

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/01/2015
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NAME OF PROVIDER OR SUPPLIER COVENTRY MEADOWS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 7833 W JEFFERSON BLVD FORT WAYNE, IN 46804
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: November 30 and December 1, 2015</p> <p>Facility number: 005846 Provider number: 005846 AIM number: N/A</p> <p>Census bed type: Residential: 81 Total: 81</p> <p>Sample: 8</p> <p>The following residential findings were cited in in accordance with 410 IAC 16.2-5.</p>	R 0000		
R 0273 Bldg. 00	<p>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. Based on observation, interview, and record review, the facility failed to store food off the floor in the dry storage area, date opened items in the dry storage area</p>	R 0273	The creation and submission of this Plan ofCorrection does not constitute an admission by this provider of any conclusionset forth in the statement of	12/22/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>and reach-in coolers, keep the reach-in freezer in the kitchen and the reach-in cooler in the Auguste's Cottage (memory care) kitchen free of spills, and have the recommended testing papers for the sanitizing solution in the kitchen. The facility also failed to ensure staff lathered their hands for the appropriate amount of time before participating in meal service, and before donning disposable gloves. The facility further failed to protect resident food, serving utensils, and dinnerware from potential contamination potentially affecting 81 of 81 residents who resided in the facility.</p> <p>Findings include:</p> <p>1. During an initial tour of the facility kitchen on 11/30/15 at 12:35 p.m., the following was observed:</p> <p>In the dry storage area a Number 10 can of lima beans was observed on the floor of the storage area propping the door open. A 20 ounce packet of cream soup base, two 15 ounce packets of brown gravy mix, a 16 ounce bag of marshmallows, a 32 ounce bag of snowflake coconut, and a 5 pound bag of wide egg noodles had been opened and re-sealed, but were not dated when opened.</p>		<p>deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. Due to the relative low scope and severity of this survey, this facility respectfully requests a desk review in lieu of a post-survey revisit on or after December 15th, 2015.</p> <p>R273 Food and Nutritional Services, It is the practice of this facility to ensure that all food preparation and serving areas are maintained in accordance with the state and local sanitation and food handling standards.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>-All food including canned goods and opened items including #10 can of lima beans, a 20 ounce packet of cream soup base, two 15 ounce packets of brown gravy mix, a 16 ounce bag of marshmallows, a 32 ounce bag of snowflake coconut, and a 5 pound bag of wide egg noodles were placed on the storage shelves and were all discarded on 12/1/15 as it was unclear when the items were opened.</p> <p>-The three door reach-in freezer was de-iced on 12/1/15. The Maintenance Supervisor assessed the freezer gasket and determined the gasket was not</p>				

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	<p>The three door reach-in freezer had ice along the lower gasket of the middle door. Between the middle door and the left side door, there was a six inch strip of ice along the outside of the freezer unit.</p> <p>The bottom of the reach-in freezer in the kitchen was soiled with food debris and spills.</p> <p>The strength of the sanitizing solution was checked with the test papers provided by the kitchen staff. It was noted the test papers were to be used with a chlorine solution, and not a quaternary solution. When queried, the staff indicated those were the test papers they used to check the sanitizing solution.</p> <p>2. During an observation of the lunch meal in the facility kitchen on 12/1/15, the following was observed:</p> <p>At 10:45 a.m., Server #1 was observed to wash her hands appropriately. She was then observed to place her left hand on her left hip and then begin to prepare beverages for residents in the dining room without re-washing her hands.</p> <p>At 10:48 a.m., Cook #2 was observed to lather her hands with soap for 8 seconds prior to rinsing. She then was observed</p>		<p>working appropriately. A new gasket was ordered on 12/1/15. The newgasket was replaced on 12/14/15.</p> <p>-The entire reach-in freezer in the kitchen wasemptied and thoroughly cleaned of any food debris and evidence of spills on12/2/15.</p> <p>-The Food Service Manager and General Manager bothaddressed the sanitization test strips with the Surveyor on 11/30/15. Theincorrect strips were being used; however the correct strips were in thekitchen on 11/30/15. The incorrect strips were discarded to ensure they were nolonger used. The Food Services Manager did use the correct strips and testedthe sanitizer and the correct strength of sanitizer was being used.</p> <p>-The items in the Memory Care reach-in coolerincluding an un-wrapped stick of butter/margarine, a 4 pack of yogurt, a 16ounce jar of pickle chips, a gallon of 2% milk with ¼ inch of milk remaining inthe jug, and a large plastic bowl of applesauce were all discarded from thecooler on 12/1/15 as it was unclear when the items were opened.</p> <p>-The Memory Care reach-in cooler was emptied on12/1/15 of all contents and thoroughly cleaned of all food debris and evidenceof spills.</p> <p>-A rolled box of parchment paper that was observedon the floor</p>				

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	<p>to don a pair of disposable gloves to take the temperature of the hot food.</p> <p>At 10:55 a.m., Cook #2 was observed to lather her hands with soap for 10 seconds prior to rinsing. She then was observed to don a pair of disposable gloves finishing preparation for the lunch meal, opening, drawers, freezers and coolers. She was not observed to remove her disposable gloves and re-wash her hands before continuing with meal service.</p> <p>At 11:05 a.m., in the dry storage area a Number 10 can of stewed tomatoes was observed on the floor of the storage area propping the door open.</p> <p>At 11:10 a.m., Cook #2 was observed to lather her hands with soap for 10 seconds prior to rinsing. She was then observed to don a pair of disposable gloves. She then handled slices of bread and cheese to make a grilled cheese sandwich for a resident. She was then observed to leave the service area, open the reach-in freezer in the kitchen, and retrieve a bag of breaded cauliflower. She returned the bag of breaded cauliflower to the reach-in freezer and then returned to the service area and handled slices of bread for a sandwich without washing her hands.</p> <p>At 11:14 a.m., Cook #2 was observed to</p>		<p>under the stainless steel cabinet in the Memory Care was alsodiscarded.</p> <p>-Paper towels were restocked in the Memory Care handwashing sink on 12/1/15.</p> <p>-All Food Service staff will be in-serviced on orbefore December 22nd , 2015 on proper food storage, dating andlabeling all opened food, cleaning the freezers and refrigerators, using thecorrect test papers for the sanitizing solution in the kitchen, appropriatehand washing/lathering, glove usage, and protecting food, serving utensils, anddinnerware from contamination.</p> <p>-All facility staff will be in-serviced on or beforeDecember 22nd, 2015 on hand washing.</p> <p>-Cook #2 was educated on proper handwashing/lathering protocol and appropriate glove usage during foodpreparation/serving.</p> <p>-Servers #1 and #3 were educated on proper handwashing/lathering protocol.</p> <p>-Server #3 was educated on proper protection offood, utensils and dinnerware from contamination. Server #3 was also educated on proper foodservice (taking temperatures of all food at the point of service, as well asplacing the soup on the heat source during meal service).</p> <p>Howwill you identify other residents having the potential to be affected by thesame deficient practice and what</p>				

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	<p>lather her hands with soap for 10 seconds prior to rinsing. She was then observed to don a pair of disposable gloves, handle slices of cheese for a sandwich, and place a handful of potato chips from a plastic container onto the lunch plate of a resident.</p> <p>At 11:15 a.m., Cook #2 was observed to leave the service area and obtain 2 tomatoes from the 3 door reach-in cooler. She returned to the service area and sliced the tomatoes for sandwiches. She then continued to handle bread and cheese for sandwiches for the residents. She was not observed to remove her disposable gloves and wash her hands after opening the reach-in cooler and before handling the bread and cheese.</p> <p>At 11:25 a.m., Cook #2 was observed to serve lasagna on a plate for a resident. She was observed to place her gloved index finger on top of the serving of lasagna to help steady it on the serving spatula while placing it on the plate for the resident. She had not been observed to wash her hands since 11:14 a.m.</p> <p>3. During an observation of the lunch meal on 12/1/15 in the Auguste's Cottage kitchen, the following was observed:</p> <p>At 11:55 a.m., a stainless steel bowl</p>		<p>corrective action will be taken:</p> <ul style="list-style-type: none"> -All residents have the potential to be affected by the alleged deficient practice. -The Food Service Manager/Designee will round the facility on an on-going basis and will check the all food storage areas including but not limited to the dry food storage, the pantry, the reach-in freezers and coolers in the main kitchen, the reach-in freezers and coolers in the Memory Care kitchenette for cleanliness as well as unlabeled or undated food or beverages. -The facility will in-service all staff on proper food storage, labeling/dating, and protecting food, serving utensils, and dinner ware from potential contamination on or before December 22nd, 2015. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> -The Food Service Manager/Designee will round the facility on an on-going basis and will check the all food storage areas including but not limited to the dry food storage, the pantry, the reach-in freezers and coolers in the main kitchen, the reach-in freezers and coolers in 				

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	<p>containing an un-wrapped stick of butter/margarine, a 4 pack of yogurt, a 16 ounce jar of pickle chips, a gallon of 2% milk with 1/4 inch of milk remaining in the plastic jug, and a large plastic bowl of applesauce were not labeled and dated when opened in the reach-in cooler. The bottom of the reach-in cooler was soiled with food debris and dried spills of a red sticky substance. There was also a roll of boxed parchment paper observed on the floor under a stainless steel cabinet.</p> <p>At 12:20 p.m., Server #3 was observed to push an insulated cart containing the hot food for Auguste's Cottage into the kitchen area. A serving spatula and spoodle were observed un-covered on top of the insulated cart. The cart had been transported down to the Auguste's Cottage kitchen through a common elevator and through a common hallway.</p> <p>At 12:22 p.m., Server #3 was observed to lather his hands with soap for 13 seconds prior to rinsing. There were no paper towels observed at the handwashing sink. Server #3 left the kitchen area and retrieved paper towels from the handwashing sink in the Auguste's Cottage dining room. He was required to open the door from the Auguste's Cottage dining room to the kitchen, touching a soiled surface. He was not observed to</p>		<p>the Memory Care kitchenette for cleanliness as well as unlabeled or undated food or beverages.</p> <p>-The facility will in-service all staff on proper food storage, labeling/dating, and protecting food, serving utensils, and dinner ware from potential contamination on or before December 22nd, 2015.</p> <p>-The Food Service Manager/Designee will in-service Department Heads who serve as weekend managers to ensure rounding and checking for cleanliness and labeled/dated food in all food storage areas including but not limited to the dry food storage, pantry, reach-in coolers and freezers in the main kitchen and the reach-in coolers and freezers in the Memory Care kitchen occurs 7 days a week.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>-The following CQI monitoring tools, Labeling and Dating Food, Cleanliness of the food storage areas, Hand Washing, and Food Service (taking temperatures, glove usage, protecting food/utensils/dinnerware from contamination) will be completed weekly x 4 weeks, then monthly x 3 months, and quarterly thereafter for at least 6 months and discussed with IDT.</p>				

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	<p>re-wash his hands before donning disposable gloves.</p> <p>At 12:25 p.m., Cook #2 was observed to enter the kitchen with a stainless steel pot of soup. A ladle was on top of the covered soup uncovered. The ladle had been transported from the upper level to the Auguste's Cottage kitchen through common hallways. Server #3 was not observed to take the temperature of the soup, recording the temperature reported by Cook #2 taken in the facility kitchen instead. The stainless steel pot of soup was not placed on a heating source to keep it at the appropriate temperature, but remained on the service counter throughout the meal.</p> <p>At 12:30 p.m., Server #3 was observed to place his gloved index finger on top of a serving of lasagna to help steady it on the serving spatula while placing it on the plate for the resident.</p> <p>At 12:30 p.m., Cook #2 was observed to enter the kitchen carrying a stack of 6 white soup bowls with the thumb of her left hand touching the inside bottom of the bowl on the top of the stack. The bowls were not covered and had been transported from the upper level to the Auguste's Cottage kitchen through common hallways.</p>		<p>-Data will be collected by the Food Service Manager and submitted to the General Manager. If the threshold of 100% is not met, an action plan will be developed.</p> <p>-Non-compliance with the facility procedure may result in disciplinary action up to and including termination.</p>	

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	<p>At 12:42 p.m., Server #3 left the Auguste's Cottage kitchen to retrieve tongs from the facility kitchen to served grilled cheese sandwiches which had been prepared for the residents who did not want the lasagna. He was observed to re-enter the kitchen carrying the tongs uncovered. The tongs had been transported from the upper level to the Auguste's Cottage kitchen through common hallways.</p> <p>At 12:44 p.m., Server #3 was observed to lather his hands with soap for 7 seconds prior to rinsing. He was then observed to don disposable gloves and continue meal service for the residents.</p> <p>At 12:56 p.m., the last bowl of soup was served to a resident in the Auguste's Cottage dining room. The soup had remained on the service counter without a heat source for 31 minutes.</p> <p>At 12:57 p.m., the white soup bowls which had been transported uncovered to the kitchen were used to serve applesauce to the residents.</p> <p>The General Manager was interviewed on 11/30/15 at 11:00 a.m. During the interview he indicated the wrong test papers had been used in the kitchen to</p>			

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	<p>test the strength of the sanitizing solution. He also indicated the test papers the dietary staff were to use should be for a quaternary solution and not a chlorine solution.</p> <p>The General Manager and the Dietary Manager were interviewed on 12/1/15 at 3:15 p.m. During the interview they indicated staff were to lather their hands with soap for 20 seconds prior to rinsing. They also indicated cans of food were not to be on the floor and all opened foods should be dated. They further indicated food temperatures were to be taken at the time of service to residents, serving utensils and dishes were to be covered when leaving the facility kitchen to protect them from contamination, and food ready to eat by residents should be not touched with disposable gloves.</p> <p>A current facility policy "General Food Preparation and Handling", with a revision date of July 2015 and provided by the General Manager on 12/1/15 at 4:18 p.m., indicated "...The kitchen is clean...equipment is clean...Bare hands should never touch raw or ready to eat food directly. Food will be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements so as to avoid bare hand contact of prepared foods...Any utensils</p>			

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	<p>or dishware transported to other areas will wither be covered or placed in covered containers/enclosed carts...."</p> <p>A current facility policy "Hand Washing", with a revision date of April 2014 and provided by the General Manager on 12/1/15 at 4:18 p.m., indicated "...An essential component of infection control is hand washing...Apply antibacterial soap to palm of hand; join hands, palm to palm, working up lather on hands, wrists and forearms for a minimum of twenty (20) seconds...."</p> <p>A current facility policy "Use of Gloves", with a revision date of July 2015 and provided by the General Manager on 12/1/15 at 4:18 p.m., indicated "...Hands will be washed when entering the kitchen and before putting on gloves...Gloves are just like hands; they get soiled. Anytime a contaminated surface is touched, gloves must be changed and hands washed...After handling anything soiled...Any time you touch a contaminated surface...Any time you change tasks...."</p> <p>A current facility policy "Food Handling", with a revision date of February 2008 and provided by the General Manager on 12/1/15 at 4:18 p.m., indicated "...To provide quality</p>			

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R 0356 Bldg. 00	<p>food that is handled in a safe and sanitary manner...The Community will serve food at a safe and appropriate temperature...."</p> <p>Daily Cleaning Schedules for the dietary department, provided by the General Manager on 12/1/15 at 4:25 p.m., indicated coolers and freezers were to be organized and cleaned daily, and dates were to be checked in the coolers daily.</p> <p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the</p>			

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	<p>family members or other persons to be contacted in the event of an emergency or death.</p> <p>(6) Information on any known allergies.</p> <p>(7) A photograph (for identification of the resident).</p> <p>(8) Copy of advance directives, if available.</p> <p>Based on interview and record review the facility failed to maintain a complete emergency information file containing a photograph of each resident, potentially affecting 12 of 81 residents in the facility.</p> <p>Findings include:</p> <p>The facility emergency information file was reviewed on 12/1/15 at 2:00 p.m. During the review it was noted photographs of 12 residents were missing of the 81 residents currently residing in the facility. Their admission dates into the facility of the 12 residents ranged from 3/9/13 to 11/21/15.</p> <p>The Clinical Manager was interviewed on 12/1/15 at 3:45 p.m. During the interview she indicated nursing did not put the residents' photograph in the Emergency Information Binder. She indicated she was not sure who was responsible for making sure a photograph for each resident was in the Emergency Information Binder. She also indicated a photograph of a resident should be in the MARS (Medication Administration</p>	R 0356	<p>R356 Clinical Records-It is the practice of this facility to maintain a current emergency information file that is immediately accessible for each resident.</p> <p>What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>-All 12 missing photos in the emergency information file were printed and placed in the file on 12/2/15.</p> <p>-The facility Clinical Director was educated on the emergency information file; and her responsibility to oversee the file.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>-All residents have the potential of being affected by the alleged deficient practice.</p> <p>-Clinical Director/Designee will review the emergency information file each week to ensure it is current with all required information/photos.</p> <p>-The facility will in-service the Clinical Director and Assistant Clinical Director on the regulation</p>	12/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/01/2015
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NAME OF PROVIDER OR SUPPLIER COVENTRY MEADOWS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 7833 W JEFFERSON BLVD FORT WAYNE, IN 46804
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	<p>Record Sheet) within 48 to 72 hours of admission to the facility. She further indicated the facility did not have a policy about photographs in the MARS.</p> <p>The General Manager was interviewed on 12/1/15 at 3:46 p.m. During the interview he indicated photographs of residents were to be taken upon admission to the facility and the photographs should be placed in the Emergency Information File Binder within 48 hours of admission. He also indicated the facility took the photographs and printed the residents' photographs. He further indicated he did not have a facility policy about residents' photographs in the Emergency Information File.</p>		<p>of the emergency informationfile and it's requirements on or before December 22nd, 2015. Their-service took place on 12/14/15.</p> <p>Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur: -ClinicalDirector/Designee will review the emergency information file each week toensure it is current will all required information/photos. -The facility will in-service the Clinical Directorand Assistant Clinical Director on the regulation of the emergency informationfile and it's requirements on or before December 22nd, 2015. -The Clinical Director/Designee will be responsiblefor ensuring the photos of new residents are in the emergency information filewithin the first 48 hours of moving into the facility.</p> <p>Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place: -ACQI monitoring tool, Emergency Information File will be completed weekly x 4weeks, then monthly x 3 months, and quarterly for at least 6 months anddiscussed with the IDT. -Data will collected by the General Manager. If thethreshold</p>	

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NAME OF PROVIDER OR SUPPLIER COVENTRY MEADOWS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 7833 W JEFFERSON BLVD FORT WAYNE, IN 46804		
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			of 100% is not met, an action plan will be developed. -Non-compliance with facility procedure may result in disciplinary action up to and including termination.		