STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE HEALTH CARE FACILITY	337 GRACE VILLAGE DR WINONA LAKE, IN 46590

(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
F0000	This visit was for Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00112951. This visit resulted in an extended survey.-immediate jeopardy. Complaint IN00112951 substantiated. Federal/state deficiencies related to the allegations are cited at F-279 Survey dates: August 1, 2, 3, 6, 7, 8, and 9, 2012 Facility number: 000501 Provider number: 155635 AIM number: 100266260 Survey team: Tim Long, RN-TC Julie Wagoner, RN Christine Fodrea, RN Shelly Vice, RN (August 2, 2012) Census bed type: SNF: 14 NSF/NF: 65 Other: 50 Total: 129 Census payor type: Medicare: 17 Medicaid: 34	F0000	Submission and implementation of this plan of correction shall not constitute an admission by Grace Village Health Care to any allegations of deficiency as stated within the "Summary Statement of Deficiencies" or an agreement with any conclusions made therein. Rather, this plan of correction is submitted in accordance with State and Federal requirements.	

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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	Other: 78 Total: 129 Residential sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 8/15/12 Cathy Emswiller RN			

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F0156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	Based on observation, interview and record review, the facility failed to provide the residents and/or representatives with notification of potential financial charges for 3 of 3 residents reviewed (#19, 121, 81). In addition, the facility failed to accurately post nurse staff information for 1 of 1 observed staff posting . In addition, the facility also failed to provide the residents or representatives with documentation of the written descriptions of non-covered items for Medicare and Medicaid . This potentially affected 51 of 51 residents whose stay was covered by Medicare and/or Medicaid. Finding includes: 1. Review of the liability notices given	F0156	I. CORRECTIVE ACTION(S) FOR AFFECTED RESIDENTS IDENTIFIED: Item 1- Two of the three residents identified by the survey to have been discharged to home and incurred no additional charges beyond those covered by their Medicare benefit. The third resident's responsible party has been issued an Advance Beneficiary Notice (ABN) informing them of potential financial charges. (see att.A) Item 2- The correct staff hours postings were made immediately when brought to the attention of administration. No residents were identified as affected. Item 2a- The required Medicaid/Medicare (MCD/MCR) information and other required contact numbers have been lowered to a height that provides easier access by residents confined to wheelchairs	09/08/2012

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	to Residents #19, 121, and 181, on 08/08/12 at 10:00 A .M. indicated the notices included the date the Medicare was to be ending but did not provide a list of expected charges the residents were going to be responsible to pay. Interview with Admission Director, on 08/07/12 at 10:10 A.M., indicated the facility did not provide any documentation of the charges the residents were to incur for continued stay after the Medicare discontinuation date. 2. Observation of nurse staffing posting, on 08/01/12 at 10:15 A.M. during the entrance tour of the facility, indicated the posting was for 07/30/12. Observation of the nurse staffing posting, on 08/06/12 at 8:45 A.M. indicated the posting was for 08/03/12. On 08/06/12 at 8:45 A.M., the Medicaid/Medicare, Indiana State Department of Health, Ombudsman and other contact numbers, posted in a frame by the nurses station by hall 1 and 2, was not at wheelchair height.. The posting of contact information located on the rehab unit		and the missing contact information on the Rehab Unit was added. No residents were identified as affected. Item 3- No specific residents were identified by the survey to have not received a list of MCD/MCR covered items and services. II. CORRECTIVE ACTION(S) FOR POTENTIALLY AFFECTED RESIDENTS: Item 1- The Admissions Director (AD) reviewed all residents who were discharged from skilled care in the last 90 days. Those who were still in the nursing facility were sent ABNs. Item 2- To the best of our knowledge, no residents were adversely affected by the inaccurate postings of staff hours. Item 2a- To the best of our knowledge, no residents were adversely affected by the posting of Medicaid/Medicare or other contact info which was either too high ot incomplete. Item 3- The AD has identified all current residents who should have been given information regarding MCD/MCR covered and non-covered items and services. A form has been developed and has been distributed to those residents or their responsible parties. (see att.B) III. STEPS TAKEN TO ENSURE CONTINUED COMPLIANCE: Item 1- The AD and the SSD have reviewed the State and Federal regulations that apply to Notices of Rights & Services as found in 410 IAC	

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	was incomplete and did not provide all of the contact information and telephone numbers. 3. Interview with the Admissions Director, on 08/06/12 at 10:25 A.M., indicated the facility does not give residents and/or families a written list of what is included in Medicare and/or Medicaid covered items/supplies/services upon admission or when they become eligible for Medicaid. She indicated prior to changing to an electronic nursing charting system, she thought they used to have written forms but did not utilize them anymore. She also indicated there was no facility policy specific to providing information to Medicare and/or Medicaid admissions. 3.1-4(a)		16.2-3.1-4. The CMS designated ABN form has been obtained and will be issued to residents in conjunction with another required document (Notice of Medicare Non-Coverage) that shares the same notification timeframe (48 hours prior to last skilled day) and which has been delivered consistently without fail by the AD. Item 2- The day shift unit clerk position has been assigned the responsibility of posting the staff hours every morning, seven days a week. Weekday and weekend unit clerks are already involved with daily scheduling assistance and are therefore very familiar with the details of the schedule and any last minute changes. They will be in-serviced on the requirement for this posting. Item 2a- A diagram has been developed of all the required MCD/MCR and contact info postings for the HC unit and for the Rehab unit which will aid in the identification and maintenance of all required postings and their proper location on the wall. (see att.C) Item 3- A new form has been created to communicate covered and non-covered items and services to MCD/MCR beneficiaries. (att. B) The AD or the SSD will issue the form to all MCD/MCR residents along with the rest of the admission packet and at the time of MCD eligibility. IV. MONITORING: Item 1- The	

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			AD or SSD will furnish to the Administrator a log of the residents who have been discharged from skilled care and the signed copies of the notices that have been given to each one. This monitoring will be conducted on a weekly basis for one month and will continue on a monthly basis for the following 90 days. Item 2- The DON, or her designee, will check the staff hours postings for accuracy at least 5 days per week for 30 days and will continue to check them at least one day per week for the following 90 days. Item 2a- Once per week for 60 days, the DON, or her designee, will utilize the diagram of the required MCD/MCR info and contact postings to ensure that all required postings are present and in the correct location. Item 3- The AD or SSD will furnish to the Administrator a list of all MCD/MCR admissions and newly eligible MCD/MCR recipients and copies of the signed notices of covered and non-covered items and services (att.B) that were given to each one. This monitoring will be conducted on a weekly basis for one month and will continue on a monthly basis for the following 90 days. For each item, the QA Committee, which meets quarterly, will review the results of the monitoring. If at least 95% compliance is demonstrated, the Committee will decide on either a	

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			reduction in the frequency of monitoring or a stop in the monitoring. If less than 95% compliance is demonstrated, the Committee will require that the original monitoring parameters continue until reviewed again at the next quarterly QA meeting.	

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F0159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that			

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	receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.			
	Based on record review and interview the facility failed to ensure 3 of 3 resident fund accounts (22, 73, 21) accrued interest on personal fund accounts managed by the facility of more than $50.00. This potentially affected 11 of 11 residents in the facility for whom the facility managed personal funds. (Residents #22, 73, 21, 200, 201, 202, 203, 204, 205, 206, and 207) **Findings include:** During the review of personal resident fund accounts, conducted on 08/06/12 at 1:00 PM, Employee #14, a facility accounting employee, indicated the interest earned by resident fund accounts with a balance greater than $50.00 just goes into a facility checkbook and they did not have any way to separate it or apply it to individual accounts. She indicated it would be too difficult to separate the interest because it might only be. 03 cents in a months time	F0159	I. CORRECTIVE ACTION(S) FOR AFFECTED RESIDENTS IDENTIFIED: Employee #14 was accurate in the statement that the total interest earned on the entire resident fund account in a one month period was literally three cents. The existing resident fund policy did not prescribe a method for distributing fractions of pennies to resident accounts. Accounting staff have reviewed bank statements for prior periods and now credited the accounts of residents 21, 22 and 73 with interest earned according to an updated resident funds policy. (see att.D) II. CORRECTIVE ACTION(S) FOR POTENTIALLY AFFECTED RESIDENTS: Accounting staff are reviewing the accounts of all other residents maintaining deposits with Grace Village. Those who have had average daily balances in the amount of $50 or more will be credited interest according to the method described in the updated resident fund policy. III. STEPS TAKEN TO ENSURE CONTINUED COMPLIANCE: The resident funds policy has been revised to describe	09/08/2012

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	and 11 residents had personal fund accounts.. Review of the facility "Resident's Handbook" given to new admissions indicated the following: "...Money may also be deposited into a separate interest bearing savings account...." 3.1-6(c)		the method by which interest earned on deposits that exceed the $50 threshold is calculated and credited in accordance with State and Federal guidelines. (see att.D) Accounting staff responsible for administering resident funds related duties have been instructed on the application of the policy revisions. IV. MONITORING: The company books are audited annually by an independent auditing firm. A Medicaid financial audit is also conducted periodically. Bank statement reconciliations are completed monthly. The bank reconciliations and resident fund account ledger will be inspected monthly by the Administrator for the next three months to ensure the proper credits have been issued to qualified resident accounts. The QA Committee, which meets quarterly, will review the results of the monitoring. If at least 95% compliance is demonstrated, the Committee will decide on either a reduction in the frequency of monitoring or a stop in the monitoring. If less than 95% compliance is demonstrated, the Committee will require that the original monitoring parameters continue until reviewed again at the next quarterly QA meeting.	

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F0161 SS=B	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.			
	Based on record review and interview the facility failed to maintain a surety bond policy with an amount larger than the pooled resident funds account. This potential affected 11 of 11 residents in the facility for whom the facility managed a personal fund account. **Findings include:** Review of Personal funds accounts, on 08/06/12 at 1:00 P.M. indicated the facility had a current Surety Bond to cover resident fund accounts in the sum of $4500.00. The June 2012 Resident fund balance in the pooled check book was $6, 022.52. The CFO (Chief Financial Officer), employee #15, indicated the balance was not normally that high and she did not think they needed to increase the amount because they were not consistently running "that high." Review of April and May 2012 end of month balances indicated both months ending balances were over $4500.00.	F0161	I. CORRECTIVE ACTION(S) FOR AFFECTED RESIDENTS IDENTIFIED: Administration would like to note that although the amount of the surety bond it had in place was slightly less than the maximum pooled funds in the resident account, there has never been a loss to a resident fund account in the history of the organization, including the period in the mid 90's during which the organization underwent bankruptcy and reorganization. Furthermore, it is the contention of Administration that the relatively small dollar amount of the resident funds account at any point in time could be, and would be restored from other assets of the company in the unlikely event of an incident resulting in a loss of resident funds, let alone an incident that would result in a loss greater than the amount of the surety bond. Nevertheless, the amount of the surety bond has been increased to $12,000, which is roughly double the unusually high balance obtained from the June 2012 bank statement. (see att.E) II. CORRECTIVE ACTION(S) FOR POTENTIALLY AFFECTED	09/08/2012

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	3.1-6(i)		RESIDENTS: The corrections identified in section I. apply to all residents potentially affected. III. STEPS TAKEN TO ENSURE CONTINUED COMPLIANCE: The Chief Financial Officer (CFO) has revised the Resident Fund policy to include a statement about the required surety bond according to State and Federal regulations. (see att.D) Accounting staff responsible for administration of resident funds have been instructed on the policy revisions. The CFO will evaluate the balance in the resident funds pooled account on a monthly basis. If the highest amount reached in the account gets close to or ever exceeds the amount of the surety bond, the CFO will instruct the company's insurance agent to raise the amount of the bond to a sufficient level. IV. MONITORING: The CFO will furnish a copy of the Resident Fund ledger to the Administrator monthly for the next 6 months. The Administrator will confirm that the highest pooled amount recorded in the ledger has not exceeded the amount of the surety bond coverage. The QA Committee, which meets quarterly, will review the results of the monitoring. If at least 95% compliance is demonstrated, the Committee will decide on either a reduction in the frequency of monitoring or a stop in the monitoring. If less than 95% compliance is demonstrated,	

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			the Committee will require that the original monitoring parameters continue until reviewed again at the next quarterly QA meeting.	

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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).			
	Based on record review and interview the facility failed to initiate care plans for 2 of 9 residents (#A, B) reviewed for care plans for medications and/or behavior needs. Findings include: **1.** Resident #A's record was reviewed 8-6-2012 at 10:44 a.m. Resident #A's diagnoses included, but were not limited to: anxiety, high blood pressure and Parkinson's disease. Review of resident #A's quarterly	F0279	I. CORRECTIVE ACTION(S) FOR AFFECTED RESIDENTS IDENTIFIED: Item 1- A behavior care plan to address the occasional interference with his spouse's dinner has been updated for Resident A to include interventions for that specific issue. It should be noted that there has been no adverse nutritional effect on the spouse (Resident B) as evidenced by a small, positive weight gain since admission to the facility. Staff awareness of the concern was evident. They knew what interventions were appropriate and they used them	09/08/2012

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	Minimum Data Set (MDS) dated 5-24-2012, indicated Resident #A had trouble sleeping, poor appetite, trouble concentrating, and moving or speaking slowly. The MDS further indicated no behavior occurred during the assessment reference period. In an interview on 8-6-2012 at 5:33 p.m., CNA #2 indicated occasionally, Resident #A did not allow his wife to finish her meals, so they served him last. In an interview on 8-6-2012 at 5:35 p.m. CNA #1 indicated Resident #A sometimes did not allow wife to finish her meals. In an observation on 8-6-2012 at supper meal at 5 PM in dining area, Resident #A was served at 5:30 p.m. At 5:45 p.m., resident #A had completed eating and Resident #B was still eating. At 5:51 p.m., Resident #A left the dining area and left Resident #B to finish her meal. Review of a care plan dated 6-2-12, entitled anxiety and resisting care, indicated Resident A's resisted care and yelled at staff regarding Resident #B's care. Interventions included redirection and reassurance, but did not address taking Resident #B away		effectively when the need arose, despite the lack of a very specific care plan for an infrequent concern. The matter had also been discussed with family in care plan meetings. Item 2- The surveyor writing the description for this finding has evidently confused documentation from two other residents and therefore is completely unfounded. The first paragraph under (2.) lists the diagnoses of Resident #33, not Resident B. The second paragraph under (2.) refers to a physician order for Coumadin for Resident #62, not Resident B. Resident B has no diagnosis which would indicate a need for Coumadin nor does she have an order for Coumadin - which is why there is no care plan for Coumadin for Resident B. II. CORRECTIVE ACTION(S) FOR POTENTIALLY AFFECTED RESIDENTS: Item 1- The behavior care plans of all residents who have them have been reviewed. No other care plans were found to lack interventions for specific concerns of which facility staff are aware. Item 2- Despite this finding not being accurately detailed on the survey report, the care plans of all residents with Coumadin orders have been reviewed and all were found to have Coumadin care plans in place. III. STEPS TAKEN TO ENSURE CONTINUED	

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	from table before she is done eating. In an interview with SSD#6 on 8-7-2012 at 8:59 am, she indicated Resident #A was easily redirected if you tell him Resident #B was not finished with her meal. SSD #6 indicated in Resident #A's care plan, Resident #A did not allow staff to care for Resident #B. SSD #6 further indicated all interventions and problems should have been on a care plan. 2. Resident B's record was reviewed 8-6-2012 at 8:10 am. Resident B's diagnoses included but were not limited to depressive disorder, stroke, and bradycardia (slow heart rate) A review of current physician orders dated 8-12 indicated Resident #B was to receive Coumadin 15 milligrams (mgs) on Sunday and Wednesday and Coumadin 10 mgs on Monday, Tuesday, Thursday and Saturday. Review of Resident B's care plans indicated the facility did not have a care plan for Coumadin. A bruising care plan had been initiated 3-27-2012, but did not indicate the use of Coumadin. In an interview on 8-7-2012 at 9:31		COMPLIANCE: Item 1- Nursing and social service staff will be in-serviced on recognizing behaviors and the required care planning for them. Nursing staff will also be reminded of the fact that they need to document behaviors and can and should initiate behavior care plans when they see or have been made aware of new behaviors. Item 2- Again, despite this finding not being valid, administration has added initiation of Coumadin care plans to the admission check off sheet and for review of re-admissions. IV. MONITORING: Item 1- Review of behavior care plans will be conducted during a weekly interdisciplinary behavior meeting. Any known behaviors, previously documented or not, will be added to the care plan during this meeting if they are not already in place. Any known behaviors that should have been documented by nursing staff will be addressed with the appropriate individual(s) by the DON or her designee. The Director of Social Services (AD) or her designee will also review all documented behaviors to ensure appropriate and complete interventions have been implemented. This monitoring will be ongoing with no end date or change in frequency. The QA Committee will review the results of the monitoring quarterly. Item 2- The DON, or her designee, will	

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	a.m. RN #4 indicated a care plan should have been initiated to include anticoagulant therapy. A current undated policy titled Resident Care Planning, provided by the Director of Nursing on 8/8/12 at 11:00 A.M., indicated care plans were to have been initiated to include and identify each of the resident's problems and needs. This federal tag relates to complaint number IN00112951. 3.1-35(a)		review the charts of all residents with new or existing Coumadin orders on a weekly basis for the next 60 days to ensure that Coumadin care plans are in place. The QA Committee, which meets quarterly, will review the results of the monitoring. If at least 95% compliance is demonstrated, the Committee will decide on either a reduction in the frequency of monitoring or a stop in the monitoring. If less than 95% compliance is demonstrated, the Committee will require that the original monitoring parameters continue until reviewed again at the next quarterly QA meeting.	

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F0280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview the facility failed to revise a nutrition care plan after a significant weight loss for 1 of 3 residents (#19) reviewed for nutritional needs. Finding includes: The closed clinical record for Resident #19 was reviewed on 08/08/12 at 1:30 P.M. Resident #19 was admitted to the facility on 04/10/12 with a weight of 105 pounds. The resident's normal weight range was noted to be between 101 - 110 pounds. The resident was in isolation on admission, had edema noted in	F0280	I. CORRECTIVE ACTION(S) FOR AFFECTED RESIDENTS IDENTIFIED: Resident #19 had been discharged prior to the survey. When resident #19 was discharged, her decubitus had been healed and edema was no longer present. Her last weight measurement was within 3% of her normal weight range. II. CORRECTIVE ACTION(S) FOR POTENTIALLY AFFECTED RESIDENTS: The ADON is reviewing charts for all current residents to identify any residents with significant weight loss during the last 60 days. If any significant weight losses are found for which care plans and interventions have not been updated, they will be	09/08/2012

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	both ankles, and had a decubitus, A dietary assessment was completed 04/12/12. It indicated the resident needed 1500 calories a day, 57 grams of protein. The assessment indicated the resident had a BMI (body mass index of 18.5) and was a low risk for weight loss/gain due to BMI 19 - 27. The assessment indicated the resident consumed 76 -100 percent of her meals and consumed 1500 - 2000 calories a day. The assessment also indicated the resident required extra kilocalories and protein due to her skin issues and a yogurt to each meal, monitor intakes, and labs was recommended. A care plan was initiated on 05/04/12, for Alteration in Nutrition with a goal for the resident to maintain her weight within 5 pounds of current weight. The interventions to the plan included: monitor weight, record food intake and encourage resident to consume 75 - 100 percent, provide ordered diet. The care plan was reviewed on 06/07/12 and "goal remains the same" was documented. Review of the resident's subsequent weights indicated the following: 04/09/12 - 105.2 pounds, 04/30/12 - 116 pounds, 05/07/12 - 105 pounds,		updated immediately. Reweighs will be done for any residents that appear to have significant weight changes in a short period of time. III. STEPS TAKEN TO ENSURE CONTINUED COMPLIANCE: A weekly skins and nutrition at risk (SNAR) meeting has been reinstituted. The nurse responsible for monitoring and treating skins, the Certified Dietary Manager (CDM) and the Registered Dietician (RD) will participate in this meeting in which nutritional needs of residents who have experienced significant weight loss, or who have weights outside their normal range and residents with skin issues that require nutritional interventions will be reviewed. Nutritional care plans will be updated as a result of the collaboration in this meeting. Minutes of the meetings will be maintained. The RD will provide a minimum of two hours of instruction to the CDM on the requirements pertaining to nutritional care plans and appropriate interventions. The CDM will initiate nutrition assessments utilizing a revised nutrition assessment form. (see att. G) The RD is in the building one day per week and will review and complete the nutrition assessments. Entry of weights on resident charts will now be the responsibility of nurses rather than aides. The nurses have access to prior weight information	

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	05/25/12 - 95 pounds. A 05/04/12 dietary assessment review indicated the resident had edema and weight gain. A 06/08/12 dietary assessment review indicated the resident had a 6 % weight loss in one month and received yogurt with meals. There were no changes to the resident's care plan to address the resident's significant weight loss. Interview with Food Service Supervisor, on 08/08/12 at 1:30 P.M.. indicated she had spoken with the Registered Dietician and the dietician indicated she did not recommend revising the health care plan for Resident #19 because she had issues with edema and had been consuming 75 - 100 percent of her meals. The Food Service Supervisor indicated usually when there's a weight loss, she instructed tell nursing to institute fortified cereal and placed the intervention on the meal tickets. However, she did not keep copy of rehab tickets for the past time frame for Resident #19.		and will initiate reweighs according to the resident weighing policy. Nurses will be given a refresher in-service on the policy. IV. MONITORING: The RD will review the weekly skin report and weight report each week for the next 90 days. The RD will confirm that care plans and interventions have been initiated or updated accordingly. If no concerns are noted during that period, the RD will continue with random monitoring on a monthly basis for the 6 month period following. If concerns are noted, the monitoring process will start over from the beginning. The DON, or her designee, will also review resident charts on a weekly basis for the next 90 days to ensure that recommendations from the nursing department have been noted and incorporated into nutritional care plans and will audit resident weight changes to ensure that reweighs have been made when necessary. If no concerns are noted during that period, the DON, or her designee, will continue monitoring on a monthly basis for the next 6 months. If concerns are noted, the monitoring process will start over from the beginning. The QA Committee, which meets quarterly, will review the results of the monitoring. If at least 95% compliance is demonstrated, the Committee will decide on either a reduction in the frequency of	

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	3.1-35(d)(2)(B)		monitoring or a stop in the monitoring. If less than 95% compliance is demonstrated, the Committee will require that the original monitoring parameters continue until reviewed again at the next quarterly QA meeting.	

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F0323 SS=L	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on observations, record review, and interviews, the facility failed to ensure safe water temperature were maintained for 4 of 5 nursing units in the facility. This potentially affected 68 of 79 residents in the facility, including 21 of 79 residents who were cognitively impaired and able to ambulate and/or propel their own wheelchairs and could possibly burn themselves with the hot water. The immediate jeopardy began on 07/30/12 when the facility obtained unsafe, elevated hot water temperature readings and failed to take immediate action to remedy the situation to ensure safe water temperatures. There is a potential for a 3rd degree burn to occur in 2 (two) seconds when the water temperature reaches 148 degrees. The Administrator and the Director of Nursing were notified of the immediate jeopardy at 4:30 P.M., on 08/01/12. The immediate jeopardy that began on 07/30/12 was removed on 08/02/12 at 4:00 P.M. by immediately draining the hot water from the hot water heater tank, turning down the hot water heater, and replumbed the mixing valve	F0323	I. CORRECTIVE ACTION(S) FOR AFFECTED RESIDENTS IDENTIFIED: No residents were found to have been injured or harmed by the high water temperature. When the problem was brought to the attention of the administrator by the survey team leader, the Director of Environmental Services (ES) was immediately called to coordinate actions to lower the hot water temperatures. Maintenance personnel were dispatched to the mechanical room containing the hot water heater. The temperatures on the two water heaters feeding the affected area were turned back and the mixing valve was adjusted until the temperature gauge read within the acceptable range. The water heaters were emptied to a floor drain. The spigots in all resident rooms were also run out under supervision to drain the hot water out of the lines. After those steps were completed, maintenance personnel tested the water temperature in each room and found them all to be within the acceptable range of 100 – 120 degrees. The survey team also checked the water temperatures	08/10/2012

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	and hot water heater access. The facility remained out of compliance at a scope and severity of pattern with no actual harm with the potential for more than minimal harm that was not immediate jeopardy as the facility needed to continue to monitor the hot water temperatures to ensure the newly plumbed system distributed water at safe temperatures. . Finding includes: During an observation of the bathroom for Room 424, conducted on 08/01/12 2:55 P.M., the hot water temperature in the bathroom sink was noted to be 150 degrees Fahrenheit. There was visible steam coming from the water and a "caution - water hot" sign was noted to be taped to mirror above the sink. The hot water in the bathrooms for resident rooms #417 - 432 were assessed, on 08/01/12 from 2:55 P.M. - 3:25 P.M. and all were noted to be 150 degrees Fahrenheit. Interview with CNA (certified nursing assistant) #10, on 08/01/12 at 3:00 P.M., indicated the hot water temperatures had been "too hot" for at least the last two weeks on Hall #5. Hall #5 included Room #417 - 432 and housed 15 residents. The hot water temperature in the shower room, located on hall #2 was assessed on 08/01/12 at 3:40 P.M. and noted to be 150 degrees Fahrenheit. The hall #2 shower room was utilized to shower residents on hall 1, 2, and 3 which totaled 54 residents. An interview with housekeeper, employee #11, on 8/1/12 at 3:40 P.M., indicated the hot water "really got very hot." The housekeeper indicated it had been like that ever since he had started working at		and also determined that they were within the safe range. Water temps were confirmed to be in compliance within approximately one hour after Administrator was notified of the problem. II. CORRECTIVE ACTION(S) FOR POTENTIALLY AFFECTED RESIDENTS: All resident rooms in the healthcare center and one hall of Assisted Living are connected to the same hot water system. No resident contact with exessively hot water was reported at any time. Nursing staff assessed every resident in HC for signs and symptoms of burns. No residents of the facility were found to have been harmed or injured by hot water. III. STEPS TAKEN TO ENSURE CONTINUED COMPLIANCE: Prior to the commencement of this survey, the facility had employed the aid of 2 separate and respected plumbing contractors, in addition to facility maintenance personnel to address complaints from several residents that they sometimes experienced a lack of hot water. The central mixing valve was suspected to be the cause and was replaced. A third engineer was brought in to evaluate the system again as occasional complaints of cold water at seemingly random times and locations still continued. That engineer attributed the problem of cold water to an incompatibility of the new central mixing valve with	

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	the facility a few months ago. He indicated he thought it was supposed to be that hot. An interview with CNA #1 on 8/1/12 at 4:00 P.M. indicated there was no hot water last week but now the water is too hot. An interview with CNA #2 on 8/1/12 at 4:00 P.M. indicated there was no hot water last week but now the water is too hot. The resident rooms on hall #2 were assessed and noted to be between 146 degrees - 150 degrees. Hall #2 included rooms #399 - 415 and housed 18 residents. The bathrooms on hall #3 were assessed and noted to be 150 degrees Fahrenheit. Hall #3 included Rooms #433 - 233 and housed 17 residents. Hall #1 included Resident room #196 - 217 and housed 19 residents. The hot water temperatures were noted to be 150 degrees. Interview with the Maintenance supervisor, employee #12, on 08/01/12 at 3:40 P.M. indicated there was only one water heater for the health care and all of the water temperatures should read the same. The main water heater and mixing valve were observed on 08/01/12 at 3:45 P.M. with the Administrator, the Maintenance Director, employee #12, and a maintenance assistant, employee #13. The thermometer on the hot water heater was reading 136 degrees. Employee #13 indicated he had already turned the water heater down, "a few minutes ago", but could turn it down again. The Administrator indicated the mixing valve did		the existing plumbing leading into that valve. His assessment was that water temps were varying as the water usage dropped below a certain gallon-per-minute flow. (Up to this point, administration was unaware that there was a problem with water temps being too high. All reports that made it to administration had been of water temps being too low.) The plumber and engineer began work on the recommended re-plumbing at 8PM on the day the survey team found the water to be too hot and worked through the night to complete the job. Hot water was offline while the work was being done. During the course of their work, the plumbing contractor discovered that a check valve was not installed where it should have been to prevent cold water from flowing back toward the water heaters. The check valve was installed. It is assumed that the check valve was the true cause of the original cold water problems. Frequent water temp checks have continued since the aforementioned plumbing work was done and the temperatures are confirmed to be have been maintained under 120 degrees. A temperature monitoring device was installed on the output side of the mixing valve which is tied into the facility's fire alarm system. If the temperature measured coming out of the mixing valve exceeds 120 degrees, the device	

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	not have a temperature setting just a hot/cold side with arrows. He indicated the thermometer just registered the temperature of the water coming out of the hot water heater. The Maintenance supervisor, employee #12 then instructed his staff to drain the hot water heater tank in the utility room and the Administrator directed other maintenance staff to run the hot water in the pipes going to resident room sinks out and recheck the temperatures. The hot/cold valve was turned again to the cold side to reduce the temperature of the hot water. A recheck of the water temperatures throughout the building, at 4:15 P.M. indicated they were all reading between 104 degrees - 110 degrees. Interview with the Maintenance supervisor, on 08/01/12 at 3:20 P.M. indicated the facility had been experiencing trouble with too cool of water temperatures and had replaced the mixing valve a few weeks ago. He indicated since the mixing valve had been replaced the facility had been experiencing "erratic" water temperatures. He indicated a plumber was scheduled to come to the facility on 08/01/12 around 9:00 P.M. to work on the water temperature problems. Review of the July 2012 hot water temperature logs indicated on 07/24/12, with water temperatures ranging from 97 degrees - 123 degrees Fahrenheit. Handwritten on the 07/24/12 date was "quarter turn at 3:30 P.M." There were no other temperatures recorded until 07/30/12. The hot water temperatures on 07/30/12 were noted to range from 111 degrees Fahrenheit - 152 degrees Fahrenheit. All of the health care water temperature documentation, except on the 100 unit, ranged from 144 degrees Fahrenheit - 152 degrees Fahrenheit. There were no other hot		triggers a trouble alert in the alarm system which is monitored 24/7/365 by an alarm monitoring company. That company will immediately call the mobile phones of the Administrator, ES and Chief Executive Officer (CEO) who in turn will work with onsite staff to make sure that any necessary adjustments are made immediately. As an additional precautionary measure to ensure that every possible component of the domestic hot water system has been addressed the water heaters themselves, which were original to the building in 1988, have also been replaced with new high-quality, high-efficiency units. Administration recognizes that the failure that should have been avoided was ultimately a matter of staff education. Had staff who had knowledge of the excessive water temperatures immediately reported that information to their supervisor and they to their supervisor, the Administrator would have received this information, and being well aware of the danger of high water temps to residents, would have immediately taken action to see that the threat to resident safety was removed. Thus, all environmental services staff and nursing staff throughout the facility have been instructed and have signed off that they are now aware that they must immediately notify their supervisor if they hear	

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	water temperatures documented from 07/30/12 - 08/01/12. The immediate jeopardy that began on 07/30/12 was removed on 08/02/12 at 4:00 P.M. by the facility immediately draining the hot water from the hot water heater tank, turning down the hot water heater, and replumbed the mixing valve and hot water heater access. The facility remained out of compliance at a scope and severity of pattern with no actual harm with the potential for more than minimal harm that was not immediate jeopardy as the facility needed to continue to monitor the hot water temperatures to ensure the newly plumbed system distributed water at safe temperatures. The water temperatures were noted to be safe and a system was put into place to adequately monitor water temperatures and staff were inserviced and knowledgeable regarding the correct procedure to notify administrative staff if water temperature exceeded 120 degrees. . 3.1.-45(a)(1)		of or suspect that water may be too hot in any location throughout HC and AL. They have also been in-serviced that water temps are never to exceed 120 degrees. An additional in-service will be required of staff that describes the effects of hot water on the skin of residents at various temperatures and various lengths of time. (Please see att. K for copies of invoices for parts and labor from the several companies who were involved in all of the efforts to correct the water temperature problems.) IV. MONITORING: Frequent monitoring and an established chain of reporting is vital to the success of this plan of correction. A new log sheet has been developed on which to record random water temp testing results. The new log sheets have the date field pre-populated for the date each testing is required and the sample rooms pre-populated that will be tested in a pattern such that each room will be tested once per every 4 times that water temps are sampled. Maintenance personnel will test water temps at least one time per shift for the next 30 days. If any water temp is found to exceed the acceptable range, the ES and the Administrator are to be notified immediately. Nursing staff will also be notified of the condition so they can take any precautionary measures for residents deemed necessary.	

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			Maintenance personnel will adjust water heaters and the central mixing valve and re-test water temps until they have reached the acceptable level and the contract plumber will be called in to evaluate for any needed adjustments or repairs. Provided that no temperatures are found to be greater than 120 degrees, random temp checks will continue at least daily for the next 6 months. Any temperature check that confirms a result greater than 120 degrees will also restart the monitoring process to the beginning. After 6 months of daily temp checks without incident, temp checks will continue to be logged on a weekly basis thereafter. Both the ES and the Administrator will review the water temp logs daily for the next 30 days and weekly for the following 6 months. The logs will continue to be monitored on a monthly basis thereafter. The QA Committee, which meets quarterly, will review the results of the monitoring. Unless 100% compliance is demonstrated, the Committee will require that the original monitoring parameters continue until reviewed again at the next quarterly QA meeting.	

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F0325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview the facility failed to ensure 1 of 3 residents (#19) reviewed for nutritional needs, maintained acceptable nutritional parameters. Finding includes: The closed clinical record for Resident #19 was reviewed on 08/08/12 at 1:30 P.M. Resident #19 was admitted to the facility on 04/10/12 with a weight of 105 pounds. The resident's normal weight range was noted to be between 101 - 110 pounds. The resident noted to be in isolation on admission, had edema noted in both ankles, and had a decubitus, A dietary assessment was completed 04/12/12. It indicated the resident needed 1500 calories a day, 57 grams of protein. The assessment	F0325	I. CORRECTIVE ACTION(S) FOR AFFECTED RESIDENTS IDENTIFIED: Resident #19 had been discharged prior to the survey. When resident #19 was discharged, her decubitus had been healed and edema was no longer present. Her last weight measurement was within 3% of her normal weight range. II. CORRECTIVE ACTION(S) FOR POTENTIALLY AFFECTED RESIDENTS: Charts for all current residents are being reviewed to identify any residents with BMIs outside of recommended parameters. If any BMIs are found to be outside of recommended parameters, the CDM, with the guidance of the RD, will review their nutritional care plans to ensure appropriate nutritional interventions have been implemented. III. STEPS TAKEN TO ENSURE CONTINUED COMPLIANCE: The facility nutrition care planning policy and procedure has been	09/08/2012

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	indicated the resident had a BMI (body mass index of 18.5 and)was a low risk for weight loss/gain due to BMI 19 - 27. The assessment indicated the resident consumed 76 - 100 percent of her meals and consumed 1500 - 2000 calories a day. The assessment also indicated the resident required extra kilocalories and protein due to her skin issues and a yogurt to each meal, monitor intakes, and labs was recommended. A care plan was initiated on 05/04/12, for Alteration in Nutrition with a goal for the resident to maintain her weight within 5 pounds of current weight. The interventions to the plan included: monitor weight, record food intake and encourage resident to consume 75 - 100 percent, provide ordered diet. The care plan was reviewed on 06/07/12 and "goal remains the same" was documented. Review of the resident's subsequent weights indicated the following: 04/09/12 - 105.2 pounds, 04/30/12 - 116 pounds, 05/07/12 - 105 pounds, 05/25/12 - 95 pounds. A 05/04/12 dietary assessment review indicated the resident had edema and weight gain. Interview with the dietary manager, employee # , on		reviewed and revised to include specific parameters based on CMS guidelines. The RD will provide instruction and guidance to the CDM on proper nutrition care planning. The members of the weekly SNAR meetings will review residents to ensure they are maintaining acceptable parameters and will initiate new interventions as needed. Entry of weights on resident charts will now be the responsibility of nurses rather than aides. The nurses have access to prior weight information and will initiate reweighs according to the resident weighing policy. Nurses will be given a refresher in-service on the policy. IV. MONITORING: The RD will review the weekly skin report and weight report each week for the next 90 days. The RD will confirm that care plans and interventions have been initiated or updated accordingly. If no concerns are noted during that period, the RD will continue with random monitoring on a monthly basis for the 6 month period following. If concerns are noted, the monitoring process will start over from the beginning. The DON, or her designee, will also review resident charts on a weekly basis for the next 90 days to ensure that recommendations from the nursing department have been noted and incorporated into nutritional care plans and will audit resident weight changes to	

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	08/09/12 at 11:20 A.M., indicated she had reviewed the nurse's notes and the admission assessment and edema was noted so she had documented the weight gain as caused by edema. When queried as to the facility policy when there was a large weight gain and/or loss noted on a weekly weight, she indicated normally there would have been a reweigh to ensure accuracy. There was no reweigh documented for the 04/30/12 weight of 116.4 pounds for Resident #19. In addition, while nursing documentation continued to indicate the resident had 1 - 2 plus pitting and/or nonpitting edema in her ankles, there was no documentation the edema had drastically increased to account for the large weight increase. The medications for Resident #19 were not noted to have changed and there was no increase in any diuretic type medication for Resident #19. Documentation for the end of May 2012 through the resident's discharge did indicate the resident's edema was no longer present. A 06/08/12 dietary assessment review indicated the resident had a 6 % weight loss in one month and received yogurt with meals. There were no changes to the resident's		ensure that reweighs have been made when necessary. If no concerns are noted during that period, the DON, or her designee, will continue monitoring on a monthly basis for the next 6 months. If concerns are noted, the monitoring process will start over from the beginning.The QA Committee, which meets quarterly, will review the results of the monitoring. If at least 95% compliance is demonstrated, the Committee will decide on either a reduction in the frequency of monitoring or a stop in the monitoring. If less than 95% compliance is demonstrated, the Committee will require that the original monitoring parameters continue until reviewed again at the next quarterly QA meeting.	

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	care plan to address the resident's significant weight loss. Interview with Food Service Supervisor, on 08/08/12 at 1:30 P.M.. indicated on she had spoken with the Registered Dietician and the dietician indicated she did not recommend revising the health care plan for Resident #19 because she had issues with edema and had been consuming 75 - 100 percent of her meals. The Food Service Supervisor indicated usually when there's a weight loss,she instructed tell nursing to institute fortified cereal and placed the intervention on the meal tickets. However, she did not keep copy of rehab tickets for the past time frame for Resident #19. The BMI index had fallen for Resident #19 from her admission BMI of 18.5 to a discharge BMI of 16.8, which is below the recommended dietary parameters for adequate nutrition health. 3.1-46(a)(1)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions			
	Based on observation interview and record review the facility failed to maintain a clean ice machine for 1 of 4 ice machines in the facility reviewed (main kitchen) potentially affecting 77 of 79 residents receiving oral fluids. Findings include: During the initial kitchen tour on 8-1-12 at 10:00 AM, the large ice machine in the kitchen was observed to have a black, shiny, slick substance on the shield over the ice area. In an interview on 8-1-12 at 10:00 AM., Dietary Manager #8 indicated the black substance should not be there. A current cleaning schedule dated 6-25-12 indicated the filter had been changed on 6-25-2012 and the outside of the ice machine cleaned on Saturday 7-29-2012. The schedules did not indicate the inside of the ice	F0371	I. CORRECTIVE ACTION(S) FOR AFFECTED RESIDENTS IDENTIFIED: No residents were identified on the survey report to have been affected by the substance (assumed to be a form of algae) found on the shield over the ice bin. The substance was immediately cleaned off with a bleach solution when noted by the State inspector. II. CORRECTIVE ACTION(S) FOR POTENTIALLY AFFECTED RESIDENTS: No residents were found to be exhibiting signs or symptoms of being affected by the substance found on the shield of the health care kitchen's ice machine. III. STEPS TAKEN TO ENSURE CONTINUED COMPLIANCE: Manufacturer recommendations for cleaning and sanitizing of the inside of the ice machines is once every six months. The Environmental Services department is responsible for the inside cleaning which they have added to a preventative maintenance (PM) checklist. Dietary staff is responsible for the sanitizing procedure which will be done immediately following a cleaning	09/08/2012

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	machine had been cleaned. 3.1-21(i)(2)		while the ice is still emptied. Dietary has a cleaning log for the exterior (which includes the rim around the lid) which is done on a weekly schedule. They have added a visual inspection of the interior of ice machines to the weekly cleaning log and will notify ES if there is evidence of any foreign substance in the machine before the next regularly scheduled interior cleaning and sanitizing. Dietary staff have been given instruction on the additional procedure for ensuring sanitary ice machines. IV. MONITORING: The CDM will furnish a copy of the weekly cleaning/inspection logs to the Administrator at the end of each month for the next 6 months to confirm that cleanings and inspections are being done according to the schedule. The CDM will also visually inspect the interior and exterior of the ice machines on a monthly basis for the next 6 months to ensure that the cleanings have been thorough and effective. The QA Committee, which meets quarterly, will review the results of the monitoring. If at least 95% compliance is demonstrated, the Committee will decide on either a reduction in the frequency of monitoring or a stop in the monitoring. If less than 95% compliance is demonstrated, the Committee will require that the original monitoring parameters continue until reviewed again at	

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			the next quarterly QA meeting.	

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and record review the facility failed to ensure 1 of	F0441	Grace Village administration wishes to respectfully note that	09/08/2012

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	3 nursing staff (Employee #9) observed providing personal care maintained proper hand hygiene/glove use for 1 of 3 residents (#42) observed for personal hygiene care. Findings include: On 08/08/12 9:17 am, CNA #9 was observed preparing to provide care for Resident #42. The resident was on a bedpan and had pulled her call light and indicated she was ready to receive assistance to get off of the bedpan. CNA #9 was noted to wash her hands, put a box of disposable wipes on an overbed table, and donned a pair of gloves. After providing privacy, CNA #9 had directed Resident #42 to roll off of the bed pan. The resident had urinated and had a small solid piece of fecal matter still stuck to her buttock. Then CNA #9 removed bedpan and placed it at the end of the bed, then used disposable wipes to clean Resident #42's buttocks area after removing the piece of fecal matter. Next, without changing or removing her soiled gloves, CNA #9 obtained a tube of ointment from Resident #42's dresser top and put it on residents buttocks then reattached the brief		one of the findings related to this citation demonstrates an inherent flaw in the survey process and one that we have experienced several times in previous surveys. This finding is not based on documentation, but rather, observations of alleged wrongdoing by one inspector of one employee. No corraborating witness by the State and no other facility representative were present as a witness. CNA #9 is an experienced aide with a long record of service and excellent reviews. CNA #9 steadfastly denies the assertion of the inspector that she failed to follow proper perineal (peri) care procedures by neglecting to clean the front of resident #42 after she had urinated. Administration is inclined to believe the word of this trusted aide. Administration requests that all such future observations of personal caregiving be done with at least one member of nurse administration present as a witness. I. CORRECTIVE ACTION(S) FOR AFFECTED RESIDENTS IDENTIFIED: The tube of ointment used for resident #42 has been disinfected. Resident #42 was assessed and did not exhibit signs or symptoms of infection in the days following the allegation of incomplete peri care by CNA #9. II. CORRECTIVE ACTION(S) FOR POTENTIALLY AFFECTED RESIDENTS: All other residents	

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	tabs and pulled up a blanket over the resident. CNA #9 then excused herself, took the bedpan and went into the bathroom to clean it out and removed her gloves, and washed her hands. CNA #9 then came back to the resident and offered to remove Resident #42's outside pant, but the resident refused, CNA #9 did remove the resident's shoes, smoothed the blanket, attached her call light, and fixed her overbed table. CNA #9 did not provide peri care for the front of the resident even though she had urinated. Review of the undated facility policy, titled, "Perineal Care", provided by the Director of Nursing, on 08/08/12 at 11:25 A.M., included the following instructions: "6. Fill the bat (sic) basin with warm water and have the resident check the temperature; 7. put on gloves; 8. Assist the resident to spread legs and lift/bend knees, if possible; 9. Wet and soap folded washcloth...;11. Wipe from the front to the back and from the center of the perineum to thighs. Change washcloth as necessary; 12. For females: separate the labia. Wash urethra area first. Wash between and outside the labia in downward strokes, alternating from side to side and moving outwards to thighs. Use		residing on the unit where the alleged incomplete peri care occurred have been assessed and no signs or symptoms indicative of improper peri care were found. All bedside items on the unit likely to be touched during the process of pericare have been disinfected. III. STEPS TAKEN TO ENSURE CONTINUED COMPLIANCE: The peri care policy has been revised to specifically say that gloves must be changed after cleaning steps are accomplished which have soiled the gloves and before coming into contact with other items in the room that may also be involved in the completion of peri care. (see att.H) Nursing staff have been in-serviced on the revised policy and will also be required to demonstrate a complete peri care procedure (on a dummy). The facility will implement an annual skills competency assessment and an orientation skills competency assessment for all aides in which they will demonstrate proper peri care technique along with other basic nurse aide skills. IV. MONITORING: For the next 30 days, the DON, or her designee, will observe at least one peri care procedure per day, 5 days per week, to ensure that staff are following procedure correctly. Provided that no instances of incorrect procedure are noted, monitoring will continue on a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/09/2012
NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590	

(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
	a different part of the washcloth for each stroke....;14. Change water in basin. With a clean washcloth, rinse area thoroughly in the same direction as when washing." 3.1-18(a)		weekly basis for 90 days thereafter. If no concerns are noted during that period, random monthly monitoring will continue ongoing. Any incorrect following of peri care procedures found will result in remedial training and potentially disciplinary action for the staff involved. The QA Committee, which meets quarterly, will review the results of the monitoring. If at least 95% compliance is demonstrated, the Committee will decide on either a reduction in the frequency of monitoring or a stop in the monitoring. If less than 95% compliance is demonstrated, the Committee will require that the original monitoring parameters continue until reviewed again at the next quarterly QA meeting..	