

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155616	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/20/2015
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NAME OF PROVIDER OR SUPPLIER ROBERT E LEE	STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN 47150
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(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
F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Date: January 13,14, 15, 18, 19, 20, 2015</p> <p>Facility number: 001145 Provider number: 155616 AIM number: 200120200</p> <p>Survey team: Gloria Reisert, MSW/TC Jennifer Sartell, RN Trudy Lytle, RN Joshua Emily, RN (January 14, 15, 16 and 20, 2015)</p> <p>Census bed type: SNF/NF: 67 Residential: 13 Total: 80</p> <p>Census payor type: Medicare: 03 Medicaid: 52 Other: 25 Total: 80</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>PREPARATION AND/ OR EXECUTION OF THIS PLAN OF CORRECTION IN GENERAL OR THIS CORRECTIVE ACTION IN PARTICULAR, DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THIS FACILITY OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THIS STATEMENT OF DEFICIENCIES. The plan of correction and specific corrective actions are prepared and/ or executed in compliance with state and federal laws.</p> <p>The facility is requesting a Desk Review of compliance for this plan of correction.</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.

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F000371 SS=D	<p>Quality review completed by Debora Barth, RN.</p> <p>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 follow policy for sanitary handling of food in one of three dining rooms during 3 of 3 lunch observations.</p> <p>Findings include:</p> <p>On 01/12/15 at 12:40 p.m., CNA # 3 was observed twice touching the bread with her bare fingers while removing it from the waxpaper sleeve to serve to two unspecified residents. Hand sanitizer was used by the CNA between tray service.</p> <p>On 01/13/15 at 12:25 p.m., CNA # 1 was observed holding the corner of a slice of bread to apply butter for an unspecified resident. CNA # 2 was observed to remove a slice of bread from the</p>	F000371	<p>1. No immediate action could be taken for the residents as they were not identified during the survey. However no residents presented with a negative outcome related to.</p> <p>2. No other residents were identified as being affected.</p> <p>3. The Nursing staff was immediately in-serviced related to the proper way to handle bread during meal service.</p> <p>4. The DON and/or Designee will be assigned to the dining rooms to ensure proper handling of food/bread occurs during meal service. The audits will occur 5 times weekly for 4 weeks then 3 times a week for 4 weeks then 2 times a week for 4 months. Any areas of concern will be addressed immediately. The results of the audits will be reviewed by the QA committee on a monthly basis</p>	01/22/2015

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	<p>waxpaper sleeve with his bare hands and place on the unspecified resident's tray. Both CNAs were observed to apply hand sanitizer between each resident's food service.</p> <p>On 01/15/15 at 12:30 p.m., during the lunch service in the Main Dining Room, CNA # 3 was observed to open a waxpaper package and pull out a dinner roll. She then pushed her thumbs into the roll to open it. The resident then stopped her from putting butter on the halves, because he did not want butter.</p> <p>On 01/15/15 at 1:12 p.m. the Dietary Manager # 1 provided a copy of the General Food Preparation and Handling, which indicated, but was not limited to, "Bare hands should never touch raw or ready to eat food directly."</p> <p>On 01/15/15 at 3:12 p.m., the Dietary Manager # 1 indicated the staff were not allowed to handle breads with bare hands when serving the residents in the Dining Room.</p> <p>3.1-21(i)(3)</p>		<p>to ensure compliance and review for the need of further educational needs.</p> <p>5. Date of Compliance: January 22, 2015</p>		

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R000000	Robert E. Lee was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R000000	PREPARATION AND/ OR EXECUTION OF THIS PLAN OF CORRECTION IN GENERAL OR THIS CORRECTIVE ACTION IN PARTICULAR, DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THIS FACILITY OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THIS STATEMENT OF DEFICIENCIES. The plan of correction and specific corrective actions are prepared and/ or executed in compliance with state and federal laws. The facility is requesting a Desk Review of compliance for this plan of correction.		