

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

PRINTED: 02/14/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045184</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/31/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKE VILLAGE HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>903 BORGOGNONI DRIVE LAKE VILLAGE, AR 71653</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221 SS=E	<p><b>483.13(a) PHYSICAL RESTRAINTS</b></p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that alternative measures were attempted prior to the use of physical restraints, that restraint-reduction attempts were made and/or that reassessments for appropriateness of restraint use were conducted for 2 ( Residents #2 and #5) of 3 (#2, #5 and #8) case mix residents that used a physical restraint. This failed practice had the potential to affect 12 residents in the facility with physical restraints as documented on the Resident Census and Conditions of Residents dated 01/28/08. The findings are:</p> <p>1. Resident # 5 had a diagnosis of Cerebrovascular Accident and Dementia without Behavior. The Minimum Data Set (MDS) dated 11/15/07 documented the resident had a short term memory problem, had modified independent cognitive skills for daily decision making, fall in the pass 30 days, and used a trunk restraint daily.</p> <p>a. The Physical Restraint Informed Consent form dated 11/12/07 documented, " ... Soft Belt while [up] in chair ... to prevent [resident] from getting [up] unassist ... medical symptoms: forgetfulness. ..."</p> <p>b. The physician's order dated 11/13/07 documented, " ... soft belt restraint while up in wc</p>	F 221		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE

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

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F 221	<p>Continued From page 1</p> <p>(wheelchair), check Q ( every) 30 minutes release Q 2 hours for exercise, repositioning . . . "</p> <p>c. The care plan dated 11/15/07 documented, "11/11/07 Actual fall ...11/13/07 soft belt while up in w/c . . .observe q (every) 2 hours for needs ... "</p> <p>d. The physical restraint elimination assessment dated 11/22/07 documented " ... total score 23 ... Candidate status [for a restraint reduction] as determined by TOTAL SCORE on ... Good ... 3. additional comments: family request soft belt due to several falls recently. Will re-evaluate later." There was no documentation of further reevaluation or other interventions put in place.</p> <p>e. On 1/28/08 at 12:10 p.m., during initial rounds, LPN ( Licensed Practical Nurse) # 4 stated, "[resident #5] uses a soft belt while up in the wheelchair. "</p> <p>f. On 1/28/08 at 5:08 p.m., and 1/29/08 at 10:00 a.m., the resident was up in a wheelchair and a soft belt restraint was in place.</p> <p>g. On 1/30/08 at 2:05 p.m., the resident was up in a wheelchair and a soft belt restraint was in place. The resident was asked what was that [pointing to the soft belt], she replied, "This is a bunch of bullshit, I don't like it." The resident was asked what was it for, she replied, "To keep me from going forward and hitting the windshield and getting glass all over me. I would like to get a pocket knife and cut it off, I do not like it." The resident also stated that she had fallen on 2 occasions.</p> <p>2. Resident # 2 had a diagnosis of Congestive Heart Failure and Depressive Disorder. The MDS</p>	F 221			

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F 221	<p>Continued From page 2</p> <p>dated 1/15/08 documented the Resident had short and long term memory problems, had severely impaired cognitive skills for daily decision making and required a chair to prevent rising used daily.</p> <p>a. The physical restraint consent form dated 1/26/07 documented " ...DC (discontinue [hand written in margin]) Lap Buddy when [up in wheel chair ... Soft belt while [up] in [wheel chair] to prevent falls. [Resident] cont (continue) to remove lap buddy [and] get [up without] assist (assistance) [increase] risk for falls due to weakness ... medical symptoms: generalized weakness ... "</p> <p>b. The physician's order dated 1/31/07 documented, " ... may use soft belt while up in w/c (wheelchair) to prevent falls visual check Q (every) 30 minutes release Q 2 hrs (hours) for 10 minutes for repositioning and exercise.</p> <p>c. The physical restraint elimination assessment dated 11/7/07 documented " ... total score 24 ... " The form documented that with a score from 21 -35 the resident was a good candidate for restraint reduction, less restrictive restraining measures, or total restraint elimination.</p> <p>d. The care plan dated 1/15/08 documented, " ... chair and bed alarm ... soft belt as enabler when up in w/c ... eval (evaluate) at least q 3 months for possible less restrictive device ..."</p> <p>e. On 1/28/08 during initial rounds LPN (Licensed Practical Nurse) #4 stated that the resident used a soft belt restraint when up in chair.</p>	F 221			

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F 221	Continued From page 3	F 221			
F 226 SS=C	<p>f. On 1/29/08 at 10:00 a.m. and 12:45 p.m. the resident was observed in a wheelchair with a soft belt restraint was in place.</p> <p>483.13(c) STAFF TREATMENT OF RESIDENTS</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>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure their Abuse Prohibition Policy was followed to ensure potential employees background checks, employment registry checks were done in a timely manner, and abuse training and orientation was completed in a timely manner. These failed practices had the potential to affect 40 cognitively impaired residents in the facility as identified by the Roster/Sample Matrix dated 1/28/08. The findings are:</p> <p>1. The facility's Abuse Prohibition Policy documented: " ... All applicants for employment in the facility shall, at a minimum, have the following screening checks conducted: ... 2. Appropriate licensing board or registry check, 5. Criminal background check pursuant to facility policy or state law. Training: a. Upon hire, each new staff member shall be informed of the obligation to report alleged violations. Training shall include appropriate interventions to deal with aggressive and/or catastrophic reactions of resident, definition of alleged violations, and caregiver stress. Training shall also include examples of reportable incidents to assist staff in detection of such incidents. Training for</p>	F 226			

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F 226	Continued From page 4 volunteers shall take place during orientation. ... "  2. On 1/29/08 at 12:30 p.m. five personnel records were reviewed. The following items were identified:  a. Dietary Employee #1 date of hire was 1/17/08. There was not an Employment Clearance Registry check completed.  b. Certified Nurses Assistant #5 was hired on 1/10/08. The Criminal Record Check was completed and sent off on 1/24/08, 10 working days past the five day requirement.  c. Certified Nurses Assistant #6 was hired on 1/15/08. The Criminal Record Check was completed and sent off on 1/24/08, 7 working days past the five day requirement. There was no documentation of the employee having had orientation or any form of abuse prohibition training.  d. On 1/29/08 at 2:45 p.m. the Personnel Director was asked about the Employment Clearance Registry check on Dietary Employee #1, she stated; "She is a cook, I don't have a registry check on her, I only do registry checks on licensed staff and certified aides, otherwise they are not on the registry."  e. On 1/30/08 at 9:10 a.m., the Administrator was informed of the above information, she responded; "I have in-serviced my staff on what is expected of them in the future. We couldn't get the money from Corporate to get them (criminal background checks) off in time. Our policy is they are to be done within 5 working days of hire."	F 226			
F 279	483.20(d), 483.20(k)(1) COMPREHENSIVE	F 279			

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F 279 SS=D	<p>Continued From page 5 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>This REQUIREMENT is not met as evidenced by: Based on observation, and record review the facility failed to develop, and revise the resident 's comprehensive care plan for 1 case mix resident (Resident #7) of 2 (Resident #4 and 7) case mix residents that had been assessed for a pressure ulcer. The failed practice had the potential to affect 7 residents that had pressure ulcers according to the Resident Census and Conditions of Residents form dated 1/28/07. The findings are:</p> <p>1. Resident #7 had a diagnosis of Muscle Weakness and Osteoporosis. The Minimum</p>	F 279		

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F 279	Continued From page 6 Data Set (MDS) dated 1/29/08 documented the resident had modified independent cognitive skills for daily decision making, had a Stage II ulcer and required the use of pressure relieving device(s) for the chair and bed.  a. The Hospital Nursing Discharge Summary form dated 1/21/08 documented, " Heel protectors Bil. (bilaterally) healing Stage II decub (L) (left heel). ..."  b. The Admission Nursing Assessment dated 1/21/08 documented, "... Stage II decubitus (L) Left heel ... "  c. The Physician Admission Orders dated 1/21/08 documented "... Heel protectors x (times) 2."  d. The Plan of Care dated 1/29/08 did not document any skin issues or preventive measures.	F 279			
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that the Plan of Care for supplemental feedings were implemented and diet orders were followed for one case mix resident ( Resident #10 ) of one case mix resident with physician orders for	F 282			

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F 282	Continued From page 7 supplemental feedings and no fried food. This failed practice had the potential to affect 23 residents with physician's order for supplemental feedings according to the Physician Orders List for supplemental feedings provided by the Administrator on 1/28/08 at 1:00 p.m., and had the potential to affect 1 resident with physician orders for no fried foods according to the Dietary Physician Orders List dated 1/28/08 . The findings are:  1. Resident #10 had Diagnoses of Decubitus Ulcer, Psychosis, Diabetes Mellitus and Esophageal Reflux. The Quarterly Minimum Data Set dated 1/7/08 documented the resident had independent cognitive skills for daily decision making and required set up help only for eating.  a. A physician order dated 1/26/07 documented that the resident was to receive a mighty shake three times a day between meals. Another Physician's order dated 10/5/07 documented for the resident to receive a Low Concentrated Sweets diet with No Fried Foods.  b. The Nutritional Assessment dated 1/7/08 documented for the resident to receive mighty shakes three time a day between meals.  c. The care plan dated 1/7/08 documented, Problem: Alteration in Nutrition due to Therapeutic diet ... approaches ... give Fortified foods at lunch/ Extra margarine with meals and to provide supplement as ordered .  d. On 1/28/08 at 1:20 p.m., the resident's tray card documented, "Regular Ground Low Concentrated Sweets No Fried Foods. Dislikes: No Pork, No Cheese No Beef Liver Only, Fortified	F 282			

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F 282	<p>Continued From page 8</p> <p>foods And Fried Foods." The resident was served fried squash, a bowl of pinto beans, ground Santa Fe chicken with cheese and gravy, corn bread and a carton of butter milk. She left the chicken with cheese and fried squash and wheeled herself out of the dining room.</p> <p>e. On 1/28/08 at 2:30 p.m., the resident was sitting in front of the Nurses Station when the snacks was being passed out. The resident was given a packet with a cookie inside, instead of a mighty shake as per the physician's order.</p> <p>f. On 1/29/08 at 8:15 a.m., the resident was served scrambled eggs, one small sausage link, one toast, a carton of whole milk, a bowl of corn flakes, 8 ounces orange juice, 8 ounces of water and 8 ounces of coffee. The resident stated, "I don't eat eggs and beef. She ate the cold cereal, drank her fluids and left the eggs and sausage.</p> <p>g. On 1/29/08 at 10:15 a.m., the snack tray was on the utility cart at the nurses station, the resident's name was not on any of the containers of snacks that were set out. At 11:15 a.m., the Certified Nursing Assistant (CNA) #1 that was passing the snacks took the snack tray back to the kitchen and did not offer any snack to the resident.</p> <p>h. On 1/29/08 at 2:30 p.m., CNA #2 was passing out snacks and offered the resident a bag of cheetos. The resident refused the cheetos and stated, " I don't eat it, because it constipates me." CNA #2 gave her a packet of graham cracker. The resident then asked for a chocolate mighty shake. CNA #2 told the resident that she only had a vanilla flavor and gave it to the resident. The CNA stated, "That was extra, it has no ones</p>	F 282		

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F 282	Continued From page 9 name on it." The resident drank all of the shake.  i. On 1/29/08 at 3:46 p.m., CNA#1 stated, " We give snacks to the ones that have their names on it, then give graham crackers and juice to the ones that do not have their names written on the snacks. "No, I did not give any thing to [resident #10]."	F 282		
F 314 SS=D	483.25(c) PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure that heel protectors were applied and that the heels were off loaded, and interventions were established to prevent the potential for further deterioration and/or pressure ulcer (s) for 1 case mix resident (Resident #7) of 2 (Resident #4 and #7) case mix residents that had pressure sores. This failed practice had the potential to affect 7 residents in the facility with pressure sores according to the Resident Census and Conditions of Residents form dated 01/28/08. The findings are:  1. The facility ' s Policy and Procedure entitled Skin Integrity/Pressure Ulcer Protocol documented, "Purpose: ... To decrease pressure	F 314		

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F 314	<p>Continued From page 10</p> <p>ulcer formation by identifying those residents who are at risk for pressure ulcer formation and developing interventions. To promote healing of pressure ulcers in an efficient and timely manner. ... Care Interventions. ... 10. Use heel protectors or elevate heels off of the bed with pillows under legs. ..."</p> <p>2. Resident #7 had a diagnosis of Muscle Weakness and Osteoporosis. The Minimum Data Set (MDS) dated 1/29/08 documented the resident had modified independent cognitive skills for daily decision making, had a Stage II ulcer and required the use of pressure relieving device(s) for the chair and bed.</p> <p>a. The Hospital Nursing Discharge Summary form dated 1/21/08 documented, " Heel protectors Bil. (bilaterally) healing Stage II decub (L) (left heel). ..."</p> <p>b. The Admission Nursing Assessment dated 1/21/08 documented, "... Stage II decubitus (L) Left heel ... "</p> <p>c. The Physician Admission Orders dated 1/21/08 documented "... Heel protectors x (times) 2."</p> <p>d. The Plan of Care dated 1/29/08 did not document any skin issues or preventive measures.</p> <p>e. On 1/28/08 at 3:15 p.m., the resident was in a wheelchair with her feet propped up on a plastic square box with a pillow under her feet. The residents heels were directly on the pillow and there were no heel protectors on.</p>	F 314			

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F 314	Continued From page 11	F 314		
F 318 SS=E	<p>f. On 1/29/08 at 11:10 a.m., the resident was lying in bed. The resident had a pillow beneath her knees, and her heels were on the bed. She did not have heel protectors on.</p> <p>483.25(e)(2) 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>This REQUIREMENT is not met as evidenced by: Based on observation, and record review the facility failed to ensure that an assistive device was used consistently to help prevent decline in range of motion for 1 case mix resident (Resident # 5) of 1 (Resident #5) case mix residents who required the use of a splint/brace. This failed practice had the potential to affect 2 residents in the facility who had assistive devices as identified by documentation provided by the Director of Nursing on 1/30/08 at 3:00 p.m. The findings are:</p> <p>1. Resident #5 had a diagnosis of Cerebrovascular Accident (CVA). The Minimum Data Set dated 11/15/07 documented the resident had modified independent cognitive skills for daily decision making, short term memory problem and had received a splint or brace assistance in the past 7 days.</p> <p>a. A physician order dated 10/01/07 documented, " Keep splint on left hand at all times, except for</p>	F 318		

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F 318	Continued From page 12 bathing."  b. A physician order dated 10/09/07 documented, "... restorative to treat for R.O.M. (Range of Motion) exercise LUE (left upper extremity), splint to left hand daily and to be worn at all times except for bath."  c. On 1/28/08 at 12:10 p.m., on initial rounds, LPN (Licensed Practical Nurse) #4 stated the resident has contractures of the left hand. The resident was observed in the wheelchair with no device or splint on the left hand.  d. On 1/28/08 at 3:30 p.m., and 4:40 p.m., the resident was in bed with no brace or splint on the left hand.  e. On 1/28/08 at 5:08 p.m., the resident was transferred to a wheelchair by CNA (Certified Nursing Assistant) #3 and CNA # 4. A brace was not on the residents left hand.  f. On 1/29/08 at 8:34 a.m., the resident was transferred to a wheelchair. A brace was not on the residents left hand.  g. On 1/29/08 at 10:00 a.m., the resident was up in a wheelchair. There was not a brace/splint on the resident ' s left hand.  h. On 1/29/08 at 11:00 a.m., the resident was lying supine in bed and the brace/splint was on the bedside table.  i. On 1/29/08 at 1:27 p.m., the resident was in bed with no brace/splint on the left hand.  j. On 1/29/08 at 3:15 p.m., the resident was	F 318			

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F 318	Continued From page 13 asked if she wore a brace/splint for her hand. The resident stated, "I really don't like to wear it. I don't think it helps me any." She stated that the staff did not offer to put the brace/splint on every day.	F 318		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION  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.  This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure that the axilla was not used to support a resident's weight during a transfer for 1 case mix resident (Resident # 5) of 1 (Resident #5) case mix residents who required the assistance of 2 staff members for transfers. This failed practice had the potential to affect 19 residents in the facility that required the assistance of 2 staff member for transfer according to the Director of Nursing (DON) on 1/30/08 at 3:00 p.m. The findings are:  Resident # 5 had diagnoses of CVA (Cerebrovascular Accident ) and Pain in Joints. The Minimum Data Set dated 11/15/007 documented the resident had modified independent cognitive skills for daily decision making, and required total assistance of 1 person	F 323		

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F 323	Continued From page 14 for transfers.	F 323			
F 332 SS=E	<p>On 1/28/08 at 5:08 p.m. the Resident was transferred from the bed to a wheelchair by CNA (Certified Nursing Assistant) # 3 and CNA # 4. They placed one of their arms under each axilla area of the resident, lifted and twisted the resident around to the wheelchair. The resident did not assist with the transfer and her feet were dragged across the floor during the transfer process. All of the Resident's weight was supported by the axilla area.</p> <p>483.25(m)(1) MEDICATION ERRORS</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation of the 4 p.m. medication pass on 1/29/08 and the 8 a.m. medication pass on 1/30/08, the facility failed to follow Physician's Orders to ensure that the medication error rate was less than 5%. Physicians Orders were not followed on 3 (Resident 's #4, #18 and #19) of 12 residents observed during the medication passes. Medication errors were made by 3 LPN (Licensed Practical Nurse) #1, #2 and #3 of 5 nurses that administered medication. This failed practice had the potential to affect 49 residents receiving medications from these nurses according to the Director of Nursing on 1/30/08. The medication error rate was 7.27% based on administration of 55 medications and observation of a total of 4 errors. The findings are:</p> <p>1. Resident #18 had a Physicians Order dated</p>	F 332			

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F 332	Continued From page 15 1/18/08 for Renagel 800 mg. (milligrams) to administer 2 capsules 3 times a day with meals. It was administered at 4:25 p.m. on 1/29/08 by LPN #1, one hour and ten minutes before the evening meal. The meal times were 7:30 a.m., 12:30 p.m., and 5:30 p.m., according to the Facility Employee List provided by the Administrator on 1/28/08 at 12:50 p.m.  2. Resident #4 had a Physician's Order dated 1/8/08 to reduce Prilosec 20 mg. everyday to Prilosec 10 mg. everday. LPN #2 administered Prilosec 20 mg. on 1/30/08 at 8:19 a.m.  3. Resident #4 had a Physicians Order dated 1/8/08 to reduce Prilosec 20 mg. everyday to Prilosec 10 mg. everyday. LPN #3 administered Prilosec 20 mg. on 1/30/08 at 8:55 a.m.  4. Resident #19 had a Physicians Order dated 1/17/08 to reduce Lorazepam 1 mg. every morning to Lorazepam .5 mg. every morning. LPN #3 administered Lorazepam 1 mg. on 1/20/08 at 8:55 a.m.	F 332			
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE  The facility must store, prepare, distribute, and serve food under sanitary conditions.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure refrigerated food items were stored properly to prevent potential for cross contamination and failed to ensure the ice	F 371			

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F 371	<p>Continued From page 16</p> <p>machine was free of debris. The failed practice had the potential to affect 69 residents who received their meal trays from the kitchen as identified on the Resident Census And Conditions Of Residents form dated 1/28/08. The findings are:</p> <p>On 1/28/08 at 11:16 a.m., during a tour of the kitchen the following observations made were:</p> <p>a. A box of sausage on the shelf in the refrigerator was not sealed.</p> <p>b. A pan that contained roast beef stored on the shelf in the walk in refrigerator had foil on it. The foil did not cover both sides of the pan to protect the meat from any thing falling on it. The edge of the foil, where it stopped on the pan, had a brownish liquids substance on it.</p> <p>c. Two bags of french fries on a shelf in the walk in freezer were not sealed.</p> <p>d. The following containers in the storage room with these food items in it did not have fitting lids on them; rice, flour, blackeyed peas, pinto beans, great northern beans, corn bread and graham crackers crumbs. All the food items were exposed to air and pest could crawl into these food containers.</p> <p>e. The ice machine located by the exit door to the kitchen had reddish/blackish substance on the panel where ice shoots down to the ice collector. The ice scoop hung on the right side of the wall and had wet grayish matter on it. The ice scoop was resting directly on it.</p>	F 371			