

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 05/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PARK PLACE II, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4411 PARK PLACE DR FORT WAYNE, IN 46845
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: May 29 and 30, 2014</p> <p>Facility Number: 012582 Provider number: N/A AIM number: N/A</p> <p>Survey team: Rick Blain, RN - TC Tim Long, RN Carol Miller, RN Diane Nilson, RN (5/29/2014)</p> <p>Census bed type: Residential: 113 Total: 113</p> <p>Census payor type: Medicaid: 17 Other: 96 Total: 113</p> <p>Sample: 8</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on June 2, 2014 by Randy Fry RN.</p>	R000000	<p>This plan of correction is neither an agreement of wrong doing by this facility or it's staff members. Rather it is submitted for compliance purposes This facility alleges substantial compliance with this plan of correction as of May 30, 2014 and requests paper compliance or this survey</p>	
---------	--	---------	--	--

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.

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 05/30/2014	
NAME OF PROVIDER OR SUPPLIER  PARK PLACE II, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4411 PARK PLACE DR FORT WAYNE, IN 46845			
(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			
R000148	<p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:</p> <p>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility.</p> <p>(2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes.</p> <p>(3) All plumbing shall function properly and comply with state plumbing codes.</p> <p>(4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on observation and interview, the facility failed to ensure the electrical panels were readily accessible to the Maintenance Director. This deficiency had the potential to affect 37 residents on the Memory Care unit.</p> <p>Findings include:</p> <p>During the environmental tour on the Memory Care unit, on 5/29/14 at 3:00 p.m. with the Maintenance Director, the following was observed: In the electrical room, 2 of the 4 electrical panels on the</p>	R000148	The electrical room was cleared of all obstructions, so that all 4 panels were readily accessible. A sign was posted to remind staff not to store items in that room. Maintenance Director or General Manager to monitor, see attachmen A for QA tool x 6 months	05/30/2014			

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 05/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PARK PLACE II, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4411 PARK PLACE DR FORT WAYNE, IN 46845
--	---

(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
R000273	<p>wall were obstructed by an insulated dietary cart. Also, observed in the electrical room was an assortment of activity supplies, and a wheelchair.</p> <p>An interview with the Maintenance Director on May 29, 2014 at 3:00 PM, indicated the food cart was impeding access to 2 of the 4 electrical panels and was a direct violation. The Maintenance Director indicated the cart should not have been stored in the electrical room. The Maintenance Director further indicated when he had found a violation in the past he had addressed this in a monthly "all staff meeting".</p> <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, record review, and interview, the facility failed to ensure 1 of 2 cooks observed during the lunch meal, washed hands and/or changed gloves after touching different surfaces during food preparation and serving, and failed to ensure 2 dietary staff members had their hair entirely secured under a hair net. The facility also failed to ensure a fan located in the kitchen was free from</p>	R000273	<p>In-service was immediately held with all dietary staff on duty regarding hairnets, glove use and hand washing, by the General Manager. See attachment B An in-service on infection control and glove use was done by our dietician on May 30, 2014 See attachment C Fan was removed and leaned A sign has been posted that the fan is not to be blowing in the</p>	05/30/2014

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 05/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PARK PLACE II, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4411 PARK PLACE DR FORT WAYNE, IN 46845
--	---

(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
	<p>dust .</p> <p>Findings include:</p> <p>During observation of the lunch meal, between 11:00 a.m., and 11:30 a.m., on 5/29/14, dietary cook #1 was observed preparing food for the lunch meal. The cook was wearing gloves and was observed to open a drawer where condiments were stored with the gloved hand, take a bun from a plastic bag with the gloved hand, used the gloved hand to open a steamer where a pan of mushrooms were removed, take the temperature of the mushrooms, and take slices of cheese from a container and place on the hamburgers, without changing his gloves or washing his hands. The cook was observed opening the drawer where the condiments were stored several times, without removing the gloves.</p> <p>Dietary aide #2 was observed coming from the Server Alley into the kitchen several times during the lunch meal. She was wearing a hair net, but there was hair hanging out from the front and sides of the hair net.</p> <p>Dietary aide #3 was observed coming from the Server Alley into the kitchen several times during the lunch meal. She was wearing a ball cap on her head and</p>		<p>direction of the food serving area See attachment E or QA tool Re: hairnets. glove use and hand washing See attachment F for QA tool Re: Fan monitoring Dietary Manager or General Manager to monitor x 6 months</p>	

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 05/30/2014	
NAME OF PROVIDER OR SUPPLIER  PARK PLACE II, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4411 PARK PLACE DR FORT WAYNE, IN 46845			
(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			
	<p>had her hair in a bun in the back, but hair was noted to be hanging out of the hair net in the back.</p> <p>A fan was observed on the floor in the area Cook #1 was preparing hamburger sandwiches for lunch. The back of the fan was dusty, the fan was on and blowing in the direction of the food serving area.</p> <p>The Dietary Manager was interviewed, on the telephone, with the Administrator present, at 12 noon on 5/29/14. She indicated hair was supposed to be covered completely within the hair nets, and if caps were worn, hair was to be tucked up under the hat completely.</p> <p>The Clinical Director was interviewed, at 2:15 p.m., on 5/29/14, and indicated there was no policy for hair nets or fans. She provided a policy on Use of Gloves which indicated gloves should be worn for handling of food.</p>						