

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155532	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/03/2013
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NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 28, 29, 30, 31 and June 3, 2013</p> <p>Facility number: 000460 Provider number: 155532 AIM number: 100290620</p> <p>Survey Team: Leia Alley, RN-TC Cheryl Mabry, RN Diana McDonald, RN Melissa Gillis, RN</p> <p>Census bed type: SNF: 1 SNF/NF: 31 Total: 32</p> <p>Census payor type: Medicare: 1 Medicaid: 30 Other: 1 Total: 32</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on June 12, 2013; by Kimberly Perigo, RN.</p>	F000000	<p>June 24, 2013 Bloomington Nursing and Rehabilitation Center 120 East Miller Drive Bloomington, IN 47401-6538 Dear Ms. Rhoades, Please accept this Plan of Correction for Annual Survey conducted on June 3, 2013. All deficiencies from 2567 will be corrected as of date certain July 2, 2013. I would like to formally request paper compliance for these deficiencies. Thank you for your consideration in this matter. Scott McNeelan, Administrator</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>				

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to provide appropriate notice as required to Medicare beneficiaries who were being discharged from the Medicare program. This involved 3 of 3 residents reviewed for liability notifications and beneficiary appeal rights. (Resident #12, #36, and #45)</p> <p>Findings Include:</p> <p>1) A review of the Notice of Medicare Non Coverage Form for Resident #12 was reviewed on 5/31/13 at 2:45 p.m. Resident #12's Medicare Coverage for Physical and Occupational Therapies were to end as of 12/14/12. The form was signed by Resident #12 on 12/14/12, the date coverage would end.</p> <p>A review of the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) form, signed by Resident #12, was told in person and in writing on the same day, 12/14/12, and was not given any notice before the date the coverage would end.</p> <p>2) A review of the Notice of Medicare Non Coverage Form for Resident #36 was reviewed on 5/31/13 at 2:50</p>	F000156	<p>F156 483.10(b)(5)-(10),483.10(b)(1)NOTICE OF RIGHTS, RULES, SERVICES, CHANGES</p> <p>I. RDCO reviewed residents #12, #36, #45 with SSD.</p> <p>II. All residents at facility have the potential to be affected. A complete facility audit/review if current resident charts revealed no additional infractions of untimely notifications per LTCABN guidelines.</p> <p>III. RDCO provided education pursuant to correct implementation of CMS guidelines 483.10 "Resident Rights" with leadership team (Administrator, DON, SSD, Rehab Coordinator, BOM, MDS coordinator).</p> <p>IV. MDS/designee will audit/monitor all notifications and residents discharging from Medicare program weekly as a part of facility Medicare meeting process to ensure notifications to Medicare beneficiaries (residents/POAs) at least 48 hours prior to their discharge from</p>	07/02/2013

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	<p>p.m. Resident #36's Medicare Coverage for Physical and Occupational Therapies were to end as of 1/12/13. A note on the form, from the Social Services Director (SSD) stated, "Verbal phone notification to POA [power of attorney]" and is dated 1/14/13, two days after coverage had ended.</p> <p>A review of the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) form, signed by the SSD, indicated Resident #36's Power of Attorney was told coverage had ended over the phone by SSD on 1/14/13, and was not given any notice before coverage had ended.</p> <p>3) A review of the Notice of Medicare Non Coverage Form for Resident #45 was reviewed on 5/31/13 at 3:00 p.m. Resident #45's Medicare Coverage for Physical and Occupational Therapies were to end as of 2/9/13.</p> <p>A review of the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) form, signed by Resident #45, was told in person and in writing on the same day, 2/9/13, and was not given any notice before the date the coverage would end.</p>		<p>the Medicare program. In addition, regional support staff will monitor on facility visits until 100% compliance is achieved for one full quarter. Administrator/designee will monitor monthly thereafter and report any non-compliance to QA committee and RDCO.</p>				

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	<p>The Advance Beneficiary Notice Form dated April 2011, indicated, "A Medicare provider must give a completed copy of this notice to beneficiaries receiving services from skilled nursing facility's (SNF),...not later than two days before termination of services."</p> <p>During an interview with the SSD on 6/3/13 at 3:00 p.m., she indicated she was aware that Residents or Power of Attorney were to be notified 48 hours before Medicare coverage would end.</p> <p>3.1-4(a)</p>			

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F000225				07/02/2013	

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	<p>interview, the facility failed to report an allegation of abuse to the state agency within 24 hours of the alleged abuse. (Resident's #25 and #56.)</p> <p>Findings Include:</p> <p>During an interview with Resident #25 on 5/28/13 at 1:00 p.m., he indicated he was hit by Resident #56, in the head with a small decorative bird cage. He also indicated that Resident #56 had been causing a "lot of trouble" to other residents in the facility.</p> <p>The clinical record review of Resident #56 was reviewed on 5/28/13 at 3:00 p.m.</p> <p>Diagnoses for Resident #56 included, but were not limited to Alzheimer disease and dementia with behaviors.</p> <p>A note from the Social Services Director (SSD) on 5/24/13 indicated Resident #56 was "confused about people and objects" and indicated resident gets "mildly upset and curses at staff."</p> <p>During an interview with the Administrator on 5/28/13 at 2:00 p.m., he indicated there was an Incident Report Form for the altercation</p>		<p>F225 483.13 (c)(1)(ii-iii), (c)(2)-(4) INVESTIGATIVE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>Bloomington Nursing and Rehabilitation does ensure that allegations of mistreatment. Neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported to administrator and to other officials in accordance with state law through established procedures, and are thoroughly investigated and all attempts to prevent further potential abuse while investigations are in process.</p> <p>I. Resident #25 was re-interviewed/assessed, it was determined that no lasting physical/psychological effects were present.</p> <p>II. All residents have the potential to be affected.</p> <p>III. The facility's "Abuse Prevention" Policy was reviewed and found to be appropriate. Leadership staff were re-educated on Abuse Prevention (and reporting) Policy on 6-19-13 by RDCO. Staff members were re-educated on Abuse Prevention and Reporting on 6-28-13 by Administrator and RDCO.</p>				

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	<p>between Resident #56 and Resident #25 on 5/26/13, but it had not yet been reported to the state health department as required. He indicated they send the Incident Report Forms via electronic mail and on Sunday 5/26 and Monday 5/27/13, the facility Internet was not working properly. He indicated he could not provide information from the Internet provider that could verify the Internet was not working properly.</p> <p>A facility policy provided by the Administrator on 5/28/13 at 12:00 p.m., titled Abuse Prevention, dated 9/2011, indicated " Allegations of abuse are reported to the state survey agency within 24 hours. If the abuse involved serious bodily injury it must be reported to ISDH (Indiana State Department of Health) within 2 hours."</p> <p>3.1-28(e)</p>		<p>IV. In addition to the process noted above, SSD/designee will interview Residents using the Resident Interview Observation Form (CMS-20050) Section G no less often than quarterly during the assessment reference period according to the RAI schedule. Interviews will continue according to RAI schedule until 100% compliance is met for a full quarter. Administrator/designee will continue to monitor monthly thereafter and report any non-compliance to QA committee and RDCO.</p>				

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview the facility failed to implement a written policy to report an allegation of abuse to the state agency within 24 hours of alleged abuse. (Residents #25 and #56.)</p> <p>Findings Include:</p> <p>During an interview with Resident #25 on 5/28/13 at 1:00 p.m., he indicated he was hit by Resident #56, in the head with a small decorative bird cage. He also indicated Resident #56 had been causing a "lot of trouble" to other residents in the facility.</p> <p>The clinical record review of Resident #56 was on 5/28/13 at 3:00 p.m.</p> <p>Diagnoses for Resident #56 included, but were not limited to Alzheimer disease and dementia with behaviors.</p> <p>A note from the Social Services Director (SSD) on 5/24/13 indicated Resident #56 was "confused about people and objects" and indicated</p>	F000226	<p>F226 483.13(c) DEVELOPMENT/IMPLEMENTATION OF ABUSE/NEGLECT, ETC. POLICIES</p> <p>Bloomington Nursing and Rehabilitation does ensure that allegations of mistreatment. Neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported to administrator and to other officials in accordance with state law through established procedures, and are thoroughly investigated and all attempts to prevent further potential abuse while investigations are in process, and within regulatory time frames.</p> <p>I. Resident #25 was re-interviewed/assessed, it was determined that no lasting physical/psychological effects were present.</p> <p>II. All residents have the potential to be affected.</p>	07/02/2013			

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	<p>resident gets "mildly upset and curses at staff."</p> <p>During an interview with the Administrator on 5/28/13 at 2:00 p.m., he indicated there was an Incident Report Form for the altercation between Resident #56 and Resident #25 on 5/26/13, but it had not yet been reported to the state health department as required. He indicated they send the Incident Report Forms via electronic mail and on Sunday 5/26 and Monday 5/27/13, the facility Internet was not working properly. He indicated he could not provide information from the Internet provider that could verify the Internet was not working properly.</p> <p>A facility policy provided by the Administrator on 5/28/13 at 12:00 p.m., titled Abuse Prevention, dated 9/2011, indicated " Allegations of abuse are reported to the state survey agency within 24 hours. If the abuse involved serious bodily injury it must be reported to ISDH (Indiana State Department of Health) within 2 hours."</p> <p>3.1-28(a)</p>		<p>III. The facility's "Abuse Prevention" Policy was reviewed and found to be appropriate. Leadership staff were re-educated on Abuse Prevention (and reporting) Policy on 6-19-13 by RDCO. All staff members will be re-educated on this policy. Special emphasis was placed on the timeliness of reporting alleged events within 24 hours to ISDH.</p> <p>IV. In addition to the process noted above, SSD/designee will interview Residents using the Resident Interview Observation Form (CMS-20050) Section G no less often than quarterly during the assessment reference period according to the RAI schedule. Interviews will continue according to RAI schedule until 100% compliance is met for a full quarter. Administrator/designee will continue to monitor monthly thereafter and report any non-compliance to QA committee and RDCO.</p>				

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review, and interview, the facility failed to develop a comprehensive plan of care for a quadriplegic resident with contracture. This involved 1 of 4 residents reviewed for contracture without a splint device. (Resident #9)</p> <p>Findings Include:</p> <p>During an observation of Resident #9 on 5/28/13 at 2:00 p.m., Resident #9 was noted to have a contracture [stiff, rigid joints and muscles that are not able to move) of the left arm and</p>	F000279	<p>F279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>Bloomington Nursing and Rehabilitation utilizes the results of resident assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>I. MDS coordinator reviewed and amended MDS for</p>	07/02/2013	

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	<p>wrist.</p> <p>The clinical record for Resident #9 was reviewed on 5/30/13 at 10:00 a.m. Resident #9 was admitted on 1/25/13.</p> <p>A Quarterly Minimal Data Set (MDS) assessment done on 3/20/13 indicated Resident #9 had an impairment in his range of motion on both the left and right sides of his body, and both upper and lower halves of his body.</p> <p>Diagnoses included but were not limited to quadriplegia (unable to move any part of the body on your own).</p> <p>During an interview with the Director of Nursing (DON) on 5/30/13 at 11:45 a.m., further information was requested in regard to care plan services for contracture.</p> <p>During an interview with the DON on 5/30/13 at 2:30 p.m., the DON indicated no such care plan was available for Resident #9. She also indicated no further information was available.</p> <p>3.1-35(a)</p>		<p>resident #9 and obtained order clarification from MD regarding diagnosis of "Quadriplegia". Plan of Care updated accordingly. Therapy performed assessment and developed Plan of Care for resident #9.</p> <p>II. All residents have the potential to be affected. 100% facility review of current Residents was completed, no further incorrect/incomplete Resident MDS/diagnoses/Absence of Care Plans identified.</p> <p>III. RDCO provided re-education of leadership team to adhere to facility standards in assessment of all new residents/residents with declines to meet their medical, nursing, mental and psychological needs and plan services to attain/maintain resident's highest practicable physical, mental and psychosocial wellbeing.</p> <p>IV. MDS coordinator/designee will monitor weekly via the Medicare Meeting all new Residents, and all current residents to ensure proper assessments and Plans of Care are developed/implemented until 100% compliance is met for one full quarter. Administrator/designee will continue to monitor monthly thereafter and report any non-compliance to QA committee</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155532	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2013
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			and RDCO.	

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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 record review and interview, the facility failed to provide services, as indicated by the resident's plan of care, for 1 of 1 residents reviewed for dialysis services and care. (Resident #42)</p> <p>Findings Include:</p> <p>The clinical record for Resident #42 was reviewed on 5/31/13 at 2:00 p.m.</p> <p>Diagnoses for Resident #42 included, but were not limited to renal failure (kidney failure) and hemodialysis (a treatment to remove waste from the body).</p> <p>A written Interdisciplinary Care Plan for Dialysis/ Renal Failure indicated an approach for treatment was...</p> <p>"Check dialysis access site every shift for pain or discomfort"</p> <p>"Check peripheral pulses distal to access site"</p> <p>"Communicate with dialysis center regarding medication, diet, and lab results. Coordinate resident's care in collaboration with dialysis center."</p>	F000282	<p>F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>Bloomington Nursing and Rehabilitation does ensure that the resident services provided or arranged by the facility by qualified persons in accordance with each resident's written plan of care.</p> <p>I. Resident #42 was assessed and no negative outcomes identified.</p> <p>II. 100% review of residents in facility indicates that two residents could have been affected. Second resident assessed with no negative outcomes identified. Both resident's care plans were reviewed and are currently following policy, which requires access site monitoring as well as pulses distal to access site every shift.</p> <p>III. Facility policy "End</p>	07/02/2013			

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	<p>The clinical record lacked documentation services were being provided as indicated in Resident #42's plan of care.</p> <p>Further information was requested from the Director of Nursing (DON) on 6/3/13 at 10:30 a.m., in regard to communication with the dialysis center and monitoring while Resident #42 was at the facility.</p> <p>During an interview with the DON on 6/3/13 at 2:00 p.m., she indicated no such information was available.</p> <p>A facility policy titled, End-Stage Renal Disease, Care of a Resident with, (undated), indicated "...assessment data that is to be gathered about the resident's condition on a daily or per shift basis" and...</p> <p>Agreements between this facility and the contracted ESRD [End Stage Renal Disease] facility include all aspects of how the resident's care will be managed, including...</p> <ol style="list-style-type: none"> <li>How the care plan will be developed and implemented;</li> <li>How information will be exchanged between the facilities and</li> <li>Responsibility for waste handling, sterilization and disinfection of</li> </ol>		<p>Stage Renal Disease, Care of Resident with" was reviewed and found to be appropriate. All clinical staff will be re-educated on "End stage renal Disease, care of resident with" policy and care review.</p> <p>IV. Director of Nursing will audit the two residents affected and any new residents daily x 2 weeks to ensure proper assessment and documentation in place. Then weekly audits of same x 6 weeks then monthly thereafter. Results will be monitored via monthly QA committee meetings.</p>		

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	equipment if applicable."  3.1-35(g)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155532	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/03/2013
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F000318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Based on observation, record review, and interview, the facility failed to provide a resident with limited range of motion with treatment to prevent a decrease in range of motion or contracture. This involved 1 of 4 residents reviewed for contracture without a splint device. (Resident #9)</p> <p>Findings Include:</p> <p>During an observation of Resident #9 on 5/28/13 at 2:00 p.m., Resident #9 was noted to have a contracture (immobility of joints/muscles) of the left arm and wrist.</p> <p>A Quarterly Minimal Data Set (MDS) assessment done on 3/20/13 indicated Resident #9 had an impairment in his range of motion on both the left and right sides of his body, and both upper and lower halves of his body.</p> <p>Diagnoses included but were not</p>	F000318	<p>F318 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Bloomington Nursing and Rehabilitation does ensure that the resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion</p> <p>I. Resident #9 was assessed on 6-18-13 by therapy department and treatment/plan of care was initiated to include BUE splints/and therapy regimen/plan of care.</p> <p>II. All other residents currently in building were reviewed by MDS/therapy to identify any other residents with limited Range of Motion not on current plan of care program. None were found.</p>	07/02/2013	

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	<p>limited to quadriplegia (unable to move any part of the body on your own).</p> <p>During an interview with the Director of Nursing (DON) on 5/30/13 at 11:45 a.m., further information was requested in regard to care plan services for contracture.</p> <p>During an interview with the DON on 5/30/13 at 2:30 p.m., the DON indicated no such care plan was available for Resident #9. She also indicated no further information was available.</p> <p>The clinical record for Resident #9 was reviewed on 5/30/13 at 10:00 a.m. Resident #9 was admitted on 1/25/13.</p> <p>3.1-42(a)(2)</p>		<p>III. MDS/therapy will review new admissions to facility weekly as well as any current residents that require assessment due to a functional decline or decrease in range of motion.</p> <p>IV. MDS/designee will monitor weekly and will report any concerns to administrator immediately. Results of weekly progress will be reported monthly until 100% compliance is achieved, then quarterly thereafter. Results and findings will be reviewed monthly via QA committee meetings.</p>		

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F000323 SS=E	<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, record review, and interview, the facility failed to ensure adequate supervision for a cognitively impaired resident who exhibited behaviors towards other residents for 1 of 1 residents reviewed for wandering behaviors. (This involved Residents #5, #8, #26, #34, and #56)</p> <p>Findings Include:</p> <p>During an interview with Resident #25 on 5/28/13 at 1:00 p.m., he indicated he was hit by Resident #56, in the head with a small decorative bird cage. He also indicated that Resident #56 had been causing a "lot of trouble" to other residents in the facility.</p> <p>The clinical record review of Resident #56 was reviewed on 5/28/13 at 3:00 p.m.</p> <p>Diagnoses for Resident #56 included but were not limited to Alzheimer disease, and dementia with</p>	F000323	<p>F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>Bloomington Nursing and Rehabilitation does 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.</p> <p>I. Resident #56 was immediately assessed per SSD. On 5/31/13, resident discharged from facility to an advanced Dementia (locked unit) facility in Scottsburg per family.</p> <p>II. After a review of residents at facility with known behaviors, all were re-assessed and reviewed by social services department and care plans were developed to address mood, behavior and other psychiatric symptoms exhibited by residents</p>	07/02/2013			

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	<p>behaviors.</p> <p>A note from the Social Services Director (SSD) on 5/24/13 indicated Resident #56 was "confused about people and objects" and indicated resident gets "mildly upset and curses at staff."</p> <p>During an interview with the Administrator on 5/28/13 at 2:00 p.m., he indicated there was an Incident Report Form for the altercation between Resident #56 and Resident #25 on 5/26/13, but it had not yet been reported to the state health department as required. He also provided an Incident Report form dated 5/27/13, which indicated Resident #56 went into the room of Resident #5. Resident #5 yelled at Resident #56 to leave her room and "get out" and Resident #56 then slapped Resident #5 on the arm several times.</p> <p>During an observation of Resident #56, #34, and #8 on 5/30/13 at 3:30 p.m., and in the presence of the Director of Nursing (DON), the three residents were around a dining room table. Resident #56 approached Resident #34. Resident #34 loudly asked Resident #56 to "get away" from her. Resident #56 called</p>		<p>with interventions and alternatives put into place. Staff were trained regarding specific resident care plans and interventions.</p> <p>III. RDCO reviewed current "Standard and Guideline Behavior Program" for facility, and found it to be sufficient. Facility re-inserviced by RDCO regarding "Behavior Program Standard and Guideline", to include establishment of Behavior committee and adherence to facility policy. All clinical staff will also be re-educated on Behavior Program immediately.</p> <p>IV. In addition to the process noted above, the Administrator/SSD/designee will monitor Behavior Program weekly until 100% compliance achieved in regards to adherence to Behavior Program Standard and Guidelines. Results of monitoring will be reviewed monthly by QA committee for 3 months then quarterly thereafter.</p>		

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	<p>Resident #34 a "piece of **it" and Resident # 8 yelled "oh **ck you!"</p> <p>The DON intervened in the argument at the time foul language was used.</p> <p>During an interview with the Administrator on 5/29/13 at 2:30 p.m., he indicated he was aware Resident #56 was causing concern among the other residents and indicated he was working with Resident #56's family and the Social Services Director to move Resident #56 to a facility that had a special care unit for persons with dementia.</p> <p>During an interview with the DON on 5/30/13 at 4:00 p.m., she indicated Resident #56 would be discharging the facility the morning of 5/31/13.</p> <p>A facility policy titled Abuse Prevention, dated 9/2011, indicated "It is the policy of this facility to provide each resident with an environment that is free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion."</p> <p>3.1-45(a)(2)</p>						

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions The Requirement is not met as evidence by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff use proper hand washing, stored, prepared, distributed, and served food under sanitary conditions. This had the potential to effect 32 of 34 residents served from the kitchen.</p> <p>Findings included:</p> <p>1. During the initial kitchen tour on 5/28/13 at 10:10 a.m., and in the presence of DM (dietary manager) and Cook #1 the following observations were made:</p> <p>a) At 10:10 a.m., the hot water took 3 minutes to reach a 100 degrees Fahrenheit (F). Cook #1 indicated, "Water always cold that's why I use this other sink." b) Observed peeling and hanging paint inside the hood over the stove.</p>	F000371	<p>F371-483.35(i) Food Procure,Store/Prepare/Serve-Sanitary</p> <p>Bloomington Nursing and Rehabilitation does ensure that all food/food items will be stored, prepared, distributed and served under proper sanitary conditions.</p> <p>I. Policy "Dietary Department Dishwasher, Proper Use of" was immediately written and implemented to ensure proper water temperatures and processes adhered to according to manufacturer's recommendations. Areas of peeling paint inside the hood and over the stove were scraped and painted. Holes in the window screen of kitchen were repaired. The vent on the wall near refrigerator was cleaned and dusted.</p> <p>Mighty shakes in refrigerator were inspected and dated, all open</p>	07/02/2013

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	<p>Holes in the window screen. There were water spots in several areas on the ceiling. The vent on wall by the refrigerator very dirty and full of dust. Cook #1 indicated, "Had water leak some years ago."</p> <p>c) Mighty shakes in the refrigerator without expiration date. Pasta in dry storage had neither an open date nor expiration date. Brownie mix had no open or expiration date and no identification label was on the brownie mix. Bacon container in the refrigerator did not have dates nor label on it.</p> <p>d) Cook #1 using hand sanitizer between pureeing lunch items indicated, "That is what I've always done, nobody ever told me differently."</p> <p>e) Cook #1 washed puree pot and upon completion of the washing the pot remained wet and was used for the next food to be pureed.</p> <p>On 5/28/13 at 10:30 a.m., the DM (dietary manager) indicated, "The date must be on box for the mighty shakes which is in the freezer."</p> <p>On 5/28/13, at 11:00 a.m., dish washer rinse temp (temperature) was measured at 110 degrees (F) and the rinse temp at 30 degrees (F). The metal plate on the dishwasher</p>		<p>undated items were discarded. Pasta in dry storage was discarded, and all other boxes were inspected and discarded if opened without dates present. Bacon was removed from refrigerator and discarded. Brownie mix without date present was discarded.</p> <p>Staff were immediately re-educated on proper handwashing with soap and water, hand sanitizer dispensers were removed from kitchen area.</p> <p>Pots were all rewashed, dried and stored per policy.</p> <p>All dietary staff were re-educated on how to read thermometers when checking temperature compliance, proper glove use, proper handling of dinnerware, temperatures and proper storage of dishes, pots and pans.</p> <p>II. All Residents have the potential to be affected.</p> <p>III. All food service personnel have been re-educated regarding preparing and serving foods, cleaning schedules and expectations of the cleaning schedules. An updated cleaning list has been created to increase the frequency of cleaning.</p> <p>IV. The Dietary Manager/designee is completing a quality improvement audit of the</p>	

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	<p>indicated the temp should be 120 degrees for the wash and rinse cycle and chlorine ppm (parts-per-million) 50. A second wash cycle was performed reaching a temp of 100 degrees.</p> <p>The DM was observed washing hands for only 10 seconds. The DM indicated that the length of time to hand wash "20 seconds."</p> <p>Review of Policy and Procedure: " Handwashing " with no date was received on 5/28/13 at 12:05 p.m., from the DM indicated " ...6. Lather all areas of the hands and wrists rubbing vigorously for 20 seconds ... "</p> <p>Interview on 5/28/13 at 11:10 a.m., Cook #1 indicated she read the temp as 147 degrees for the wash cycle. She indicated, " _____ [Name, previous dietary manager] told me to add top number and bottom number." She was adding Fahrenheit and Celsius together; instead of getting the actual reading of 110 degrees she was getting 147 degrees. When cook #1 asked what does she do when wash temperature incorrect indicated, " It 's just how it is ." She then indicated, "Notify the Dietary Manager."</p>		<p>cleanliness, environmental concerns, serving techniques and proper storage of dinnerware three times weekly for 30 days, then weekly for one month, then monthly for 6 months. Results of all audits are being reviewed monthly by facility's quality assurance committee for additional recommendations as necessary.</p>		

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NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401
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	<p>Interview on 5/28/13, at 11:14 a.m., with the DM indicated, "reading both numbers on thermometer is how I was trained." She indicated she would call maintenance if temps were not correct.</p> <p>On 5/28/13, at 12:00 p.m., Cook #2 was observed taking food temps indicating the temperature on a glass of milk was 43 degrees and bowl of cottage cheese was 45 degrees.</p> <p>Review of " Dish Machine Temperature Log "for April 2013 and May 2013, were received on 5/28/13 at 12:05 p.m., indicated that dishwasher temperatures were being misread and recorded incorrectly.</p> <p>On 5/28/13, at 11:15 a.m., receive a paper from the DON titled Procedure: "Subject: Food Labeling and Dating" dated April 2003 indicated:</p> <p>"1. ...All food products that are purchased and brought into the Dietary department inventory are dated upon delivery and storage. A red permanent marker is used for this purpose.</p> <p>2. ...all opened, perishable items are dated with the current date and discarded after 48 hours. If items is not readily identifiable, the name of</p>			

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NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401
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	<p>the item is also written on the label</p> <p>3. ...not considered perishable ...are dated when the original container is opened ...monitored by the DM or designee on routine basis. ...discarded monthly ...</p> <p>4. ... (Mighty Shakes) have a 14 -day refrigerated shelf life and are dated when pulled from the freezer. ...have a system in place to assure that shakes are discarded after 14 days in the refrigerator."</p> <p>During second kitchen observation on 5/29/13 at 10:10 a.m., the handwashing sink's hot water remained cold and took 3 to 4 minutes to reach 100 degrees.</p> <p>The DM observed preparing icing for meal she was called out of the kitchen to speak with a resident, she was observed returning to kitchen no handwashing observed at this time but she went over and placed aluminum foil over the icing bowl. She then proceeded to wash her hands for 10 seconds and opened the refrigerator.</p> <p>During an interview on 5/29/13 at 3:10 p.m., with DM (dietary manager) indicated, "Maintenance guy quit 2 weeks ago and he knew about these items" and she walked out of kitchen.</p>			

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	<p>During a third kitchen observation on 5/30/13, at 10.00 a.m., dishwasher temp was 90 degrees for the wash cycle and 118 degrees for rinse cycle.</p> <p>Review of manufacturers manual "American Dish Service effective June 2008" received 5/30/13 at 1:00 p.m., from the ADM (administrator) indicated "The chemical sanitizing agent provides comparable germ killing ability in 140 degree rinse water as in the conventional machines ... The rinse-aid causes the water to flow from the dishes ...This allows the dishes to dry faster ... 5. ... If water temperature gauge has not reached 120 degree Fahrenheit (49 degree Celsius) ...drain water from machine ...fill until proper temperature is attained."</p> <p>Review of " Customer Service Report " dated 5/17/13, received 6/3/13 at 1:50 p.m., from the DM indicated " ...Test Result Titration 200 ppm (parts-per-million) , Wash Temp 130 ' (degree), Final Rinse Temp 130 ' ...Chlorine Sanitizer Adjusted and Tested Per State Board of Health Requirements? Yes 50 ppm "</p> <p>Review of Policy " Dishmachine use " dated " Revised March 2004 "</p>			

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	<p>received on 6/3/13 at 1:50 p.m., from the DM indicated " Policy Statement Food service staff required to operate the dishmachine will be trained in all steps of dishmachine use by the supervisor or a designee proficient ... f. After running items through entire cycle, allow to air dry."</p> <p>During final kitchen observation on 5/31/13, at 3:14 p.m., Cook #3 showed me stored pans that were still wet. Cook #3 indicated " these were recently washed and stored. " The DM was not able to provide policy and procedure for storage of sanitized and dry dishes.</p> <p>3.1-2(i)(2) 3.1-2(i)(3)</p>			

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NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401			
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F000372 SS=B	<p>483.35(i)(3) DISPOSE GARBAGE &amp; REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This Requirement was not met as evidence by:</p> <p>Based on observation, interview, and record review, the facility failed to dispose of garbage properly and keep lids closed.</p> <p>Finding included:</p> <p>During initial kitchen observation on 5/28/13 at 10:30 a.m., observed garbage can not being used and lid was on the floor behind the garbage can.</p> <p>During a second kitchen observation 5/29/13 at 3:19 p.m., garbage remained uncovered with the lid on the floor behind the garbage can.</p> <p>During observation of dumpster behind the facility on 5/30/13 at 12:46 p.m., indicated a full trash bag on top on one side of dumpster and lid open on other side of the dumpster with a visible sign saying "lid must remain closed per Indiana Board of Health." Trash on ground around the dumpster. The garbage can in the kitchen continues to remain</p>	F000372	<p>F372 483.35(i)(3) Dispose Garbage and Refuse Properly</p> <p>Bloomington Nursing and Rehabilitation does ensure that refuse and garbage are disposed of and contained properly.</p> <p>I. Kitchen garbage containers were replaced with self covering lids and staff re-educated on their use.</p> <p>In addition, trash bags on top of and around dumpster area have been removed and area has been cleaned. Staff have been re-educated as to proper disposal of trash/garbage inside dumpsters per policy.</p> <p>II. All residents have the potential to be affected.</p> <p>III. A policy "Proper Disposal of Refuse. Garbage" was implemented and all staff were educated on this policy.</p> <p>IV. In addition to the process noted above, the Administrator or designee will</p>	07/02/2013			

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	<p>uncovered and the lid remained on the floor behind the garbage can.</p> <p>During interview with the ADM (Administrator) on 5/30/13 at 2:00 p.m. ,indicated staff is aware of garbage disposal, "but look who had to clean it up."</p> <p>On 6/3/13 at 11:30 a.m., a final kitchen observation indicated the lid for the garbage can remained on the floor in the same place it had been on the previous observations.</p> <p>3.1-21 (i)(5)</p>		<p>monitor dumpster area and garbage storage during daily walking rounds. Results will be presented in Quality Assurance Meeting monthly until 100% compliance is achieved for one full quarter.</p>		

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F000441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> 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 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 insure infection</p>	F000441	F441-483.65(i)(5) Infection	07/02/2013			

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	<p>control measures were followed by failing to wash hands between each resident contact. (Residents #6, #35, #3, #36, #22, #21, #30, and #17) (RN#1)</p> <p>Findings Include:</p> <p>1) During an observation of medication administration on 5/28/13 at 11:00 a.m., RN #1 was observed to have passed medications to Residents #6, #35, #3, #36, #22, #21, #30, and #17. RN #1 was not at any time observed to wash or sanitize her hands.</p> <p>2) During an observation of wound care on 5/28/13 at 2:15 p.m., RN #1 was observed to re-enforce a bandage dressing on the arm of Resident #12. RN #1 was observed to don gloves, but was not observed to wash her hands prior to donning gloves.</p> <p>During an interview with RN #1 on 5/28/13 at 2:20 p.m., RN #1 stated, "Am I supposed to wash my hands before I put gloves on?"</p>		<p>Control, Prevent Spread, Linens</p> <p>Bloomington Nursing and Rehabilitation does ensure that Infection Control, including preventing the spread of infection during resident contact is strictly adhered to.</p> <p>I. Residents #6, #35, #3, #36, #22, #21, #30, and #17 were re-assessed with no negative outcomes for the allegedly deficient practice.</p> <p>Nurse #1 is no longer employed at the facility.</p> <p>II. All residents had the potential to have been affected by this practice.</p> <p>III. The Policy entitled "Hand Washing" was reviewed and found to be effective and current. RDCO re-educated all department heads on this policy on 6-24-13 and staff were re-educated by Administrator and RDCO on 6-28-13 on this policy and resident based infection control practices.</p> <p>IV. The Director of Nursing/designee will audit/observe at least three</p>		

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	<p>Policy and Procedure: " Handwashing " with no date was received on 5/28/13 at 12:05 p.m., from the DM indicated " ...6. Lather all areas of the hands and wrists rubbing vigorously for 20 seconds ... "</p> <p>3.1-18 (I)</p>		<p>clinical staff performing direct resident care to include med pass and dressing changes (to include all three shifts) x 5 days /week for 4 weeks, then weekly for 4 weeks, then monthly x 4 months. This monitoring will include observation and monitoring of staff to resident interaction across all shifts. Any staff found/observed will be further educated until staff compliance achieved. Thereafter, will be monitored quarterly and results will be reported and reviewed per QA meeting process.</p>		

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F000456 SS=E	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Requirement is not met as evidence by:</p> <p>Based on observation, interview, and record review, the facility failed to maintain equipment in a safe operating manner.</p> <p>Findings included:</p> <p>During initial kitchen observation on 5/28/13 at 10:10 a.m., indicated the two outer burners on the rear of the stove would not automatically light when turned on. Also the middle front burner would not light unless lit with a lighter.</p> <p>During same observation on 5/28/13 at 10:10 a.m., the hot water took 3 minutes to reach a temperature of 100 degrees F ( Fahrenheit). Cook #1 indicated, "Water always cold that's why I use this other sink." Also observed light bulbs out by the stove.</p> <p>During same observation on 5/28/13 at 11:00 a.m., dish washer rinse temperature (temp)110 degrees and the rinse temp 130 degrees. The</p>	F000456	<p>F456-483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>Bloomington Nursing and Rehabilitation does ensure that all essential mechanical, electrical, and patient care equipment are in safe operating conditions.</p> <p>I. All stove burners were cleaned and repaired. All non-working light bulbs in kitchen area were replaced. Dishwasher temperatures and processes have been remedied and are functioning properly. Dietary staff and manager have been re-educated on how to accurately read thermometer used in testing water temperatures. Dishwasher log was reviewed and staff educated as to documentation and procedure expectations. Staff were re-educated on proper cleaning, drying and storage of all pots and pans/kitchen equipment.</p> <p>II. All residents have the potential to have been affected.</p>	07/02/2013	

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	<p>metal plate on the dishwasher indicated the temp should be 120 degrees for the wash and rinse cycle and chlorine ppm (parts-per-million) 50. A second wash cycle was observed with a temp of 100 degrees (F).</p> <p>During same observation on 5/28/13, at 11: 10 a.m., Cook #1 indicated she read the temp as 147 degrees (F) for the wash. She indicated " _____ (Name/previous dietary manager) told me to add top number and bottom number." She was adding Fahrenheit and Celsius together; instead of getting the actual reading of 110 degrees she was getting 147 degrees. When cook #1 asked what does she do when wash temperature incorrect she indicated, "It's just how it is" she then indicated, "Notify Dietary Manager."</p> <p>During same observation on 5/28/13 at 11:14 a.m., DM indicated that reading both numbers on the thermometer is how she was trained. She indicated she would call maintenance if temp were not correct.</p> <p>Review of "Dish Machine Temperature Log" for April and May 2013, received on 5/28/13 at 12:05 p.m., indicated dishwasher</p>		<p>III. All food service personnel have been re-educated regarding preparing and serving foods, cleaning/maintenance schedules and expectations of the cleaning/maintenance schedules. An updated cleaning list has been created to increase the frequency of cleaning and monitoring of needed repairs in kitchen area.</p> <p>IV. In addition to the process noted above, the Administrator/Dietary Manager/designee will complete a quality improvement audit of the cleanliness, proper equipment functioning and maintenance needs/concerns weekly for 30 days, then monthly for 6 months. Results of all audits are being reviewed monthly by the QA committee for additional recommendations as necessary.</p>		

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	<p>temperatures were being misread and recorded incorrectly.</p> <p>During interview on 5/29/13, at 3:10 p.m., with DM (dietary manager) indicated the "maintenance guy quit 2 weeks ago and he knew about these items" and she walked out of kitchen.</p> <p>During a third kitchen observation on 5/30/13 at 10.00 a.m., dishwasher T 90 for wash and 118 degrees for rinse.</p> <p>Review of manufacturers manual " American Dish Service effective June 2008 " received 5/30/13 at 1:00 p.m., from the ADM (Administrator) indicated, "The chemical sanitizing agent provides comparable germ killing ability in 140 degree rinse water as in the conventional machines ... The rinse-aid causes the water to flow from the dishes ...This allows the dishes to dry faster ... 5. ... If water temperature gauge has not reached 120 degree Fahrenheit (49 degree Celsius) ...drain water from machine ...fill until proper temperature is attained."</p> <p>Review of " Customer Service Report " dated 5/17/13 received 6/3/13 at 1:50 p.m., from the DM indicated " ...Test Result Titration 200 ppm</p>						

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	<p>(parts-per-million) , Wash Temp 130 ' (degree), Final Rinse Temp 130 ' (degree) ...Chlorine Sanitizer Adjusted and Tested Per State Board of Health Requirements? Yes 50 ppm."</p> <p>During final kitchen observation on 5/31/13 at 3:14 p.m., Cook #3 showed me stored pans that were still wet. Cook #3 indicated, "These were recently washed and stored." The DM was not able to provide policy and procedure for storage of sanitized and dry dishes.</p> <p>3.1-19(bb)</p>				