

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/15/2014
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NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064
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F000000	<p>This survey was for a Recertification and State Licensure Survey. This visit was done in conjunction with the investigation of Complaint Number IN00147358.</p> <p>Survey dates: April 7, 8, 9, 10, 11, 14, 15, 2014</p> <p>Facility number: 000248 Provider number: 155357 AIM number: 100291470</p> <p>Survey team: Toni Maley, BSW, TC Ginger McNamee, RN Tina Smith-Staats, RN Karen Lewis, RN (April 7 and 8, 2014)</p> <p>Census bed type: SNF/NF: 96 Residential: 54 Total: 150</p> <p>Census payor type: Medicare: 23 Medicaid: 54 Other: 73 Total: 150</p> <p>Residential sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p>	F000000	<p>This plan of correction is to serve as Rawlins House credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute an admission by Rawlins House or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p>	
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES			

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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	<p>(INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified of gastric residual and to hold the feeding per the physician order for 1 of 1 residents reviewed for tube feeding. (Resident #65)</p>	F000157	<p>F 157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>I. The physician for resident #65 has been notified of the residual amount. 1:1 inservicing has been provided</p>	05/15/2014

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	<p>Findings include:</p> <p>The clinical record for Resident #65 was reviewed on 4/9/14 at 8:06 a.m. Diagnoses for Resident #65 included, but were not limited to, chronic airway obstruction, dysphasia, congestive heart failure, pain, diabetes type II, depressive disorder, gastric esophageal reflux and attention of gastrostomy first g-tube 6/12 and second on 4/27/13.</p> <p>A physician order, dated 1/24/14, indicated in the special instructions "Check for residual before bolus feedings. Hold feeding and notify physician if residual is > 40ccs."</p> <p>A gastric residual result, obtained on 3/20/14 at 2:00 p.m., was documented as 75 cc. The record lacked any documentation of the physician having been notified of the gastric residual result. The record also lacked any documentation that the feeding had been held.</p> <p>During an interview with the Director of Nursing on 4/9/14 at 1:33 p.m., additional information was requested related to the lack of physician notification and holding of the feeding for Resident #65.</p> <p>During an interview with the Director of Nursing on 4/9/14 at 2:35 p.m., she indicated she had spoken with the nurse who had provided care for Resident #65 on 3/20/14 at 2:00 p.m. She indicated the nurse had not notified the physician of the gastric residual result. No further information was provided.</p> <p>3.1-5(a)(1)</p>		<p>for the nurse who did not notify the physician of the residual amount outside of the ordered parameters.</p> <p>II. Current residents who have a G Tube will be reviewed for the last 30 days to determine if any other residents had residual amounts outside of ordered parameters. This review will include determining appropriate physician notification has occurred.</p> <p>III. Education will be offered to all licensed nurses on appropriate notification of the physician if G Tube residuals are out of the ordered parameters. The systematic change includes review of all G Tube residents daily (Monday through Friday) by the unit manager or designee to determine that the physician has been notified of any G Tube residuals out of ordered parameters.</p> <p>IV. The DON/Designee will Review all G Tube residents for notification of the physician for any G Tube residuals out of the ordered parameters. The review will occur for 100% of residents with G Tubes daily (Monday through Friday) for one month, then weekly for one month then monthly for the</p>				

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F000246 SS=E	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview, and record review, the facility failed to ensure bathroom mirrors were at an accessible level for residents in wheelchairs. This had the potential to affect 30 of 30 residents that required the use of a wheelchair in the bathroom while grooming.</p> <p>Findings include:</p> <p>During an interview with Resident #131 on 4/7/14 at 12:33 p.m., he indicated his bathroom mirror was mounted too high for him to use while sitting in his wheelchair. He indicated he had a cushion in the seat of his wheelchair and he had to place two bed pillows on top of the cushion to sit on in order to see in the mirror to shave.</p>	F000246	<p>next ten months to total twelve months of monitoring. Any identified concerns will be addressed immediately. The results of these reviews will be reported to the Quality Assurance Committee.</p> <p>COMPLIANCE DATE: May 15, 2014</p> <p>F246 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>I. Resident #131 has been provided a lower mirror</p> <p>II. This deficiency has the potential to affect 30 residents who use a wheel chair in the bathroom when grooming.</p> <p>III The systemic change will include replacement of the mirrors for the identified bathrooms.</p> <p>IV. The Administrator has sent in a capital request for</p>	05/15/2014	

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F000279 SS=D	<p>During an environmental tour with the Maintenance Supervisor on 4/14/14 at 9:40 a.m., he indicated the bathroom mirrors were too high in the bathrooms for residents in wheelchairs and he had not considered the residents in wheelchairs using the mirrors.</p> <p>During an interview with the Administrator on 4/15/14 at 1:20 p.m., she indicated 30 residents use their wheelchairs in the bathroom while grooming.</p> <p>3.1-3(v)(1)</p> <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</p>		<p>purchase of mirrors.</p> <p>-When order is placed Administrator or designee will have a confirmed ship date by May 15, 2014.</p> <p>-Maintenance to install new mirrors within 30 days of delivery</p> <p>"Caring Heart" representative will interview residents to identify any concerns with installed mirrors. All concerns will be logged on grievance/concern form and reviewed daily at morning stand-up meeting. Any concerns will be addressed immediately.</p> <p>COMPLIANCE DATE: May 15, 2014</p>		

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	<p>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 record review and interview, the facility failed to ensure residents with a decline in bladder continence had a care plan related to urinary incontinence for 2 of 3 residents reviewed for a decline in bladder continence. (Resident #'s 162, 40)</p> <p>Findings include:</p> <p>1. Resident #40's clinical record was reviewed on 4/9/14 at 9:03 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, type II diabetes mellitus, and congestive heart failure.</p> <p>The resident had an order for Demadex (a diuretic) 20 mg 1 tablet every other day.</p> <p>The resident had a 1/6/14, Admission Minimum Data Set (MDS) assessment indicating the resident had moderate cognitive impairment, required extensive assistance of two for toileting and was continent of urine.</p> <p>A 3/26/14, Quarterly MDS assessment indicated the resident had no cognition impairments, required extensive assistance of one for toileting and was occasionally incontinent of urine.</p> <p>The resident had TENA/SCA Bladder Assessments dated 12/30/13 and 3/17/14.</p>	F000279	<p>F279 483.20(d), 483.20(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>I. Resident #40 no longer resides in the facility. Care Plan of resident #162 has been updated to reflect her current bladder continence status.</p> <p>II. All residents requiring assistance with toileting have been identified and their care plan has been updated to address their toileting plan.</p> <p>III. Education will be offered to all licensed nursing on completing an accurate bladder assessment.</p> <p>The systemic change includes:</p> <ul style="list-style-type: none"> -All residents will have a bladder assessment completed upon admission, quarterly and with a significant change in bladder function. Significant changes in status are discussed daily (Monday through Friday) at the morning clinical meeting. -Upon completion of the assessment, a plan care will be developed based upon the assessment and the resident's preferences (If applicable). -The C.N.A. assignment sheet 	05/15/2014

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	<p>Both assessments indicated the resident was continent of urine.</p> <p>Review of the resident's voiding pattern from March 1 to March 17, 2014, indicated the resident was incontinent of urine 13 times.</p> <p>During an interview with the MDS Co-coordinator and the MDS nurse on 4/9/14 at 10:20 a.m., they indicated resident #40 did not have a care plan for urinary incontinence. They indicated they complete care plans with the admission assessment and with the quarterly assessments.</p> <p>2. The clinical record for resident #162 was reviewed on 4/10/14 at 10:45 a.m. The resident's diagnoses included, but were not limited to, paranoid schizophrenia, muscle weakness, chronic pain, urinary tract infection, and dementia.</p> <p>The resident had a 1/3/14, Admission Minimum Data Set (MDS) assessment indicating the resident had severe cognitive impairment, required limited assistance of one for toileting and was continent of urine.</p> <p>The resident had a 3/14/14, Quarterly MDS assessment, indicating the resident required extensive assistance of one for toileting and was occasionally incontinent.</p> <p>Review of the resident's April, 2014, voiding pattern for urine indicated the resident had been incontinent seven times from April 1 to April 9.</p> <p>During an interview with the MDS Co-coordinator and the MDS nurse on 4/9/14 at 10:20 a.m., they indicated resident #162 did not have a care plan for urinary</p>		<p>will be updated with any changes in the plan of care.</p> <p>IV. The DON/Designee will audit for accuracy of bladder assessment, plan of care and C.N.A. assignment sheet for 2 residents a day, 5 times a week for 1 month; then 2 residents per week for 90 days. Any identified concerns will be addressed immediately. The results of these reviews will be reported to the Quality Assurance Committee, frequency and duration of reviews will be adjusted as necessary.</p> <p>COMPLIANCE DATE: May 15, 2014</p>	

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F000315 SS=D	<p>incontinence. They indicated they complete care plans with the admission assessment and with the quarterly assessments.</p> <p>During an interview with CNA #7 on 4/11/14 at 8:06 a.m., she indicated Resident #162 will take herself to the bathroom. She indicated the resident wanders around in her room when she needs to go to the bathroom. She indicated the resident needed to be toileted after meals.</p> <p>3.1-35(a) 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview, the facility failed to ensure residents with a decline in bladder continence were identified and/or had a plan put into place to restore or maintain bladder continence for 2 of 3 residents reviewed for a decline in bladder continence. (Resident #'s 162, 40)</p> <p>Findings include:</p> <p>1. Resident #40's clinical record was reviewed on 4/9/14 at 9:03 a.m. The resident's diagnoses included, but were not</p>	F000315	F315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER I. Resident # 40 no longer resides in facility. Resident # 162 had bowel and bladder observation completed. Due to residents severe cognitive impairment, resident is unable to participate in a continence retraining program. Resident #162 needs have been updated on care plan and on CNA assignment sheet. II. All	05/15/2014

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	<p>limited to, Alzheimer's disease, type II diabetes mellitus, and congestive heart failure.</p> <p>The resident had an order for Demadex (a diuretic) 20 mg 1 tablet every other day.</p> <p>The resident had a 1/6/14, Admission Minimum Data Set (MDS) assessment indicating the resident had moderate cognitive impairment, required extensive assistance of two for toileting and was continent of urine.</p> <p>A 3/26/14, Quarterly MDS assessment indicated the resident had no cognition impairments, required extensive assistance of one for toileting and was occasionally incontinent of urine.</p> <p>The resident had TENA/SCA Bladder Assessments dated 12/30/13 and 3/17/14. Both assessments indicated the resident was continent of urine.</p> <p>Review of the resident's voiding pattern from March 1 to March 17, 2014, indicated the resident was incontinent of urine 13 times.</p> <p>During an interview with the MDS Co-coordinator and the MDS nurse on 4/9/14 at 10:20 a.m., they indicated they completed the MDS assessments from the information gathered from CNA's documentation. They indicated the unit managers complete the TENA/SCA Bladder Assessments by talking to the CNA's.</p> <p>During an interview with the Director of Nursing on 4/10/14 at 9:40 a.m., she indicated during a recent audit it had been identified that the facility had not identified</p>		<p>residents requiring assistance with toileting have been identified and their bladder assessment has been reviewed for accuracy and inclusion of opportunity for toileting and/or alternative interventions to maintain bladder continence.</p> <p>III. All nurses responsible for care plans will be offered education regarding care planning for toileting. The systemic change includes:</p> <ul style="list-style-type: none"> ·All residents will have a bladder assessment completed upon admission, quarterly and with a significant change in bladder function. Significant changes in status are discussed daily (Monday through Friday) at the morning clinical meeting. ·Upon completion of the assessment, a plan care will be developed based upon the assessment and the resident's preferences (if applicable). ·The C.N.A. assignment sheet will be updated with any changes in the plan of care. <p>IV. The DON/Designee will audit for accuracy of bladder assessment, plan of care and C.N.A. assignment sheet for 2 residents a day, 5 times a week for 1 month; then 2 residents per week for 90 days. Any identified concerns will be addressed immediately. The results of these reviews will be</p>				

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	<p>MDS declines in function. She indicated she had not yet worked on putting a plan of action into place after the audit had identified the problem.</p> <p>2. The clinical record for resident #162 was reviewed on 4/10/14 at 10:45 a.m., the resident's diagnoses included, but were not limited to, paranoid schizophrenia, muscle weakness, chronic pain, urinary tract infection, and dementia.</p> <p>The resident had a 1/3/14, Admission Minimum Data Set (MDS) assessment indicating the resident had severe cognitive impairment, required limited assistance of one for toileting and was continent of urine.</p> <p>The resident had a 3/14/14, Quarterly MDS assessment, indicating the resident required extensive assistance of one for toileting and was occasionally incontinent.</p> <p>During an interview with the MDS Co-coordinator and the MDS nurse on 4/9/14 at 10:20 a.m., they indicated they completed the MDS assessments from the information gathered from CNA's documentation.</p> <p>Review of the resident's April, 2014, voiding pattern for urine indicated the resident had been incontinent seven times from April 1 to April 9.</p> <p>During an interview with CNA #7 on 4/11/14 at 8:06 a.m., she indicated Resident #162 will take herself to the bathroom. She indicated the resident wanders around in her room when she needs to go to the bathroom. She indicated the resident needed to be toileted after meals.</p>		<p>reported to the Quality Assurance Committee, frequency and duration of reviews will be adjusted as necessary. COMPLIANCE DATE: May 15, 2014</p>				

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F000364 SS=E	<p>3.1-41(a)(2) 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on observation, interview and record review, the facility failed to ensure food was hot and palatable for 10 of 22 residents interviewed regarding food quality (Residents #67, #91, #37, #153, #109, #56, #114, #55, #176 and #36).</p> <p>Findings include:</p> <p>1. During a 4/8/14, 1:44 p.m., interview, Resident #67, who was determined to be interviewable during the stage one survey process, indicated she had the following food palatability concern(s): Eggs were cold when served in the main dining room.</p> <p>2. During a 4/7/14, 11:21 a.m., interview, Resident #91, who was determined to be interviewable during the stage one survey process, indicated she had the following food palatability concern(s): "I don't like the food they serve for breakfast. I have told them but they bring the same thing every morning...scrambled eggs and I don't like eggs..."</p> <p>3. During a 4/8/14, 12:49 p.m., interview, Resident #37, who was determined to be interviewable during the stage one survey process, indicated she had the following food palatability concern(s): Food was cold 25%</p>	F000364	<p>F364 483.35 (D)(1)-(2)nutritive value/appear,palatable/prefer temp</p> <p>I. Resident #67, #37, #153, #109, #56, #114, #55, and #36 will be informed of education and new procedures by the food service department that will ensure food remains warm and palatable. Resident #91 and #176 no longer reside in the facility.</p> <p>II. Residents who are served their meals from the kitchen have the potential to be affected.</p> <p>III. All dietary staff will be offered education on the following:</p> <ul style="list-style-type: none"> -Food temperatures and palatability -Food preparation -Use of the toaster <p>The systemic change includes the following:</p> <ul style="list-style-type: none"> -A new dietary service manager has been put into place with a hire date of 4-8-14. -A schedule has been put into 	05/15/2014
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	<p>of the time. "Eggs are hard even scrambled eggs are often cold."</p> <p>4. During a 4/8/14, 9:48 a.m., interview, Resident #153, who was determined to be interviewable during the stage one survey process, indicated he had the following food palatability concern(s): Food was cold 75% of the time.</p> <p>5. During a 4/8/14, 8:22 a.m., interview, Resident #109, who was determined to be interviewable during the stage one survey process, indicated he had the following food palatability concern(s): Food was cold 60 to 75% of the time. "Breakfast is cold every morning."</p> <p>6. During a 4/8/14, 9:34 a.m., interview, Resident #56, who was determined to be interviewable during the stage one survey process, indicated she had the following food palatability concern(s): "The food is not hot. The coffee is not hot. That is the biggest complaint I hear."</p> <p>7. During a 4/8/14, 10:07 a.m., interview, Resident #114, who was determined to be interviewable during the stage one survey process, indicated he had the following food palatability concern(s): Food was cold.</p> <p>8. During a 4/8/14, 9:30 a.m., interview, Resident #55, who was determined to be interviewable during the stage one survey process, indicated she had the following food palatability concern(s): "Eggs are almost always cold."</p> <p>9. During a 4/8/14, 11:00 a.m., interview, Resident #176, who was determined to be interviewable during the stage one survey</p>		<p>place that assigns an administrative staff member for each meal to oversee meal service 7 days a week.</p> <ul style="list-style-type: none"> ·All hot items on the steam table will remain covered until the start of the meal service. ·The dietary cook will remain at the steam table until the meal service is complete. ·Food temperatures will be monitored at every meal and recorded using a log. Any temperatures below or above the appropriate serving temperature will be immediately corrected by the dietary cook. ·A food council will be created with permission from the resident council. (Food council was approved at resident council meeting April 28, 2014) ·The food council will meet monthly with the Dietary Service Manager to discuss food palatability and meal service concerns. ·Food council will meet the second Friday of every month. ·Any concerns will be addressed immediately. <p>IV. The Dietary Service manager or designee will conduct interviews with 5 interviewable residents weekly for four weeks then monthly to total 12 months of monitoring.</p>		

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	<p>process, indicated he had the following food palatability concern(s): Food was cold daily, each meal. Food lacked flavor. "The spices are not the spices I would use."</p> <p>10. During a 4/8/14, 10:16 a.m., interview, Resident #36, who was determined to be interviewable during the stage one survey process, indicated she had the following food palatability concern(s): "Eggs are cold." She indicated food was cold 25 to 50% of the time.</p> <p>11. During a 4/11/14, 7:20 a.m. to 7:45 a.m. breakfast meal service observation the following concerns were noted:</p> <p>a. All hot food items were on the steam table with no lid or cover on any hot food item.</p> <p>b. The toast was white with light tan corners. The toast was uncovered in a steam table pan on a food preparation table. There was no heat under the toast. The toast was cold and limp to touch. The toast had the texture of stale bread and did not have a crunchy or crispy texture.</p> <p>12. During a 4/11/14, 7:20 a.m., interview, Dietary Employee #1 indicated he had uncovered the food on the steam tables and taken temperatures of all the food items. He expected to serve no later that 7:15 a.m. and they were running late. The food was now uncovered because he was waiting to be told they were ready to serve. He had not considered the food lowered in temperature as it sat uncovered.</p> <p>13. During a 4/11/14, 7:25 a.m., interview, Dietary Employee #1 indicated the toast wouldn't get brown that morning. He stated</p>		<p>Results of the interviews will be reviewed monthly with the Quality Assurance Committee and meeting, frequency and duration of reviews will be adjusted as necessary.</p> <p>COMPLIANCE DATE: May 15, 2014</p>		

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F000371 SS=F	<p>he did not know why it didn't brown and he had not asked for assistance when the toast did not brown. He also indicated he didn't think about holding the toast on a heat source to keep it warm.</p> <p>14. During a 4/11/14, 7:28 a.m., interview Dietary Employee #2, who had come from another facility to assist by request of the corporation, indicated the toast was not toasted properly and he would not be satisfied if he were served the toast.</p> <p>15. During a 4/11/14, 7:30 a.m., test tray observation completed by Dietary Employee #2, pureed eggs only reached a temperature of 115.2 degrees. At that time, Dietary Employee #3, who was the Acting Food Services Supervisor, indicated the pureed eggs should be 135 degrees Fahrenheit (F) when served.</p> <p>16. A current, 2010, facility form title "Food Temperature Record", which was provided by the Active Food Services Supervisor on 4/11/14 at 8:40 a.m., indicated pureed eggs should be 135 degrees F or higher when served.</p> <p>17. During a 4/14/13, 2:00 p.m., interview Corporate Dietary Consultant #5 indicated the facility had identified dietary concerns and were in the process of correcting these issues with re-education of staff and the employment of a new Food Services Supervisor who was a Certified Dietary Manager and had experience and education to address the concerns.</p> <p>3.1-21(a)(2) 483.35(i) FOOD PROCURE,</p>			

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	<p>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</p> <p>Based on observation, interview and record review, the facility failed to serve food under safe sanitary conditions regarding possible cross contamination when operating the dishwasher, disposal of outdated food items, storage of food items to protect flavor and freshness, cleanliness of equipment, temperatures of milk coolers and food handling during meal service. This deficient practice had the potential to impact 94 of 96 residents who eat meals which are cooked in the facility's kitchen.</p> <p>Findings include:</p> <p>1. During the 4/7/14, 9:09 a.m. to 9:30 a.m., kitchen sanitation tour the following concerns were noted:</p> <p>a. A wire whisk was across the knobs of the hand washing sink.</p> <p>b. The large milk cooler lacked a thermometer.</p> <p>c. Dietary Employee #6 was washing dishes. He handled soiled dishes on the dirty side of the dish washing machine. He then walked to the cleaned/washed side of the dish washing area and with the same soiled hands stacked clean bowls and placed them in the clean dish area for use. During an interviews at this time, Dietary Employee #6</p>	F000371	<p>F371 483.35(i)FOOD PROCEDURE/PREPARE/SERVE-SANITARY</p> <p>I. No residents were identified as having been affected.</p> <p>II. Residents who are served their meals from the kitchen have the potential to be affected.</p> <p>III. All dietary staff will be offered education on the following:</p> <ul style="list-style-type: none"> -Placement and storage of utensils in the kitchen -Using the dishwasher -Food labeling -Discarding outdated food items -The equipment cleaning schedule and cleaning the kitchen equipment -Hand washing <p>The systemic change includes the following:</p> <ul style="list-style-type: none"> -A new dietary service manager has been put into place with a hire date of 4-8-14. -A new equipment cleaning schedule has been put into place which assigns cleaning duties to staff. 	05/15/2014			

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	<p>indicated he would not do anything differently than he had just done when doing dishes and was unaware of any error he had made. When asked if he should wash his hands when going from the soiled to clean area of the dish washer and before handling dishes, he indicated that would be a good idea.</p> <p>d. Three trays of ice cream and sherbet in individual bowls were stored uncovered in the freezer in a manner that did not prevent possible cross contamination or preserve freshness and promote flavor.</p> <p>e. Two trays of individual salad items such as beets, cottage cheese and yogurt were dated as needing disposed of on 4/6/14 and remained in the refrigerator on 4/7/14.</p> <p>f. The reach in refrigerator had trays of apple sauce and cottage cheese in individual bowls. None of the items were dated. During an interview at this time, Dietary Employee #9 indicated she had dipped up those items for daily use on 4/7/14 and would date them at the end of the day if there were any left.</p> <p>g. The drip pan located under the burners on the stove had a brown/ black liquid residue with food particles scattered about covering the surface of the drip pan. During an interview at this time, the Acting Food Services Supervisor #3 indicated there was no standard schedule to clean the drip pan but it should be cleaned a couple times a week.</p> <p>2. Review of the current, 2012, form title "Temperature Chart-Storage Area (Milk)", which was provided by the Acting Food Services Supervisor #3 on 4/7/14 at 9:45</p>		<p>·The large milk cooler has been removed from the facility as of 4-17-14.</p> <p>IV. The Dietary Service Manager or designee will monitor the refrigerator and freezer for outdated and unlabeled food, completion of assigned cleaning duties and dishwasher use including the use of disposable gloves and handwashing three times a day for 4 weeks, then 2 times a day for 4 weeks then daily for a total of 12 months of monitoring. Administrator or designee will conduct weekly kitchen audits. Corporate dining services supervisor will conduct weekly sanitation audits until the Quality Assurance Committee determines a change in frequency is necessary.</p> <p>COMPLIANCE DATE: May 15, 2014</p>		

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	<p>a.m., had an area to document temperatures for one milk cooler. During an interview at this time, Acting Food Services Supervisor #3 indicated there were two milk coolers in the storage area and there was no way to tell on the form which of the two coolers had been monitored. He indicated he could not provide a record indicating the milk cooler which lacked a thermometer had been regularly monitored.</p> <p>3. During the Dining Room Observation in the North Dining Room on 4/7/14 at 11:43 a.m., Dietary Aide #10, was observed with resident contact between two residents with gloved hands without removing the gloves and/or washing her hands. Dietary Aide #10 then removed bread from a plastic sleeve with the same gloved hands.</p> <p>4. Review of the current facility policy, dated 2012, titled "Environmental Sanitation/Infection Control," provided by the Administrator on 4/14/14 at 2:45 p.m., included, but was not limited to, the following:</p> <p>...6. Disposable gloves are used by the worker at the 'dirty' end of the dishmachine....</p> <p>...14. If there is only one (1) employee available to wash dishes, he/she will use gloves to disassemble trays and load dirty dishes. Prior to removing and storing clean dishware from the 'clean' end of the dishmachine, the worker will remove gloves and thoroughly wash hands...."</p> <p>5. During a 4/14/13, 2:00 p.m., interview, Corporate Dietary Consultant #5 indicated the facility had identified dietary concerns and</p>			

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F000441 SS=E	<p>were in the process of correcting these issues with re-education of staff and the employment of a new Food Services Supervisor who was a Certified Dietary Manager and had experience and education to address the concerns.</p> <p>3.1-21(i)(3) 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by</p>			

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	<p>accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to ensure the disinfecting wipes for cleaning the glucose meters were not expired. This deficient practice had the potential to effect 10 of 10 residents living in the facility with orders for blood sugar monitoring. (Resident # 58, #60, #65, #67, #69, #153, #120, #20, #68 and #131)</p> <p>Findings include:</p> <p>During an interview on 4/15/14 at 8:47 a.m., LPN # 4 on the South Station verbalized the procedure used in the facility to clean the glucometers. Glucometers were to be cleaned before and after use with the "Sani-Cloth Bleach Wipes" according to the manufacturer's recommendations. The box of "Sani-Cloth" wipes used to clean the glucose meter on her cart was provided and discovered to be expired. The expiration dates on the packages inside the box were 11/2013 and 01/2014.</p> <p>During review of the North Station medication cart on 4/15/14 at 9:11 a.m., the "Sani-Wipes" were found to be expired. The expiration date on the packages was 10/2013.</p> <p>During an interview on 4/15/14 at 10:13 a.m., the Director of Nursing indicated the unit managers were responsible for checking to</p>	F000441	<p>F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>I. The expired bleach wipes were removed from the medication carts when the issue was identified during the annual survey.</p> <p>II. Current residents receiving glucometer checks were reviewed to determine if there were infections related to possible blood borne pathogens. No residents were identified.</p> <p>III. Licensed nurses were offered education to verify the bleach wipes are not expired prior to using them for disinfecting the glucometers. The systemic change includes nursing supply manager will verify bleach wipes are not expired prior to giving them to the nursing staff to use. The unit manager/designee will verify the bleach wipes are not expired prior to placing them in the cart for use. The licensed nurse will verify expiration dates prior to use of bleach wipes for disinfecting the</p>	05/15/2014

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	<p>ensure the supplies were not outdated. The manufacture's recommendation for cleaning the glucometers was provided.</p> <p>During an interview on 4/15/14 at 1:30 p.m., the Director of Nursing provided a list of residents who received glucometer testing. (Resident #58, Resident #60, Resident #65, Resident #67, Resident #69, Resident #153, Resident #120, Resident #20, Resident #68 and Resident #131). No further information was provided.</p> <p>3.1-18(a)</p>		<p>glucometers.</p> <p>IV. The DON/Designee will review all med carts once a week for expired bleach wipes for one month, then 3 times a week 90 days. Any issue identified will be corrected. Results of audits will be reported to the QA Committee monthly to assist with additional recommendations if necessary.</p> <p>COMPLIANCE DATE: May 15, 2014</p>	