STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155158		06/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF THE WILLOWS	1000 ELIZABETH DR VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00173390. Complaint IN00173390- Substantiated. No deficiencies related to the allegation are cited Unrelated deficiency cited. Survey dates: June 9 & 10, 2015 Facility number: 000078 Provider number: 155158 AIM number: 100289310 Census bed type: SNF/NF: 68 Total: 68 Census Payor type: Medicare: 13 Medicaid: 47 Other: 08 Total: 68 Sample: 4 Supplemental sample: 1 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exits or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of Appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. This facility respectfully requests	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155158		06/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF THE WILLOWS	1000 ELIZABETH DR VALPARAISO, IN 46383

(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
			consideration of paper compliance for the cited deficiencies	
F 0441 SS=E Bldg. 00	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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155158	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/10/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383	

(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
	(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observations, interview, and record review, the facility failed to ensure proper infection control practices and standards were maintained, related to handwashing after incontinence care was given to Resident #C and a call light was answered for supplemental Resident #F, for 1 of 3 residents observed for resident care in a total sample of 4 and a supplemental sample of 1. This had the potential to effect 25 of 26 residents who resided on the West Unit. (CNA #1, Residents #C and #F) Finding includes: During an observation on 06/09/15 at 7:20 p.m., Resident #C had been incontinent of urine and bowel movement. CNA #1 washed her hands, applied gloves and provided incontinent care to Resident #C, then dressed the resident in a clean brief and gown. CNA #1 then placed the soiled items in a plastic bag and removed her gloves. At 7:37 p.m., CNA #1 then left the room without washing her hands, and placed the soiled items in the soiled utility room, walked out of the soiled utility room	F 0441	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No resident's were adversely affected by the deficient practice. C.N.A #1 completed hand hygiene immediately following surveyor comment. The Director of Nursing ensured proper sanitation of resident F's water pitcher; unit ice chest and ice scoop. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** Hand hygiene competency/return demonstration completed on facility staff by the Department Managers in order to insure ongoing compliance and to prevent the deficient practice from potentially affecting other residents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** C.N.A #1 received immediate education related to hand hygiene and glove use from the Director of Nursing on 6/09/15. Facility staff to complete in service training including return demonstration related to hand hygiene and proper glove use by July 6, 2015.	07/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155158	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/10/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383	

(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
	without washing her hands, and answered a call light in Resident #F's room. CNA #1 then walked out of Resident #F's room holding a water pitcher in her hand. CNA #1 then went to the ice chest, which was kept in the West Dining Room, used the ice scoop and placed ice in Resident #F's pitcher. CNA #1 was then stopped from delivering the pitcher to Resident #F. During an interview at the time of the observation, CNA #1 indicated she had not washed her hands. The Director of Nursing then took the pitcher, ice chest, and ice scoop to the kitchen to be sanitized. 3.1-18(b)(1)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Nursing Administration to monitor hand hygiene through random selection of facility staff. Nursing administration will observe/audit 10 staff members complete hand hygiene on a weekly basis for 12 weeks and will observe 5 staff members complete hand hygiene on a weekly basis for 12 weeks after that (including observation on all 3 shifts) to insure compliance. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.	