

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155086	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/28/2012
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NAME OF PROVIDER OR SUPPLIER  WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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F0000	<p>This visit was for a Recertification and State Licensure survey. This visit included the investigation of Complaint number IN00102761.</p> <p>Complaint number IN00102761 substantiated, Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: 2/20, 2/21, 2/22, 2/23, 2/24, 2/27, 2/28, 2012</p> <p>Facility number: 155086 Provider number: 000034 AIM number: 100274880</p> <p>Survey team: Carol Miller RN, TCS (2/21, 2/22, 2/23, 2/24, 2/27, 2/28/12) Shelly Vice RN (2/21, 2/22, 2/23, 2/24, 2/27, 2/28/12) Honey Kuhn RN ( 2/20, 2/21, 2/23, 2/24/12)</p> <p>Census bed type: SNF/NF: 61 Total: 61</p> <p>Census payor type: Medicare: 6 Medicaid: 48</p>	F0000		

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>Other: 7 Total: 61</p> <p>Sample: 15</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 3/2/12 Cathy Emswiller RN</p>				

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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 reviews and interviews, the facility failed to notify the legal guardians of: 1. Obtaining and the status of a lab test to confirm if the resident had contracted Clostridium-Difficile.</p>	F0157	It is the practice of Woodland Manor to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	03/09/2012			

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	<p>(Resident #13 ); 2. Notifying the guardian of clinical complications as outlined in the facility protocol for (Resident #4.) This affected 2 of 4 residents reviewed for legal guardian notification in a sample of 15.</p> <p>Findings include:</p> <p>1. On 2/23/2012 the ADON was interviewed and indicated Resident #13 had been tested by way of a stool sample by the laboratory for possible Clostridium- Difficile infection. The test had been returned with a negative result confirming Resident #13 was not infected.</p> <p>On 2/28/2012 at 9:00 a.m. an interview was conducted with Resident #13's legal Guardian through [name of legal guardian facility] Inc., a provider of Mentally Retarded/ Developmental Disability Services. The legal Guardian indicated they had not been notified of the Clostridium-Difficile lab testing done on Resident #13. The legal Guardian verbalized her desire to have been notified.</p> <p>On 2/28/2012 at 10:00 a.m. a record review was done of the 'Right to notification of changes' provided by the facility. It indicated, " The facility will</p>		<p>accordance with the comprehensive assessment and plan of care.</p> <p>I. Resident # 13 and Resident #4 Guardians are notified of significant resident condition changes.</p> <p>II. All residents have the potential to be affected. This has been addressed by the systems described below.</p> <p>III. As indicated in the survey report, the facility has a policy regarding notification of changes. Licensed nurses have been re-educated on this policy. In addition, the care plan conference record has been amended to include checking the face sheet for accurate responsible party and guardian contact information. The interdisciplinary team has been educated on this addition. The Business office manager will receive a copy and update the face sheet as necessary.</p> <p>IV. The MDS coordinator or her designee is completing a quality improvement audit to ensure that the IDT team is following the care plan conference record addition. IDT team will be observed during this procedure for the next 6 months to ensure it is being followed accurately. Results of all audits are reported to the facility's Quality Assurance Committee for</p>				

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	<p>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 ... a significant change in the resident's physical...(e.g., a deterioration in health, mental or psychosocial status either life-threatening conditions or clinical complications)</p> <p>On 2/28/2012 at 10:05 a.m. a record review was done of the "Woodland Manor Standard for Notification of Resident Change of Condition.' It stated, " It is the policy of Woodland Manor that the facility will immediately inform the resident and consult with the resident's physician, if appropriate, when changes occur. If known, the facility shall notify the resident's legal representative or an interested family member... Notifications of changes shall include: ... 2. A significant (in bold type) change in the resident's physical, mental or psychological status, such as a deterioration in health, mental or psychosocial status, in life threatening conditions or clinical complications...."</p> <p>2. On 2/28/2012 at 9:15 a.m. an interview was conducted with the legal Guardian representative provided by [name of guardian facility for] St. Joseph County for Resident #4. The Guardian</p>		additional recommendations if necessary.		

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	<p>indicated they were not contacted about changes in regards to the changes and conditions of Resident #4. This same legal Guardian oversees a peer Resident also residing in this facility. The Guardian indicated being contacted often and sufficiently for the one Resident and not Resident #4. The Guardian indicated they concluded that the facility did not keep the accurate information on Resident #4's face sheet. The Guardian stated, "...call at the last minute for Doctor appointments... not kept up with room changes and issues surrounding the medical issues ..."</p> <p>3.1-5(a)(2)</p>				

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F0252 SS=B	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>Based on observations and interviews, the facility failed to follow the regulation by not providing a facility free from strong urine smell and assuring residents do not smell of urine. This affected 13 rooms in Unit 2 of a 4 Unit facility, and 1 of 4 sampled residents.</p> <p>Findings Include:</p> <p>On 2/21/12 at 10:30 a.m., upon entering the facility there was a strong urine odor ranging from Room 100 to Room 113.</p> <p>On 2/21/2012 at 2:00 p.m. there was a strong urine odor ranging from Room 100 to Room 113.</p> <p>On 2/22/2012 at 8:15 a.m. upon entering the facility there was a strong urine smell ranging from Room 100 to Room 113.</p> <p>On 2/22/2012 at 8:17 a.m. Room 106 B smelled strongly of urine.</p> <p>On 2/22/2012 at 10:30 a.m. there was a strong urine smell ranging from Room 100 to Room 113.</p>	F0252	<p>It is the practice of Woodland Manor to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Room 100 to 113 was deep cleaned using corrected amount of cleaning chemicals.</p> <p>Unit 2 was deep cleaned using corrected amount of cleaning chemicals.</p> <p>Room 410 using corrected amount of cleaning chemicals.</p> <p>A full house sweep was completed to identify odors</p> <p>Housekeeping supervisor educated all housekeeping staff on 3/8/12 regarding the proper procedure to deep clean rooms and proper use of cleaning materials needed to effectively clean rooms.</p> <p>The Housekeeping supervisor is responsible for the completion of</p>	03/09/2012			

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	<p>On 2/22/2012 at 1:30 p.m. upon reviewing a residents clinical record it was indicated on a [name of hospital] History and Physical dated 11/26/2011 at 12:30 a.m. of Resident #4 within the physical examination portion to record, "... General: ... Smells strongly of urine."</p> <p>On 2/22/2012 at 2:30 p.m. there was a strong urine smell ranging from Room 100 to Room 113.</p> <p>On 2/23/2012 at 9:00 a.m. there was a strong urine smell ranging from Room 100 to Room 113.</p> <p>On 2/23/2012 at 2:00 p.m. there was a strong smell of urine ranging from Room 100 to Room 113.</p> <p>On 2/23/2012 from 3:30 p.m. to 3:40 p.m. there was a strong smell of urine on Unit 2 during the environmental tour.</p> <p>On 2/23/2012 from 3:45 p.m. to 3: 55 p.m. there was a strong smell of Bowel Movement on Hall 400 outside of Room 410.</p> <p>On 2/23/2012 from 3:57 p.m. to 4:00 p.m. interviews with the Housekeeping/Laundry Manager and Maintenance Manager were conducted.</p>		<p>an audit tool monitoring daily deep clean list. When deep cleans are scheduled, 3(three) rooms daily will be audited for six months and as needed when deemed necessary by the QA committee of 100% compliance is not maintained. Quality Assurance Committee is overseen by the Administrator.</p>				

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	<p>They both indicated that the use of several environmental chemicals were being used to deter smells within the unit.</p> <p>On 2/24/2012 at 8:00 a.m. thee was a strong smell of urine was noted ranging from Room 100 to 113.</p> <p>On 2/24/2012 at 10:30 a.m. there was a strong smell of urine was noted ranging from Room 100 to Room 113.</p> <p>On 2/27/2012 at 9:00 a.m. there was a strong urine smell was noted ranging from Room 100 to Room 113.</p> <p>On 2/27/2012 at 12:45 p.m. there was a strong smell of urine was noted ranging from Room 100 to Room 113.</p> <p>On 2/27/2012 at 2:15 p.m. there was a strong smell of urine was noted ranging from Room 100 to Room 113.</p> <p>On 2/27/2012 at 3:30 p.m. there was a strong smell of urine was noted ranging from Room 100 to Room 113.</p> <p>On 2/28/2012 at 8:30 a.m. there was a strong smell of urine was noted ranging from Room 100 to Room 113.</p> <p>On 2/28/2012 at 11:30 a.m. there was a strong smell of urine was noted ranging</p>				

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	from Room 100 to Room 113.  3.1-19(f)(5)				

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record reviews and interviews the facility failed to follow the regulation by not providing a written policy and procedure for reinserting a supra-pubic indwelling urinary catheter for 1 of 2 residents in a sample of 15 (#4).</p> <p>Findings include:</p> <p>On 2/22/2012 at 10:30 a.m. a record review was completed on the Policy and Procedure for 'Catheter Care(Indwelling Catheter).'</p> <p>On 2/22/2012 at 2:10 p.m. a record review of Resident #4's chart was done. A History and Physical dictated report of the Elkhart General Hospital internist included, " ... Supposedly, in the past 2 weeks, this gentleman has pulled his supra pubic catheter out 23 times. This evening the nursing home personnel were unable to reinsert it, so he was sent to the emergency room where it was reinserted...."</p>	F0309	<p>It is the practice of Woodland Manor to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. I. Resident #4 was assessed and not harmed from the supra pubic catheter replacement. II. All residents with a supra pubic catheter have the potential to be affected. This has been addressed by the systems described below. III. A new policy and procedure has been developed for the insertion of supra pubic catheters. Licensed nurses have been educated on this policy. IV. The DON or her designee is completing a quality improvement audit to ensure that nurses are following the supra pubic catheter policy and procedure. Nurses will be observed during this procedure for the next 6 months to ensure it is being followed accurately. Results of all audits are reported to the facility's Quality Assurance Committee for additional</p>	03/09/2012			

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	<p>On 2/24/12 at 9:20 a.m. an interview with CNA #2 was completed. They indicated any and all indwelling catheters, whether urinary or feeding tubes, when dislodged from the body were "not reinserted by any nursing staff ... we (facility) sends them (residents) out to be reinserted..." The CNA #2 reiterated, "No nursing staff reinserts any kind of tube..."</p> <p>On 2/28/12 at 10:20 a.m. an interview with the DON indicated there was not a policy and or procedure to reinsert supra pubic indwelling urinary catheters. The DON indicated it was the position of the DON to, "...show them (other staff) how to do it (reinsert an indwelling catheter upon dislodging)..."</p> <p>3.1-37(a)</p>		recommendations if necessary.				

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F0315 SS=D	<p>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 reviews and interviews, the facility failed to follow the regulation by not providing a written policy and procedure for reinserting a supra-pubic indwelling urinary catheter for 1 of 2 sampled residents. (#4)</p> <p>Findings include:</p> <p>On 2/22/2012 at 2:10 p.m. a record review of Resident #4's clinical record was done. A History and Physical dictated report dated 11/26/2011 at 12:30 a.m. of the [name of hospital] internist included, " ... Supposedly, in the past 2 weeks, this gentleman has pulled his supra pubic catheter out 23 times. This evening the nursing home personnel were unable to reinsert it, so he was sent to the emergency room where it was reinserted...."</p>	F0315	<p>It is the practice of Woodland Manor to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. I. Resident #4 was assessed and not harmed from the supra pubic catheter replacement. II. All residents with a supra pubic catheter have the potential to be affected. This has been addressed by the systems described below. III. A new policy and procedure has been developed for the insertion of supra pubic catheters. Licensed nurses have been educated on this policy. IV. The DON or her designee is completing a quality improvement audit to ensure that nurses are following the supra pubic catheter policy and procedure. Nurses will be observed during this procedure for the next 6 months to ensure it</p>	03/09/2012	

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F0323 SS=G	<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.</p> <p>Based on record review and interviews, the facility failed to ensure the prevention of frequent falls that resulted in a laceration to the resident's mouth and a fractured wrist. This deficiency affected 1 of 6 residents reviewed for falls in a sample of 15 (Resident X).</p> <p>Finding include:</p> <p>Resident X's record was reviewed on 2/27/12 at 10:00 a.m. Resident X's diagnoses included, but not limited to, Alzheimer's disease, senile dementia, and abnormality of gait.</p> <p>The Fall Risk Assessment dated 7/20/11 indicated Resident X was at high risk for falls.</p> <p>Review of the significant change Minimum Data Set Assessment (MDS) dated 7/31/11, indicated Resident X had short term and long term memory loss and had decision making impairment. The</p>	F0323	<p>It is the practice of Woodland Manor to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>I. Resident X was assessed and is being seen by therapy. The care plan has been reviewed and updated appropriately.</p> <p>II. All residents have the potential to be affected. This has been addressed by the systems described below.</p> <p>III. The facility has implemented an interdisciplinary team (IDT) process that includes the review of any resident who has an incident or a fall. The care plan and CNA assignment sheet are reviewed during this meeting and updated with appropriate interventions. The interdisciplinary team has been educated on this policy. Nursing personnel have been re-inserviced regarding the importance of implementing appropriate interventions for</p>	03/09/2012			

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	<p>MDS also had indicated the resident was independent for ambulation with minimal setup.</p> <p>A review of Resident X 's Fall Reports indicated the following: the post fall investigation dated 9/19/11 indicated the resident was ambulating in the hallway slightly leaning to the side when she tripped over her foot and fell to the floor. The new intervention that was put in place after the resident had fallen was to offer stand by assist when resident is ambulating until right sided leaning improved.</p> <p>The post fall investigation dated 11/10/11 indicated the resident was coming out of another resident's room when she slipped and fell to the floor. The resident was not wearing her shoes and had socks on her feet. The new intervention put into place immediately after the resident had fallen the resident was assisted in putting her shoes on. The resident was also instructed to wear her shoes during ambulation.</p> <p>The post fall investigation dated 11/17/11 indicated the resident was found in the dining room laying down on the floor. The post fall investigation form further</p>		<p>cognitively impaired residents who cannot respond to verbal cues.</p> <p>IV. The DON or her designee is completing a quality improvement audit of resident incidents including falls to ensure that appropriate interventions are implemented. This audit will be ongoing for 6 months. Results of all audits are reported to the facility's Quality Assurance Committee for additional recommendations if necessary. IDT team will be observed during this procedure for the next 6 months to ensure it is being followed accurately. Results of all audits are reported to the facility's Quality Assurance Committee for additional recommendations if necessary.</p>		

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	<p>indicated in the column for footwear shoes were check marked as present on her feet.</p> <p>The intervention put immediately in place after the fall was ice was placed on the resident's forehead and steri-strips were placed to a laceration on the nasal bridges and to closely monitor the resident.</p> <p>The care plan was updated with the interventions indicated the resident was to wear her shoes while she ambulated and she had removed her shoes prior to this fall.</p> <p>The Nurses Notes dated 1/18/12 at 10:00 a.m. indicated the nurse had heard a 'thump' coming from the hall and found the resident on the floor.</p> <p>The post fall investigation dated 1/8/12 indicated the resident had non skid foot wear on her feet and she was sent to the local hospital emergency room for a laceration to the upper lip .</p> <p>The Interdisciplinary Team Progress Notes dated 1/8/12 at 10:00 a.m. indicated the resident was guarding her left hand. The resident had returned from the hospital with a splint to her left hand and with a diagnosis of a fracture to the left wrist.</p>			

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	<p>The Rehabilitation Screen dated 11/10/11 indicated the resident was not appropriate for skilled therapy intervention at this time. In the comments section of the Rehab Screen indicated "Cognitive status is @ (at) risk for fall level. Recommend (eligible word) shoes and provide supervision during walking.</p> <p>The Physician's Order dated 12/4/11 indicated the resident was to be evaluated and treated by physical therapy for therapeutic exercise, neuromuscular re-education , gait training and E-stimulation to bilateral lower extremities to increase muscle strength..</p> <p>The Plan Of Treatment form for physical therapy dated 12/11/11 through 12/17/11 indicated the resident was seen for a diagnosis of abnormality of gait. The current gait task indicated the resident requires hand held physical assist and stand by assistance (close enough to reach the resident if assist is needed).</p> <p>The Physician's Order dated 12/30/11 indicated physical therapy was discontinued because the resident had reached her maximum potential.</p> <p>On 2/27/12 at 1:00 p.m. the Director of Nursing Services (DNS) was interviewed</p>				

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	<p>in regard to the intervention after the 11/10/11 fall. The DNS indicated the resident was good at taking her shoes off of her feet. The DNS also indicated the intervention should not had been to remind the resident to leave her shoes on but to instruct the staff to make sure the resident had her shoes on her feet.</p> <p>On 2/28/12 at 9:00 a.m. the Care Planning policy dated 10/2010 was received from the DNS and reviewed and indicated "7 The Care Planning/Interdisciplinary Team is responsible for the periodic review and updating of care plans: When there has been a significant change in the resident's condition; When the desired outcome is not met...."</p> <p>On 2/28/12 at 9:15 a.m. CNA #3 was interviewed in regard to Resident X taking her shoes off her feet and she indicated the resident "would never takes shoes off and had regular socks on".</p> <p>On 2/28/12 at 9:30 a.m. the DNS was interviewed in regard to after the 9/19/11 fall the Care Plan was not updated with new interventions. The DNS indicated the care plan should had been updated with new interventions. The DNS also indicated she inserviced staff in regard to the resident fall and her taking her shoes off her feet.</p>						

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F0456 SS=B	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>Based on observations, record reviews and interviews the facility failed to follow the regulation by not assuring the temperatures for the unit refrigerators/ freezers being used for Resident medications and or nourishments were properly monitored. This affected 3 of 3 refrigerators units.</p> <p>Findings Include:</p> <p>On 2/23/2012 at 3:00 p.m. to 4:15 p.m. an environmental tour was completed. During this tour it was found that the refrigerators/ freezer units located on Hall 100 in the Medication room, on Hall 300 in the nourishment area and on Hall 300/ 400 Medication room did not contain a freezer thermometer for assuring temperatures within these units was accurate for resident medication storage and resident nourishment storage. There was no temperatures taken of the freezer units due to their not being a thermometer within the freezer units. There were no medications being stored in the freezer units at the time of the environmental tour.</p>	F0456	<p>It is the practice of Woodland Manor to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>I. No residents were identified.</p> <p>II. All residents have the potential to be affected. This has been addressed by the systems described below.</p> <p>III. A new policy and procedure has been developed for logging daily temperature readings for the refrigerators/freezer units. Nurses have been educated on this policy.</p> <p>IV. The Maintenance Supervisor or his designee is completing a quality improvement audit to ensure that staff are following the daily fridge/freezer temperature logging policy and procedure. Nurses will be observed during this procedure for the next 6 months to ensure it is being followed accurately. Results of all audits are reported to the facility's Quality Assurance Committee for</p>	03/09/2012	

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	<p>On 2/23/2012 at 3:00 p.m. to 4:15 p.m. the temperature logs were reviewed for logging daily temperature readings for the refrigerators/ freezer units of Hall 100 Medication Room, Hall 300 nourishment area and Hall 300/400 Medication room. It was found that the logs did not contain a 'normal' range for the refrigerators and freezer unit for reading the accuracy of these units.</p> <p>On 2/23/2012 at 3:00 p.m. to 4:15 p.m. an interview was conducted with the Administrator concerning the 'normal and abnormal' ranges for the staff readings of the refrigerators/ freezer resident units. The Administrator noted the normals for accuracy readings were labeled on the actual thermometers. When queried about what tool was being used to assure a 'normal high and a normal low range' were being used for accuracy of the freezer units the facility was not using any.</p> <p>On 2/23/2012 at 3:00 p.m. to 4:15 p.m. an interview was conducted with the Hall 100 P.M. unit RN of the procedure to assure accuracy of the refrigerators/ freezer unit. The RN noted the procedure was her ability to retrieve the information from her own experience. It was indicated when an 'inaccurate reading' was read, the maintenance man was notified by placing</p>		additional recommendations if necessary.				

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	<p>the information on a clip board for his awareness to the problem. A reference for normals/ abnormal's was not provided by the facility for manufactures recommendations.</p> <p>On 2/23/2012 between 3:00 p.m. and 4:15 p.m. an interview was conducted with the Hall 300/ 400 unit RN #1 and the ADON of the use of the freezer compartment of the refrigerators/ freezer unit of this Hall. It was indicated that 'if and when' the pharmacy directed the facility to store medications within the freezer compartment of the refrigerators/ freezer unit, it would be done.</p> <p>On 2/23/2012 between 3:00 p.m. and 4:15 p.m. an observation of the Hall 300/ 400 unit refrigerators/ freezer being used for medication storage was found to be missing the unit freezer door, frost accumulation around the edges of the freezer unit and was lacking a freezer thermometer.</p> <p>3.1-19(bb)</p>				