STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TANGLEWOOD TRACE	530 W TANGLEWOOD LN MISHAWAKA, IN 46545

(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
R000000	This visit was for State Residential Licensure Survey. This included the Investigation of Complaint #IN00144575. Complaint #IN00144575 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: April 15, 16,& 17, 2014. Facility Number: 009669 Provider Number: 009669 AIM Number: N/A Survey Team: Sharon Ewing, RN - TC Shauna Carlson, RN Julie Baumgartner, RN Pam Williams, RN Census Bed Type: Residential: 90 Total : 90 Census Payer Type: Other: 90 Total: 90 Residential Sample: 5 These state findings are cited in	R000000	The Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct) on the community. Rather, it is submitted as confirmation or our ongoing efforts to comply with all the statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. WE have not presented all contrary factual or legal arguments nor have we identified all mitigating factors.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	accordance with 410 IAC 16.2. Quality Review completed on 4/24/14, by Brenda Meredith, R.N.			
R000144	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure storage rooms were clean and orderly . This deficiency affected 3 of 27 storage rooms observed. Findings include: On 4/16/14 from 2:30- 3:00 P.M., an environmental tour of the facility was conducted with employee#12. The following were observed: 1. The 600 hall nurses storage room was unorganized and cluttered with boxes on floor, two non used rolling walkers, and one non used scooter. 2. The 500 hall activities storage room was unorganized and cluttered with Christmas decorations stacked against wall from floor to three quarters the way	R000144	R 144 Corrective actions accomplished for residents foundto be affected. The 600 hall nurses storage room has been organized and boxes have been remove from the floor, the two rolling walkers and scooter have been removed. The 500 hall activity storage room has been organized and the Christmas decorations removed. The hall kitchen storage room has had	05/15/2014

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	up the walls. 3. The 300 hall kitchen storage room had with boxes and crate of dirty silverware on floor. On 4/17/14 at 1:25 P.M., an interview with employee #12 indicated items should not be on floors in storage rooms.		the boxes and crates removed. How facility will identify other residents having the potential to be affected. All residents have the potential to be affected. What measures or systemic changes facility will put in place to ensure the deficient practice does not recur. Storage rooms identified in this survey will be observed bi-monthly to ensure that they are organized and supplies are not directly on the floor. How the corrective actions	

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			will be monitored. The RCD, LED and DSD will monitor their respective storage areas bi-monthly for compliance. Compliance will be reviewed through quarterly QI meetings. Date corrective actions will be completed. 5/15/14.	
R000152	410 IAC 16.2-5-1.5(i) Sanitation and Safety Standards - Deficiency (i) The facility shall handle, store, process, and transport clean and soiled linen in a safe and sanitary manner that will prevent the spread of infection. 1. Based on observation, interview, and record review, the facility failed to ensure proper storage of soiled napkins and table clothes for one of one food service linen closets. 2. Based on observation, interview and record review, the facility failed to ensure proper handling of clean residents linens for three of three observations. Findings include:	R000152	R152 Corrective actions accomplished for residents found to have been affected. Food services linen closet linen bags have been closed and removed from the floor. Room floor has been cleaned.	05/15/2014

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	On 4/15/14 at 1:14 P.M., observation of food service linen closet to have two open dirty linen bags lying on floor, dirty linens spilled out on floor. Floor was dirty with leaves, crackers and dirt on floor. On 4/16/14 at 2:40 P.M., observed food service linen closet to have two open dirty linen bags lying on floor, dirty linens spilled out on floor. Floor was dirty with leaves, crackers and dirt on floor. On 4/16/14 at 3:00 P.M., an interview with employee #2, indicated kitchen linen closet is responsible of housekeeping. They should sweep and mop this room . Linen bags should be closed and placed in bin to await linen company to pick it up. It should not be lying open, spilled on floor...." On 4/17/14 at 1:20 P.M., the DON (Director of Nursing) provided the current policy titled "Dry Storage Linen" dated 10/2008, did not indicate how dirty tablecloths and napkins should be stored awaiting laundry pick up. 2. On 4/16/14 at 11:25 A.M., Employee #11 was observed pushing uncovered clean residents clothing down 500 hall.		Laundry bags have been purchased and residents Clean laundry is being covered during transport. How facility will identify other residents having the potential to be affected. All residents within community have the potential to be affected. What measures or systemic changes facility will put in place to ensure the deficient practice does not recur. Food service and laundry staff will be in-serviced on transportation of linen, linen storage and cleaning schedule.	

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	On 4/16/14 at 2:15 P.M., clean resident clothing was observed unattended, uncovered, and hanging outside the maintenance supervisors office. On 4/16/14 at 2:20 P.M., an interview with employee #11 indicated underwear, socks, nightwear are covered by placing them in a clean bag, but hanging clothes were not covered. On 4/17/14 at 12:34 P.M., Employee #11 was observed pushing uncovered clean residents clothing down main hallway. On 4/17/14 at 1:20 P.M., the DON (Director of Nursing) provided the current policy titled "Dry Storage Linen" dated 10/2008, did not indicate how clean residents linen is to be transported.		How the corrective actions will be monitored. The DSD and MD will monitor weekly with observations of linen storage, transportation of linen, and cleaning of floors. Compliance will be reviewed during quarterly QI meetings. Date corrective action will be completed. 5/15/14	
R000273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. 1.) Based on observation, interview and record review, the facility failed to ensure meals were served in a sanitary manor	R000273	R273 Corrective actions accomplished for residents	05/15/2014

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	related to handwashing and hairnet use. This deficiency affected 1 of 1 dining rooms. 2.) Based on observation, interview and record review, the facility failed to ensure that food was stored and prepared in a sanitary manner. This deficiency affected one of one kitchen. 3.)Based on observation, interview, and record review, the facility failed to ensure food was handled and prepared in a sanitary manor related to the use beard coverings and handwashing/glove use during 2 food prep observations. Findings include: 1.) On 4/15/14 between 12:05 P.M. and 12:40 P.M. an observation of the dining room was conducted. The following were observed: Employee # 9 was observed serving residents their lunch in the dining room. She was observed to have a long strand of hair outside of her hairnet on the right side of her face and upon further observation was observed to have a long strand of hair outside her hairnet on the left side of her head. The hair was resting on her shoulder and her back.		Found to have been affected. Food has been dated and foods with open containers have been disposed of. Staff have been informed about compliance with Hair netting including beards and procedures with hand washing. How facility will identify other residents having the Potential to be affected. All residents within the Community have the potential to be affected. What measures or systemic changes facility will put In place to ensure the deficient practice does not recur. Staff will be in-serviced	

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	Employee # 10 was observed serving residents their lunch in the dining room. She was observed to have a long strand of hair outside of her hairnet on the right side of her face. Employee # 9 was observed carrying an order pad in her left hand. She was then observed to drop her order pad on the floor she then picked the order pad up from the floor and threw it into the trash container. Employee # 9 then walked to the serving window and obtained a soup bowl she then walked into the dining room where she served potato and leek soup to a resident. At 12:30 P.M., Interview with Resident # 9 indicated there was a hair on her plate and that the glasses and silverware in the dining room were frequently dirty. Observation at this time of Resident #9's lunch plate indicated a dark hair was located on her plate next to her food. On 4/16/14 at 3:30 P.M., interview with Certified Dietary Manager indicated all employees should wear hairnets while serving food to the residents. Anything that falls on the floor should be thrown away and hands must be washed before returning to served food to residents. On 4/17/14 at 1:20 P.M., review of		on proper storage and sanitation of dishes, dating food, food storage, open containers, hairnet use, sanitation, and Food handling and Preparation policy. How will the corrective actions be monitored. DSD will ensure compliance through daily rounds of the kitchen and dining room, observation of cleaning schedule, and monitoring hand washing while serving. Compliance will be reviewed during quarterly QI meetings. Date corrective action will be completed. 5/15/14	

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	"Competency Checklist-Diet Aide/Wait Staff/Hostess" provided by the Certified Dietary Manager, indicated staff are trained on personal hygiene, handwashing and hairnet use as part of their training. He further indicated there was no policy for hairnet use. On 4/17/14 at 1:20 P.M. review of "Handwashing and Glove Use",policy provided by the Director of Nurses, updated 11/2010, indicated "...Procedure...Handwashing #1 Handwashing is a priority for infection control. #2 Hands must be washed prior to beginning work, after using the restroom, after smoking when working with different food substances i.e. raw chicken to fresh fruit, and following contact with any unsanitary surface i.e. touching hair, sneezing, opening doors, etc...." 2.)On 4-15-2014, between 10:45 A.M. and 11:35 A.M., an observation of the kitchen was conducted with the CDM (Certified Dietary Manager) and the following was noted: Observation of two metal shelving units on the back side of the dishwasher area held silverware in 3 large tubs. The silverware were observed to have a white film build up with white spots. Five			

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	coffee carafes were observed on the metal shelves, sitting upside down, with coffee dripped on them. Interview at this time with the CDM indicated "...they [the coffee carafes] should not be here, they are dirty...." The CDM then moved the coffee carafes to the dishwashing area. Observation of the wall and trim under the dishwashing area with black stains. Interview with the CDM at this time indicated, "...we have scrubbed and scrubbed and it will not come clean...I think it is mold...." Observation under a counter with dirty dishes on it had black debris on the two shelves. Observation of the floor in the grill area with black debris under and around grill. A large wire bristled brush was lying on top of the grill. Interview with the CDM at this time indicated, "we were cleaning that yesterday...they should have swept...." Observation of the cleaning closet with the door open to kitchen with rags on the floor. Interview at this time with the CDM indicated, "...those are clean and dirty rags, they should not be there...." Five metal mixing bowls were observed wet and stacked, nested together, and upright on the metal wire racks, in the			

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	dish storage room. A milk crate full of silverware and a glass dish were sitting on the floor. Interview with the CDM at this time indicated, "...I am getting rid of those...they should not be on the floor...." Under the prep table, a large bucket of chicken soup base was stored without the lid properly placed, open to air. Observation of a shelf above the prep area with a box of cream of wheat open to air and no date. A container of cinnamon open to air and no date. Interview with the CDM at this time indicated, "...these shouldn't be left open and they should have a date...." Observation of Employee #3 scooping ice from the ice machine and placing the scoop onto the top of the ice machine. Observation of a large bucket of grease between the prep table and the hand washing sink open to air. Interview with the CDM at this time indicated, "...we are dumping that today...." Observation of the dry storage pantry with a crate of bananas sitting on the floor. A box of onions, uncovered, with a bag of hoagie buns sitting on top of the onions. Several boxes of napkins were above the taped line with a sign that			

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	indicated, "Do not place anything above this line." Observation of elbow macaroni and balsamic vinegar opened and no date. Interview with the CDM at this time indicated, "...those should have been dated...." Observation of the walk-in refrigerator with a large metal pan with Salisbury steak and onions with the corner plastic pulled back and open to air. A clear container with cooked chicken breast with no date was observed. Interview with the CDM at this time indicated, "...that should have a date on it...." Observation of the Assisted Living "plating room" with debris on the counter around steam tables and floors. Interview with CDM at this time indicated, "...this will be wiped down before we serve lunch...the soup is the only thing in the steam table right now...." 3.) On 4/15/14 from 10:30 to 11:30 A.M., a kitchen tour was conducted with employee #2. The following were observed: Employee #13 was observed standing at food prep table with uncovered beard.			

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	Employee #13 was observed washing hands, then turned off water faucets with wet hands, then dried them with paper towel. Employee #13 was observed carrying a large piece of roast beef from cooler to food prep area with bare hands. On 4/16/14 at 3:20 P.M., employee #13 was observed standing at food prep table with uncovered beard. On 4/16/14 at 3:20 P.M., an interview with employee #13 indicated beard nets should be wore at all times while in kitchen. Gloves should be worn at all times when handling food. Hands should be washed for 20 seconds, then dried, then water faucets should be turned off using paper towel. On 4/17/14 at 1:20 P.M., the DON (Director of Nursing) provided the current policy titled " Food Handling and Preparation" dated 6/04/13, ..."Recreation staff, volunteers, and residents should wear protective gloves or use tongs when handling and serving food...."			

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