

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155003	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/28/2015
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NAME OF PROVIDER OR SUPPLIER MASON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 900 PROVIDENT DR WARSAW, IN 46580
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 20, 21, 22, 23, 24, 27, and, 28, 2015.</p> <p>Facility number: 000003 Provider number: 155033 AIM number: 100290600</p> <p>Census bed type: SNF/NF: 90 Total: 90</p> <p>Census: Medicare: 28 Medicaid: 54 Other: 8 Total: 90</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
F 0256 SS=E Bldg. 00	<p>483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS</p> <p>The facility must provide adequate and comfortable lighting levels in all areas. Based on observations, interviews, and record review, the facility failed to</p>	F 0256	This plan of correction has been prepared and executed because	08/21/2015

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>ensure bathroom lights on 1 of 4 halls functioned properly. There were 3 bathroom lights on the 400 hall which did not function all the time, in resident rooms 403, 409, and 412. This potentially affected 5 residents, Residents #34, #163, # 165, #166, and #167.</p> <p>Findings include:</p> <p>During room observation, on 7/21/15, at 10:17 A.M., the bathroom light in resident room 403, was checked. There were 2 residents residing in the room, Resident #34 and Resident #165. When the light switch on the wall was turned on, the fluorescent light over the sink was dim and did not fully light the bathroom.</p> <p>Resident #34 was interviewed, on 7/21/15, at 10:20 A.M., and indicated the light did not always come on, and he was told by a staff member there was moisture in the light due to all the rain. He indicated if the light switch was left on, the light would eventually work.</p> <p>Housekeeper #3 was interviewed, on 7/27/15, at 11:10 A.M., and indicated the bathroom light in room 403 didn't always light when turned on, but if the light was turned on, then turned off, and then turned on again, it would usually work.</p>		<p>it is required by the provisions of state and federal law. Mason Health and Rehab maintains that the alleged deficiency does not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. In lieu of survey results the facility respectfully requests a paper review. Fluorescent lights for bathrooms 403, 409, and 412 have been replaced with no further issues noted. All 400 hall residents have the potential to be affected by the alleged deficient practice. No fluorescent lighting is used on the 100, 200 or 300 halls. Maintenance has replaced all the bathroom lights on the 400 hall. Staff have been educated to immediately report to Supervisor/Maintenance Director if a light is found not working properly. Staff has been educated to take a resident to the shower room restroom if the light is not working in a residents bathroom until maintenance can fix the light. Maintenance/Designee will conduct monthly checks on all facility bathroom lights ongoing. Administrator will review the completed bathroom light check off sheets monthly ongoing. QA bathroom light check off sheets will be reviewed in the Quality Assurance Meetings monthly for four months and then quarterly there after ongoing.</p>	

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	<p>The Maintenance Supervisor was interviewed, on 7/27/15, at 11:13 A.M., and indicated there were problems with some of the bathroom lights on 400 hall recently due to the humidity. He indicated he had checked the bathroom light in room 403 and there was no short, but indicated the fluorescent light would sometimes start to come on, but would have to touch it or wait a minute for the light to come on completely. He indicated he had replaced a light bulb in the bathroom in June 2015.</p> <p>CNA #2 was interviewed, on 7/27/15, at 12 noon, and indicated there were 3 bathroom lights on the 400 hall which did not always light properly. She indicated she had turned in work orders for these lights, but could not remember the dates she had turned in the work orders. She indicated the three rooms were #'s 403, 409, and 412.</p> <p>She indicated one bathroom light, in room 409 was left on all the time because if it was turned off, it would not always come back on right away. She indicated there was a sign on the bathroom door to leave the light in the bathroom on due to this problem.</p> <p>The bathroom light in room 409 was observed to be on upon entering the room, on 7/27/15, at 12:05 P.M., and</p>			

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	<p>there was a sign on the bathroom door which indicated to leave on the light. There were 2 residents residing in room 409.</p> <p>Resident #s 166 and #167 were interviewed, on 7/27/15, at 12:07 P.M., and both indicated if the bathroom light was left on all the time, there was no problem, but if it was turned off and left off for awhile, when they turned the light back on, it would eventually come on, but they would have to wait awhile for it to come back on again.</p> <p>Resident #167 indicated she had been in this room since July 13, 2015, and the sign was on the bathroom door when she was admitted.</p> <p>The bathroom in room 412 (where one Resident #163 resided) was observed, accompanied by CNA #2, on 7/27/15, at 12:10 P.M. The bathroom light was off, and when attempted to turn on the light switch on the wall, the dim fluorescent light located above the bathroom sink, came on, but did not fully light. The CNA tried several times to turn the light on and off, but it remained dim. The CNA indicated this had been a problem, and indicated if she tried to adjust a knob located under the fluorescent light, this would sometimes work.</p> <p>The CNA was observed trying to adjust the knob, but the light remained dim.</p>			
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	<p>The Administrator was interviewed, on 7/27/15, at 1:40 P.M., and indicated there had been one work order for room 412, on 4/9/15. She indicated the bathroom light was not working, and a new light bulb was placed. She indicated she could not find any work orders for rooms 403 and 409.</p> <p>The Administrator was interviewed, on 7/27/15, at 4:00 P.M., and indicated she had checked room 409 again and left the light off for 5 minutes and turned it back on and it had worked. She indicated the Maintenance supervisor had switched out the lights in rooms 403 and 409 and they worked today. She indicated the Maintenance Supervisor had switched out the light in room 412, and checked all the electrical wiring and it was ok. She indicated he had replaced the whole light fixture, but it was still not working properly so an electrician would be called.</p> <p>The Administrator provided a Preventative Maintenance Repair Report, dated 6/29/15, on 7/28/15, at 8:55 A.M. The report was reviewed, on 7/28/15, at 9:00 A.M., and indicated room 412 had been checked and a new light bulb replaced. The Administrator indicated a preventative maintenance schedule was</p>			

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F 0282 SS=D Bldg. 00	<p>completed 4 times a year, and the facility policy was to check 5 rooms a week. She indicated rooms 403, 409, and 412 had been checked in February and April 2015. She indicated the fluorescent bathroom light in Room 412 was switched to a regular light on 7/27/15, and was working now.</p> <p>3.1-19(dd)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to follow physician orders for 1 of 7 residents observed during medication pass, Resident #4, in that, the LPN did not measure the topical medication prior to administration.</p> <p>Findings include:</p> <p>LPN #1 was observed passing medications to Resident #4, on 7/24/15, at 9:39 A.M. She donned gloves, and</p>	F 0282	This plan of correction has been prepared and executed because it is required by the provisions of state and federal law. Mason Health and Rehab maintains that the alleged deficiency does not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. The facility is unable to correct the alleged deficient practice for resident #4. All residents currently residing in the facility have the potential to be	08/21/2015			

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	<p>proceeded to place a ribbon of Voltaren Gel from a tube into her gloved hand, but did not measure the medication. She then rubbed the Voltaren Gel onto Resident #4's right shoulder area.</p> <p>The directions on the plastic bag in which the Voltaren Gel was stored, indicated to apply 2 grams transdermally, four times a day, for right shoulder pain.</p> <p>LPN #1 was interviewed, on 7/24/15, at 9:45 A.M., and indicated there was a plastic guide which came with the Voltaren Gel which was used to measure 2 grams of the medication. She indicated she should have used the measuring device, but applied this all the time, so knew about how much to use.</p> <p>The current July, 2015 physician orders for Resident #4 were reviewed, on 7/24/15, at 1:30 P.M., and indicated Voltaren Gel 1%, apply 2 gram transdermally four times a day for right shoulder pain.</p> <p>The current policy for Topical Medications, dated as revised on 4/2012, was provided by the Director of Nursing Services (DNS), on 7/24/15, at 1:30 P.M. The policy was reviewed on 7/24/15 at 1:35 P.M., and indicated the following: "Policy: To ensure medications are administered as prescribed in accordance</p>		<p>affected by the alleged deficient practice. All residents receiving topical medications were reviewed to ensure they are receiving the correct dosage. Nursing Staff will be in-serviced regarding following doctor's orders, specifically the measuring of topical medications prior to administration. Unit Manager/ Designee will audit medication administration twice weekly for four weeks, then one time weekly for four weeks, and then monthly thereafter ongoing. Director of Nursing/Designee will review results of audits. Audits will be reviewed during QA meeting every month ongoing.</p>				

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F 0323 SS=D Bldg. 00	<p>with standard nursing principles and practices only by staff qualified and authorized to do so."</p> <p>3.1-35(g)(2)</p> <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 observations, record reviews, and interviews, the facility failed to ensure Resident #141 had wheelchair pedals, leg rests, and a footboard on his wheelchair, and failed to ensure Resident #55 was not left in the bathroom unattended which resulted in a fall. The facility further failed to check the function of an alarm for Resident #140 which also resulted in a fall. This deficiency affected 3 of 4 residents reviewed for falls.</p> <p>Findings include:</p> <p>1. On 07/20/2015 2:53 P.M., the Assistant Director Of Nursing (ADON) was interviewed and indicated Resident</p>	F 0323	This plan of correction has been prepared and executed because it is required by the provisions of state and federal law. Mason Health and Rehab maintains that the alleged deficiency does not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Function checks for door trip alarm were added to resident #140 chart tasks. The Facility is unable to correct the alleged deficient practice for resident # 141 and Resident # 55. All residents have the potential to be affected by the alleged deficient practice. Unit Managers/Designee have audited all residents to ensure safety devices are in	08/21/2015

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	<p>#141 had fallen within the past 30 days and had obtained an abrasion to his forehead.</p> <p>The record of Resident #141 was reviewed on 7/24/15 at 1:20 P.M. Resident #141 diagnoses included, but were not limited to, personal history of falls, difficulty in walking, and altered mental status.</p> <p>On 7/27/15 at 11:30 A.M. the Director Of Nursing (DON) was interviewed and indicated Resident #141 had fallen on 7/14/15 because 2 CNAs had not applied the wheelchair leg rests and pedals to the resident's wheelchair and the 2 CNAs had not informed the nurse that they were unable to find the resident's wheelchair leg rests and pedals. The DON indicated the resident had fallen due to not having the wheelchair pedals and leg rests on the resident's wheelchair. The DON indicated the 2 CNAs were given "corrective action" due to the resident's fall out of the wheelchair.</p> <p>The "Falls Investigation Worksheet" dated 7/14/15 at 7:00 A.M. received from the Director Of Nursing (DON) on 7/28/15 at 10:15 A.M. indicated Resident #141 was sitting in his wheelchair in the 300 hall lounge and the ADON had heard the resident's alarm sounding. The</p>		<p>place and have been added to chart tasks to measure function if applicable. Unit Mangers/Designee will conduct walking rounds each business day to ensure that safety devices are in place. Nursing staff have been in-serviced on the importance of ensuring assistive devices are in place, the importance of their documentation, and in-serviced on remaining with a resident that is a fall risk. Director of Nursing /Designee to review completed rounds checklists to ensure appropriate compliance and follow-up weekly for four weeks, then monthly ongoing. QA Rounds Checklist will be reviewed at Quality Assurance Meetings monthly ongoing.</p>				

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	<p>ADON went to assist the resident and before she could reach the resident he had fallen out of the wheelchair.</p> <p>The "Summary of the IDT (Interdisciplinary team) meeting" dated 7/23/15 at 7:00 A.M. for Resident #141's fall on 7/14/15 indicated "...Resident was sitting in the lounge with activity table in front of him when staff heard alarm sound. Staff did not reach resident in time to prevent fall but witnessed him attempt to stand and she (sic) fell forward and hit his forehead on the couch in lounge area. Resident was assessed prior to moving. Abrasion noted to forehead and nose, scant blood noted...resident is currently identified as a fall risk related to impaired balance. (Resident's name) is currently a 2 person assist for transfers ...Current interventions include...nurse alert...Upon investigation resident did not have on regular foot pedals and foot board on the wheelchair. Staff was inserviced on correct pedals for this resident and footboard that should be in place. During observation and neuro (neurological) checks was noted to have changes. MD (Medical Doctor) was notified and a new order was given to send to ER (Emergency Room) to eval (evaluate) and treat. Resident returned with all testing negative and no new orders..."</p>			

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	<p>The Fall Care Plan dated 4/29/15 and updated 7/14/15 indicated Resident #141 "...Ensure foot pedals and foot board is in place when resident is up in wheelchair."</p> <p>On 7/27/15 at 11:45 A.M., Resident #141 was observed in the 300 Lounge sitting in a wheelchair and the resident's right wheelchair foot pedal was on the wheelchair and the left foot pedal and footboard were missing. The resident's left foot was propped up on the bottom bar of an over the bed table.</p> <p>On 07/27/2015 12:01 P.M., the DON was interviewed and indicated the CNA noted this morning when staff had gotten the resident up the wheelchair pedal was broken and therapy had the wheelchair pedal for an adjustment, so he did not have the left wheelchair pedal and footboard on his wheelchair.</p> <p>7/27/15 at 12:05 P.M., the therapist was observed to apply the wheelchair pedal and the blue vinyl foot board to Resident #141's wheelchair.</p> <p>On 7/28/15 at 10:30 A.M., an interview with CNA #4 indicated Resident #141 is to have the wheelchair leg rests and pedals on the wheelchair at all times when the resident is sitting in his</p>			

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	<p>wheelchair.</p> <p>2. The record of Resident #55 was reviewed on 7/27/15 at 2:00 P.M., Resident #55's diagnoses included, but were not limited to, dementia with behavioral disturbance, delusions, Alzheimer's disease and attention or concentration deficit.</p> <p>On 7/28/15 at 9:30 A.M., received from the Director Of Nursing (DON) the Falls Investigation Worksheet dated 5/14/15 at 10:00 A.M., for Resident #55 indicated CNA #5 had left the resident in the bathroom on the toilet alone to assist with a combative resident. CNA #5 indicated when she returned to Resident #55's bathroom the resident was sitting on the floor on her bottom.</p> <p>On 5/14/2015 16:41 IDT (4:41 PM) (Interdisciplinary Team) Note "...Summary of IDT meeting: IDT met to review fall on 5/14/15 at 1100 (11:00 A.M.) in residents bathroom. Resident was in bathroom and attempted to stand without assistance and fell to her bottom. Fall was un witnessed. Resident was found sitting on her bottom in front of the toilet. Resident was assessed prior to moving. No injuries were noted.</p>			

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	<p>Resident was assisted up and into wheelchair and brought to common area...Diagnosis that could contribute to falls include; dementia, Alzheimer's, COPD, hallucinations, pseudobulbar effect, depression, heart burn, anxiety, insomnia, osteoporosis, hearing loss, hyperlipids, CVA, hypothyroidism and diverticulitis. Resident has been identified as a fall risk related to poor safety awareness, weakness, decreased mobility, incontinence, osteoporosis, confusion r/t Alzheimer's and dementia, psychotropic, narcotic and analgesic medication use. Current interventions include bed/ seat alarm, laser alarm, low bed and floor mat. Since resident fell unassisted in the bathroom, staff was educated to not leave her alone while in the bathroom. Resident will remain on post fall and neuro assessments per facility policy."</p> <p>Resident #55's Quarterly Minimum Data Set Assessment dated 4/3/15, indicated resident's cognition was severely impaired and the resident required extensive assistance with toileting.</p>			

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	<p>On 7/28/15 at 10:00 A.M., an interview with the DON indicated CNA #5 had left Resident #55 alone in the bathroom on the toilet to check on another resident she heard yelling. The DON indicated the other resident was already being taking care of by staff so CNA #5 went back to Resident #55's bathroom and found the resident already sitting on the floor. The DON indicated staff was educated not to leave a resident alone in the bathroom if the resident had an alarm. Don indicated the facility did not have a policy in regard to not leaving a resident alone in the bathroom if the resident has an alarm. The DON indicated it is "understood" if resident has alarm staff is not to leave a resident alone in bathroom.</p> <p>3. Review of Resident #140's clinical record on 7/24/15 at 10:30 A.M. indicated on 6/27/15, at 1:00 P.M. an unwitnessed fall occurred in the resident's room. The progress notes indicated staff entered the resident's room and the resident was sitting beside the bed. A nursing assessment indicated no visible injury.</p> <p>On 6/29/15, at 1:28 P.M., an Interdisciplinary Team (IDT) meeting</p>			

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	<p>progress note indicated that on 6/27/15 at 1:00 P.M., Resident #140 wheeled himself into his room and attempted to transfer self into his bed unassisted. A door trip alarm was on but did not sound. A seat alarm sounded and a nurse came to the resident's room just in time to see the resident fall to his buttocks beside his bed. The IDT noted current interventions to prevent falls included: bed alarm, wheelchair seat alarm, antiroll backs to wheelchair and a door trip alarm. The IDT noted the door trip alarm was replaced with a correctly working alarm.</p> <p>Review of Resident #140's admission Minimum Data Set of 5/7/15 indicated for transfers he was a 3,3 which indicated he required extensive assist of 2 staff, resident involved in activity, staff to provide weight bearing support.</p> <p>An interview with the DON on 7/24/15 at 12:01 P.M. indicated there was no documentation the facility had been tracking the functioning of the door alarm before the fall on 6/27/15. The DON indicated the functioning of the door alarm should have been on the CNA task e-charting to ensure the door alarm was functioning each shift. The DON provided a copy of the CNA worksheet which indicated the door trip alarm was to be turned on when the resident was out</p>				

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	<p>of the room.</p> <p>An observation on 7/24/15 at 10:44 A.M. noted a door alarm on the door frame which was functioning properly.</p> <p>A care plan indicated the resident was at risk for falls related to impaired balance and an intervention was added on 6/10/15 for a trip alarm on the door frame when Resident 140 was out of his room.</p> <p>A copy of the facilities' Fall Management Protocol, last revised on 11/2010 was provided by the nurse consultant on 7/28/15 at 10:30 A.M.. The Fall Management Protocol #9 indicated: "A copy and implement a personal alarm policy and procedure and evaluate all residents prior to personal alarm use. When personal alarm are used there needs to be specific individual recommendations for each resident. Be sure to monitor the functional ability of the personal alarms and monitors. This means a daily schedule for checking the functional ability and batteries of all personal alarms. This should be documented."</p> <p>A copy of the facilities' undated Alarms Protocol was provided by the nurse consultant on 7/28/15 at 10:30 A.M.. The Alarms Protocol indicated "the staff to</p>				

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F 0371 SS=E Bldg. 00	<p>complete documentation that the function and placement of the alarm has been checked once per shift."</p> <p>3.1-45(a)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure the food preparation area was free of debris, potentially affecting 85 residents who consumed food prepared by the facility kitchen of 90 residents in the facility. In addition, the facility failed to ensure the high temperature dishmachine rinse cycle reached the minimum effective temperature for disinfecting dishes, potentially affecting 85 of 90 residents in the facility.</p> <p>Findings include:</p> <p>1. On initial tour of the kitchen on 7/20/15 at 10:15 A.M. the exhaust hood was noted with a large amount of dirt and</p>	F 0371	<p>This plan of correction has been prepared and executed because it is required by the provisions of state and federal law. Mason Health and Rehab maintains that the alleged deficiency does not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. The kitchen exhaust hood has been thoroughly cleaned and has been added to the weekly cleaning schedule. The hot water heater has been repaired ensuring the appropriate dishwasher temperatures. All staff have been in-serviced on the updated weekly cleaning schedule and the appropriate steps to take if the dishwasher temps were to fall below normal range. Dietary</p>	08/21/2015

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	<p>grime. Food was noted being prepared directly beneath the exhaust hood.</p> <p>An interview with the Dietary Manager (D.M.) on 7/20/15 at 10:15 A.M. indicated the exhaust hood had been cleaned in April 2015 and was next scheduled to be cleaned in October 2015. The DM indicated she would contact the company who routinely clean the exhaust hood and have it cleaned right away.</p> <p>Review of the policy "Management Policy & Procedure Manual, Cleaning of Hood Vents", provided on 7/22/15 at 10:40 A.M., by the D.M., indicated under policy: "The dietary exhaust hood over the cooking line will be professionally cleaned on a routine basis two (2) times each year. The exterior hood and filters will be routinely cleaned by facility staff."</p> <p>2. On initial tour of the kitchen on 7/20/15 at 10:20 A.M. the high temperature dishwasher was noted to reach a maximum temperature of 178 degrees. On a second attempt, the maximum temperature reached 171 degrees.</p> <p>On 7/20/15 at 10:30 A.M. the D.M. provided the dishmachine temperature/sanitation log from July</p>		<p>Manager/Designee will check cleanliness of the range hood weekly as well as checking the dishwasher temps each business day ongoing. Registered Dietician will audit dishwasher temps and cleanliness of range hood with each visit. Administrator will review dietary managers checklists monthly ongoing. QA dishwasher temps, cleaning schedules, and audits will be reviewed at Quality Assurance Meetings Monthly Ongoing.</p>				

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	<p>2015 which indicated six rinse cycle temperatures between 160-169 degrees at the noon dishwasher on: 7/6/15; 7/11/15; 7/12/15; 7/14/15; 7/15/15; 7/17/15.</p> <p>An interview with the D.M. on 11:50 A.M. indicated she had not been notified on any of the six occasions in July 2015 where the dishwasher rinse cycle temperatures were below the minimum temperature.</p> <p>Review of the policy provided by the D.M. on 7/22/15 at 10:40 A.M., titled: "Management Policy & Procedure Manual, Monitoring Dishmachine Temperatures", most recent revision 6/12 indicate under Process/Procedure section: "2) The Temperatures will be taken using the dish machine dials and recorded on the form supplied. High Temperature Dishmachine: minimum was temperature 150 degrees F. and rinse temperature at least 180 degrees F."</p> <p>Under Process/Procedure: "5) Unusual recordings should be closely monitored, reported to the Supervisor or designated personnel and the Maintenance Department if malfunctioning is suspected. 6) In the event the dish machine is not working properly and cannot be fixed before meal service, the Food Service Supervisor will serve on disposal table service."</p>			

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

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	3.1-21(i)(1)(2)				