/or response to the prn medication.</p> <p>On 6/28/16 at 4:00 a.m., Resident #29 ' s controlled drug use record #2 indicated morphine 2.5 mg was signed out. Documentation on the MAR indicated a morphine dose given but did not indicate reason for morphine use (pain/shortness of breath) nor effectiveness of medication after administered. Documentation was lacking in the NN (nurses notes) of the receipt and/or response to the prn medication.</p> <p>On 7/3 at 4:46 a.m. and 11:07 p.m. and 7/4/16 at 4:00 a.m. and 8:26 p.m., documentation on the MAR indicated a morphine dose given but did not indicate reason for morphine use (pain/shortness of breath) nor effectiveness of medication after administered. Documentation was lacking in the NN (nurses notes) of the receipt and/or response to the prn medication.</p> <p>Further review of Resident #29 ' s controlled drug use record #2 indicated starting quantity of 8 doses of morphine</p>			

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NAME OF PROVIDER OR SUPPLIER ADAMS HERITAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 12011 WHITTERN RD MONROEVILLE, IN 46773
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	<p>2.5 mg with the following sign out dates, times, amount on hand, amount given and amount remaining signed out by the nurse:</p> <p>On 6/28/16 at 4:00 a.m., 8 doses were on hand, one dose was given, and 7 doses remained.</p> <p>On 6/2/16 at 8:00 p.m., 7 doses were on hand, one dose was given, and 6 doses remained.</p> <p>On 6/3/16 at 4:00 a.m., 6 doses were on hand, one dose was given, and 5 doses remained.</p> <p>On 6/3/16 at 8:00 p.m., 5 doses were on hand, one dose was given, and 4 doses remained.</p> <p>On 6/4/16 at 4:00 a.m., 3 doses were on hand, one dose was given, and 2 doses remained.</p> <p>Crossed out with a line through the notation indicated that on 6/4/16 at 8:00 a.m., 2 doses were on hand, one dose was given, and 1 dose remained.</p> <p>On 6/7/16 at 11:00 p.m., 2 doses were on hand, one dose was given and 1 with a 0 written over it, was written at dose remained.</p>			

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	<p>On 6/8/16 at 4:00 a.m., 1 dose was on hand, one dose was given, and 0 doses remained.</p> <p>On 6/2, 6/3, 6/4, 6/7, and 6/8/16, Resident #29 's controlled drug use record #2 indicated morphine 2.5 mg was signed out. Documentation was lacking on the MAR of time/dates the morphine had been administered. Documentation was lacking in the NN (nurses notes) of the receipt and/or response to the prn medication.</p> <p>On 7/8/16 at 12:35 p.m., during an interview, the Director of Nursing (DON) indicated she had not been aware of any discrepancies with controlled drug use records or missing doses for residents in the facility until this day. Daily shift count sheets for controlled drug use records did not indicate any discrepancies with controlled substances from 4/25/16 through the present date.</p> <p>On 7/12/16 at 11:35 a.m., the DON indicated the facilities pharmacy does not manage or monitor controlled medications provided by hospice agencies providing care and services to residents of the facility. Manifest forms for controlled medications are provided to the DON when they are delivered to</p>			

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	<p>the facility from the pharmacy supplying these medications for the hospice agency. Upon receipt of controlled medications, generic controlled drug use records are initiated by nursing staff and used to reconcile controlled medications at each shift.</p> <p>2. On 7/8/16 at 12:05 p.m., RN #2 was observed trying to reconcile Resident #13 ' s controlled drug use record for Norco 5/325 mg tablets. She indicated there were 14 doses of Norco 5/325 mg tablets present which did not match the controlled drug use record indicating 15 doses remained. RN #2 indicated the discrepancy would be reported to the Director of Nursing (DON) per facility policy.</p> <p>On 7/8/16 at 12:15 p.m., the clinical record of Resident #13 was reviewed and indicated diagnoses, included but were not limited to, cancer. The record indicated an order dated 4/5/16 for Norco 5/325 mg tablets, take 1 tablet by mouth every 6 hours as needed for pain.</p> <p>On 4/20/16, Resident #13 ' s controlled drug use record indicated Norco 5/325 mg tablet was signed out. Documentation was lacking on the MAR and NN of time the Norco 5/325 mg tablet was administered and/or response</p>			

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	<p>to the prn medication.</p> <p>On 4/25/16 at 10:00 a.m., Resident #13 's controlled drug use record indicated Norco 5/325 mg was signed out and 15 tablets remained.</p> <p>On 7/8/16 at 12:35 p.m., during an interview, DON indicated she had not been aware of any discrepancies with controlled drug use records or missing doses for residents in the facility until this day. Daily shift count sheets for controlled drug use records did not indicate any discrepancies with controlled substances from 4/25/16 through the present date. Further, she agreed the controlled drug use record for Resident #13 indicated 15 tablets remained but only 14 tablets were present when counted.</p> <p>On 7/8/16 at 12:54 p.m., RN #1 indicated nurses counted controlled substances at the beginning and end of their shift. If discrepancies were found, nurses would attempt to determine cause of the discrepancy and if unable to determine, would notify the DON.</p> <p>On 7/8/16 at 1:45 p.m., RN #3 indicated it was the facilities policy to conduct a physical inventory of controlled substances at the beginning and end of</p>						

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F 0520 SS=F	<p>each shift worked. Any discrepancies were reported immediately to the DON.</p> <p>On 7/11/16 at 9:44 a.m., the DON provided a current policy titled " CONTROLLED SUBSTANCE STORAGE " indicated the following: ... " Procedures ...F. At each shift change or when keys are transferred, a physical inventory of all controlled substances, including the emergency supply is conducted by two licensed nurses and is documented ...G. Any discrepancy in controlled substance counts is reported to the director of nursing immediately ...K. The consultant pharmacist or designee routinely monitors controlled substance storage, records (i.e. ...individual controlled substance accountability sheets, MARS ...during (monthly) medication storage inspection"</p> <p>3.1-25(e)(2) 3.1-25(e)(3)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET</p>			

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Bldg. 00	<p>QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility's QA/PI (Quality Assurance /Performance Improvement) Committee failed to identify, implement and/or revise action plans for the identified concerns to ensure the facility's kitchen floors and vents were clean and sanitary, the dishwasher hot water temperature reached 180 degrees Fahrenheit to sanitize dishes, the temperature of the milk was measured prior to serving to the residents, and the foods and beverages were appropriately labeled with opened dates. The QA/PI</p>	F 0520	<p><u>F520 1. What corrective action will be accomplished for those residents found to have been affected by this alleged deficient practice?</u> No residents were identified.</p> <p><u>2. 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?</u> No residents were affected. The QAPI committee will oversee the development of action plans for identified concerns. Those action plans will correct the alleged citations and</p>	07/25/2016
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	<p>Committee also failed to identify and ensure accurate documentation on the clinical records of the controlled substances administered to the residents were on the MAR (Medication Administration Record) and on the Controlled Substance sign out record. They also failed to ensure the effectiveness of the administered controlled medications were documented in the resident's clinical record. The Committee further failed to identify and ensure the controlled substance counts were correct and the controlled medications were sign out by the nurse when administered. These practices had the potential to affect 46 of 46 who reside in the facility.</p> <p>Findings include:</p> <p>The QA/PI Committee consisted of the facility's Administrator, all Department Managers, the Medical Director and Therapy.</p> <p>An interview with the DON (Director of Nursing) on 7/12/16 at 4:25 p.m., indicated the QA/PI Committee met monthly. The DON indicated she was the contact person and leader of the QA/PI Committee. She indicated all of the facility's Department Managers were on the committee and attended monthly.</p>		<p>will be monitored by the QAPI committee as listed on the CMS Form 2567 response. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> The Administrator will attend any subsequent meeting of the committee for the purpose of verifying the meeting and the agenda. <u>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur?</u> Alleged deficient practices have specific monitoring and Responsibility guidelines as outlined in the CMS Form 2567 response. This information will be submitted to the QAPI committee monthly or earlier if issues arise or conditions warrant by the corresponding departments. The QAPI committee will provide insight and direction regarding ongoing monitoring of the alleged citations based on monthly results. Monitoring will begin week of July 18, 2016. <u>5. By what date the systemic changes will be completed?</u> 7/25/16</p>	

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	<p>She also indicated the Medical Director attended the meeting monthly. She indicated the Pharmacy, Laboratory, Radiology were invited to the meeting quarterly or as needs arose. The DON indicated every Department Manager monitored and reported on concerns and action plans for their department. She indicated the committee had developed action plans for fall prevention and skin excoriations. She indicated several audits statistics were reviewed monthly, which included catheters, psychoactive medications, pressure ulcers, weight loss and weight gain and infections. She indicated Social Service informed the Committee of the "Concern Reports" which included resident and family concerns. She indicated she worked with the Resident Council President closely on identified concerns of the Council. She also indicated the Resident Council President, the Residents and staff could attend the QA/PI meetings. She indicated the facility had a Guardian Angle Rounds and the assigned staff talk with their assigned residents monthly and tried to resolve any problems or concerns right away. She indicated the Committee developed action plans for identified ongoing concerns. She indicated approaches were developed, implemented and then monitored for 6 months to 1 year after the goals were met. The DON</p>			

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	<p>indicated the QA/PI Committee had not identified the concerns found during the survey. She indicated they would develop action plans for accurate documentation of administration of narcotics and controlled substances. An action plan would be developed to provide sanitary kitchen, equipment and dishes, the food temperatures would be taken and labeled correctly. She further indicated the QA/PI Committee would develop action plan approaches to resolve the identified concerns and indicated it would take all departments and staff to work together to meet goals.</p> <p>On 7/12/16 at 4:00 p.m., a review of the facility's current policy, titled Performance Improvement, with revised dated of 05/11/16 was provided by the DON on 7/6/16 at 3:00 p.m., which indicated, "...The quality Assurance Committee is responsible for identifying and monitoring areas that require preventive and corrective actions, particularly issues which negatively affect quality of care and services provided to residents. The Committee also develops and initiates plans of action to correct any identified quality of care problems, and evaluates results of corrective actions for implementation of problem resolutions...."</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	3.1-52(a)(2)				