

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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 dates: February 10,11,12,13 and 14 , 2014</p> <p>Facility number: 000158 Provider number: 155255 AIM number: 100291490</p> <p>Survey Team: Julie Call, RN, TC Sue Brooker, RD Martha Saull, RN Virginia Terveer, RN</p> <p>Census bed type: NF: 60 SNF: 37 NCC: 5 Total: 102</p> <p>Census payor type: Medicare: 10 Medicaid: 41 Other: 51 Total: 102</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on</p>	F000000	000-This Plan if correction is to serve as Woodview-A Waters Community's allegation of compliance.	

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: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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
F000280 SS=D	<p>February 19, 2014 by Randy Fry RN.</p> <p>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.</p> <p>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.</p> <p>Based on interview and record review, the facility failed to ensure the plan of care for a resident was updated after the documented admission weight was revised to a weight 40 pounds lighter, which resulted in the resident not having received dietary supplements as prescribed by the Dietician based on the resident's more recently</p>	F000280	F280 It is the practice of Woodview-A Waters Community to assess and identify residents who may be at nutritional risk and intervene with a nutritional plan in an attempt to prevent weight loss. Resident # 146's weight was corrected during survey and the plan of care was updated and a nutritional supplement was initiated. All resident's weights/BMI's have been reviewed and no other residents	03/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805			
(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>documented lower weight for 1 of 3 nutritional care plans reviewed. Resident #146</p> <p>Findings include:</p> <p>On 2/11/14 at 2 P.M., the clinical record of Resident #146 was reviewed. The resident was admitted to the facility on 1/22/14. Diagnoses included, but were not limited to, the following: Aphasia, Dysphagia oral phase, lack of coordination, Depression, Functional Digestive Disorder and Alzheimer's Disease. The initial MDS (minimum data set assessment) was completed on 1/29/14 and included, but was not limited to, the following: severely impaired cognition; for mood "poor appetite or overeating" was "yes" for symptom presence and symptom frequency was 7-11 days (half or more of the days); required limited assistance (resident highly involved in activity) for eating and ADL (activities of daily living) support provided was one person physical assist; walking in room and corridor did not occur and extensive assistance required for locomotion on unit. The height was documented as 70 inches and weight of 166 pounds (lbs). The CAA (Care Area Assessment)</p>		<p>were affected by the deficient practice. Woodview –A Waters Community has reviewed our Nutrition Risk Program policy (Exhibit A) and the policy is current and indicates that new admissions will be weighed weekly x 4 weeks. Woodview has added an addendum (Exhibit B) titled "The 5 lb Rule", which indicates when a discrepancy of 5 pounds or greater is identified, the assigned weight staff will obtain a re-weight. In the event, the re-weight is still 5 lbs or greater, the weight staff will report to the Director of Nursing (DON) or designee and the CDM (Certified Dietary Manager). The Director of Nursing or designee, and the CDM will determine the individual needs of a resident and implement interventions if appropriate. Dietary and Nursing will meet weekly for a Nutrition At Risk (NAR) meeting and ensure weekly weights are current and that there are no weight discrepancies exceeding a 5 lb difference which has not been reviewed or intervened upon as necessary. The QA/QI (Quality Assurance and Quality Improvement) Committee will oversee the NAR committee, monthly, to ensure the NAR committee is meeting weekly and to ensure residents' weights do not reflect any 5 lb or greater discrepancies without a Nursing Director and CDM review and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>Summary indicated for Nutritional Status, the area for "Care Area Triggered and/or Care Planning Decision" was left blank. This form was signed on 1/31/2014 by the RN Coordinator for the CAA Process and also signed by the MDS/Care Plan Coordinator on 2/4/14.</p> <p>A "Mini Nutritional Assessment" dated 1/23/14 by the Dietician, included, but was not limited to, the following: "Mild dementia, BMI (body mass index) 23 or greater, score of 12." This form indicated a score of 12 was "normal nutritional status."</p> <p>A "Progress Note", dated 1/29/14 at 5:25 P.M. from the FSM (Food Service Manager) included, but was not limited to, the following: "Ht (height) of 5'10" (70 inches) and weight of 166 lb...intake ranges at 50-75%...will be at risk and we will monitor intake and weight."</p> <p>On 2/11/14 at 2:22 P.M., the "Progress Notes" were reviewed from 1/23/14 to 2/11/14 and included, but were not limited to, the following: On 1/23/14 Dietary documented a BMI (body mass index) of 23 or greater. The total score for the "Mini</p>		<p>intervention. Weight Staff will be educated regarding the new policy addendum and "5 lb Rule". Training will be completed by 3/16/14 (See Exhibit C) .</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>Nutritional Assessment" was 12 points. The form indicated 12 - 14 points was normal nutritional status. The Dietician documented on 1/23/14 the resident was on a regular diet, with a weight of 166 lbs and a BMI of 25.</p> <p>On 1/29/14 at 5:25 P.M., the Food Service Manager (FSM) documented the following: "Height of 5'10" (70 inches) and weight of 166 lb...intake ranges 50-75% and fluid intake is fair...will be at risk and we will monitor intake and weight."</p> <p>A plan of care, dated 1/29/14, addressed the following: "Resident is at risk for altered intake and weight...also needs (assistance) with meal set up, cueing during meals." The Goal was "...will eat at least 50% of meals served so not to have a significant weight change noted..will maintain weight at 165# +/-5%." Interventions included, but were not limited to, "...monitor intake and weight."</p> <p>On 2/12/14 at 2:30 P.M., LPN #14 was interviewed. She indicated the resident ate 50 % of her meal today and was currently didn't receive a supplement.</p> <p>On 2/13/14 at 2:40 P.M. the Monthly</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>Vital Sheet was reviewed. This form included, but was not limited to, the following: Ideal Body weight and Height were left blank on the form; 1/22/14 an initial weight of 166 lbs was documented on admission but the weight was crossed out and had the numbers "126" written above the 166 lb. The initials "LF" were also documented by the 126. The next weight was documented as 2/11/14 with a weight of 122 (lbs).</p> <p>At this time, the weekly weight form was also reviewed and indicated the following: and initial weight on 1/22/14 was documented as 166 lb. and this had been crossed out with "re-weight 126" written above it. The next weight was documented as 2/3/14 of 122 (lbs) and 2/11/14 with a weight of 123 (lbs).</p> <p>On 2/13/14 at 1:40 P.M., the FSM and Dietician were interviewed. The indicated the resident had been admitted on 1/22/14 and had an admission weight of 166 lb. The FSM and Dietician indicated by reviewing their notes, the resident had an admission weight of 166 lbs. and a height of 5 ft 10 inches (70 inches). The FSM indicated the weight logs included in the clinical records were monthly weights and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>the weight logs contained the weekly weights. At the time, the Dietician indicated she finds the resident's admission weight on the Face Sheet and the Nursing Admission Assessment. At the time, the Dietician indicated in the current clinical record, the resident's documented weight on the Face sheet and the Nursing Admission Assessment both documented a weight of 166 lb and a height of 5'8" (68 inches). The Dietician indicated she looks at the face sheet and the nursing admission assessment for the initial weight.</p> <p>At the time, the FSM and Dietician were made aware of the weights on the Monthly Vital Sheet and the Weekly Weight Form. The Dietician indicated she and the FSM would not have looked at the resident's monthly weights yet, as staff were in the process of doing obtaining monthly weights at the time. The Dietician indicated the resident's ideal body weight range would be 135 lbs. - 165 lbs. The FSM indicated he developed the Nutrition Care Plan for the resident and this care plan was based on the documented weight of 166 pounds.</p> <p>At the time, the Dietician indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>she did an initial Nutrition Assessment on 1/23/14 and the resident's BMI was 25 and this care plan was based on the documented weight of 166 pounds. The Dietician indicated the normal range for a BMI was 19 - 25. She indicated the resident's BMI was on the high end of normal. The FSM indicated he saw the resident on 1/29/14 and 2/4/14.</p> <p>The Dietician indicated after a resident is admitted, the facility lets her know who needs to have a nutritional assessment. The Dietician indicated she is at the facility once a week. She indicated this resident had not been seen by the NAR (Nutritional At Risk) team yet as the resident "was too new." The Dietician indicated the NAR team met monthly.</p> <p>On 2/13/14 at 1:55 P.M., the FSM was interviewed. He indicated the facility was to obtain weekly weights on a resident after admission. The FSM indicated if the resident was weighed on 1/22/14, her next weekly weight should have been on 1/29/14. He indicated the nursing staff initiated the weekly weight sheets. The FSM indicated he was aware of the initial weight of the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>resident of 166 lbs. He indicated he documents the initial care plan within the first 5 - 14 days from the resident's admission. He indicated this resident had not yet been reviewed in the NAR meeting and the next NAR meeting was to be the next week. The FSM indicated the resident's meal intakes, were in the range of 50-75%. The FSM indicated he was not aware of the documented weight of the resident of 126 lbs and he also indicated the weight of 126 lbs. would have been a significant drop. The FSM indicated if he would have been aware of this weight, the resident's care plan would have been changed and indicated the BMI would have been affected. He indicated for a resident with a low BMI, a supplement would have been started and the facility would monitor the weight of the resident closely. The FSM indicated as a new admission, the resident was on weekly weights for 4 weeks to monitor her and the the resident would be monitored at the NAR meeting. The FSM indicated at the time, the resident's care plans will be revised.</p> <p>On 2/13/14 at 2:25 P.M., the ADON (Assistant Director of Nursing) was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>interviewed. She indicated newly admitted residents were weighed weekly x 4 weeks, and then monthly. The ADON indicated the resident should have been weighed again on 1/29/14 but wasn't weighed until 2/3/14. At the time, the ADON reviewed the Monthly Vital Sheet and the Weekly Weight form. She was unsure the date the resident's weight was changed to from 166 lb on admission to 126 lb. She indicated documentation was lacking on the clinical record of the date the revision was made to the resident's weight (from 166 lbs to 126 lbs) and if the weight was with or without a wheelchair. The ADON indicated the care plan was generated from the admission weight. She indicated the original care plan was done by the FSM. The ADON indicated the restorative aide obtained the resident's weights. At the time, the ADON indicated the resident's family helps to feed her and the family also brings in shakes for this resident.</p> <p>On 2/13/14 at 3 P.M., the ADON provided a copy of the Dietician's progress note, dated 2/13/14. This note included the following: "Weekly wt (weight) sheets indicate that admission wt of 166# may have been incorrect and a weight of 126#</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>was entered. Weekly wts following this have wts at 122# and 123#. Monthly wt is 122#. BMI is 17.6-low weight. Will ask for 4 oz healthshakes bid (twice a day). Will also add magic cups to lunch and supper trays for added calories. Will monitor."</p> <p>On 2/14/14 at 9:23 A.M., the Dietician was interviewed. She indicated if she would have known the resident weighed 122 lb., the Resident would have been started on a supplement. The Dietician indicated at the time, that she (the Dietician) was not notified of the weight change.</p> <p>On 2/14/14 at 9:45 A.M., the FSM was interviewed. He indicated the care plan for this resident had been updated. He provided a copy at the time. The revised care plan, dated 2/13/14, included, but was not limited to, the following: "Resident is at risk for altered intake and weight...has a low BMI...will gain 1 to 5# per month...offer supplements as planned and/or ordered...monitor intake and weight."</p> <p>3.1-35(d)(2)(B)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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
--------------------	--	---------------	---	----------------------

F000323 SS=E	<p>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 observation, interview and record review, the facility failed to ensure potentially hazardous chemicals were maintained in a secure manner for 4 of 4 shower room observations of units in the facility.</p> <p>Findings include:</p> <p>On 2/10/14 at 11:40 A.M., in the South Hall shower room, the following was observed: cabinets which were positioned on the floor, were observed to have doors on the front. The doors were below waist level for a 5 foot 2 inch person. Both cabinet doors were unlocked and easily opened by pulling the door opened. When the door was opened, observed in this cabinet was the following: Dollar General</p>	F000323	F323 It is the practice of Woodview-A Waters Community to ensure that the residents' environment remains as free of accident hazards as is possible. The unsecured chemicals were secured during survey and no residents were affected by the deficient practice. To prevent a reoccurrence, all staff will be in-serviced regarding Woodview's policy regarding storage of chemicals (See exhibit D), and the training will include ensuring staff are aware that disciplinary actions will be rendered to any staff who are found to be non-compliant. Training will be completed by 3/16/2014 (See Exhibit I). Nurse Managers will be responsible for monitoring for staff compliance and observing for any unsecured chemicals, at a minimum of 2 times weekly. The Nurse Manager will be responsible for collecting any observed unsecured chemicals	03/16/2014
-----------------	--	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805			
(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>brand citrus scented disinfectant spray. This cabinet had no locking mechanisms on it.</p> <p>Beside the tub was an upright standing cabinet. This cabinet was also unlocked and was observed to have 4 bottles of "April bath body wash", which was in a wash basin on a shelf, positioned below waist level for a 5 ft 2 inch person standing. At the time, there were no staff and/or residents in the shower room.</p> <p>On 2/10/14 at 11:45 A.M., the North hall shower room was observed. Between the hall and the shower room, was an alcove, without a door, which housed a cabinet. The unlocked cabinet was observed to have a bottle of "Dermasoft with aloe." At the time, there were no staff and/or residents in the shower room area. Residents were observed to be ambulating and self propelling in wheelchairs throughout the survey.</p> <p>On 2/10/14 at 11:50 A.M., the Skilled unit shower was toured and the following was observed: a bottle of "Lemon Lift Heavy Duty Kitchen and Bathroom cleaner was on the waist level sink counter top. This 20</p>		and implementing disciplinary actions to any non-compliant staff as appropriate. The Nurse Manager will utilize an audit form (See exhibit E) to document the monitoring and any required intervention and be required to submit the audits to the QA/QI Committee who will oversee the Nurse Managers' compliance with monitoring (See exhibit F).				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>oz. product was labeled "Ecolab." The label also indicated to "keep out of reach of children."</p> <p>Underneath the sink countertop, there were cabinet doors, which had a locking mechanism in place but the cabinet doors were unlocked. In the unlocked cabinet space was the following observed: 2 bottles of Niagra spray starch and 2 spray bottles of D-Cide Disinfectant cleaner (which the label was observed to indicated to "Keep out of reach of children.").</p> <p>Also observed in this shower room, was a tall, free standing floor cabinet. This cabinet had a flap type mechanism, in which a pad lock could be placed to lock the cabinet. The flap type mechanism was observed to not have a pad lack in place, and the cabinet was unable to be locked. The following items were observed unsecured in this cabinet: 2 bottles of Jergen lotion with no name on them; 2 bottles of "Sparkle mouthwash" with no identifying resident name and the bottle documented "DO NOT SWALLOW"; in a wash basin (with no identifying resident names) were observed the following: 2 combs and 1 brush, two tubes of toothpaste, 2 bottles of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>body wash and shampoo gel, tube of A and D ointment, and 2 bottles of Dermasoft with Aloe (which label indicated for external use only); also on the shelf was an opened box of Epison salt; and a bottle of "April Fresh, Icy Mint Mouthwash (the label indicated to "keep out of reach of children."</p> <p>At this time, CNA #2 was observed to come into the shower room, open the tall free standing cabinet, and then close it without locking the cabinet before exiting the shower room.</p> <p>On 2/10/14 at 11:55 A.M., the Rehabilitation Unit shower room was observed. The tall cabinet in the shower room was found to be unlocked. The outside of the doors were observed to have a flap type mechanism in which a pad lock would be placed to lock the doors. The interior of the cabinet was observed with an 8 oz bottle of "April bath and body wash and gel" observed to be on a shelf in the unlocked cabinet. Also observed inside the unlocked cabinet on a shelf was an unlocked pad lock.</p> <p>On 2/10/14 at 4 P.M., the Skilled Unit Shower room was observed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805			
(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>The upright cabinet remained unlocked with the above described items still unlocked.</p> <p>On 2/10/14 at 4 P.M., the South unit Shower room remained with the spray bottle of citrus disinfectant spray still in the cabinet located below the sink.</p> <p>On 2/10/14 at 4:10 P.M., the Administrator (Adm) was made aware of the items which were not locked in the South, North, Rehabilitation and Skilled unit shower rooms. The Administrator indicated at the time, none of the items, which were observed unlocked in the shower rooms should have been left unsecured.</p> <p>On 2/14/14 at 8:30 A.M., the Adm was interviewed. She indicated the chemicals and soaps, should not been left out unattended and unsecured in the shower rooms. She indicated that typically the residents keep their personal supplies in their rooms and these are taken to the shower room when the resident is showered.</p> <p>At the time, the Adm provided the following MSDS information: " *Toothpaste, Fluoride, Sparkle</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>Fresh: for eye contact: flush with copious amounts of water.</p> <p>*Jergens original scent moisturizer: avoid contact with eyes, if this occurs, flush well with water; in the event of ingestion, contact a poison control center or a physician.</p> <p>*April Bath Body Wash and Shampoo Gel with Aloe Vera: in case of accidental ingestion seek professional assistance or contact a poison control center immediately;</p> <p>*Colgate Toothpaste: if swallowed drink 3-4 glasses of water. DO NOT INDUCE VOMITING. Call a physician.</p> <p>*Dermasoft with Aloe: if ingested consult a physician</p> <p>*Disinfectant Spray G: Inhalations of high concentrations may cause irritation of the respiratory tract. Intentional misuse by concentrating and inhaling vapors may be harmful or fatal. Eyes: will cause irritation; Ingestion: will cause irritation, nausea, vomiting, pain and possible loss of consciousness.</p> <p>From the Internet site U.S. Department of Health and Human Services indicated the following for Denture Adhesive: May produce transient eye irritation. Ingestion of large amounts may cause nausea or vomiting. Esophageal blockage</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805		
(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>could occur in rare cases.</p> <p>From the Internet site of Material Safety Data Sheet, (MSDS) the following hazard statement: Caution, may cause irritation to eyes, skin and respiratory system. Avoid contact with eyes and prolonged contact with skin Avoid breathing dusts. Wash thoroughly after handling. Keep container closed. Use with adequate ventilation. The MSDS form for Niagra Spray Starch was dated 5/7/07 and included, but not limited to, the following: "Intentional misuse by deliberately concentrating and inhaling the contents can be harmful or fatal...Ingestion may cause temporary discomfort in the mouth and upper gastrointestinal tract.</p> <p>On 2/14/14 at 10:45 A.M., the Social Service staff provided the following information: in the facility there were 12 residents identified by the facility as cognitively impaired (had a BIMS (Brief interview for mental status) of 8 or less and were independently mobile. Two residents were identified by the facility as cognitively impaired and independently ambulatory.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805		
(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	
F000325 SS=D	<p>3.1-45(a)(1)</p> <p>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 observation, interview and record review, the facility failed to ensure significant documented weight variances were communicated to the Dietician and/or Food Service Manager (FSM), which resulted in a resident with a low BMI (body mass index) not having received supplements in a timely manner for 1 of 5 residents who met the criteria for being underweight and not receiving any supplements. Resident #146</p> <p>Findings include: On 2/11/14 at 2 P.M., the clinical record of Resident #146 was reviewed. The resident was</p>	F000325	F325 It is the practice of Woodview-A Waters Community to assess and identify residents who may be at nutritional risk and intervene with a nutritional plan in an attempt to prevent weight loss. Resident # 146's weight was corrected during survey and the plan of care was updated and a nutritional supplement was initiated. All resident's weights/BMI's have been reviewed and no other residents were affected by the deficient practice. Woodview -A Waters Community has reviewed our Nutrition Risk Program policy (Exhibit A) and the policy is current and indicates that new admissions will be weighed weekly x 4 weeks. Woodview has added an addendum (Exhibit B) titled "The 5 lb Rule", which indicates when a discrepancy of 5	03/16/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805		
(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>admitted to the facility on 1/22/14. Diagnoses included, but were not limited to, the following: Aphasia, Dysphagia oral phase, lack of coordination, Depression, Functional Digestive Disorder and Alzheimer's Disease. The initial MDS (minimum data set assessment) was completed on 1/29/14 and included, but was not limited to, the following: severely impaired cognition; for mood "poor appetite or overeating" was "yes" for symptom presence and symptom frequency was 7-11 days (half or more of the days); required limited assistance (resident highly involved in activity) for eating and ADL (activities of daily living) support provided was one person physical assist; walking in room and corridor did not occur and extensive assistance required for locomotion on unit.</p> <p>The height was documented as 70 inches and weight of 166 pounds (lbs). The CAA (Care Area Assessment) Summary indicated for Nutritional Status, the area for "Care Area Triggered and/or Care Planning Decision" was left blank. This form was signed on 1/31/2014 by the RN Coordinator for the CAA Process and also signed by the MDS/Care Plan Coordinator on</p>		<p>pounds or greater is identified, the assigned weight staff will obtain a re-weight. In the event, the re-weight is still 5 lbs or greater, the weight staff will report to the Director of Nursing (DON) or designee and the CDM (Certified Dietary Manager). The Director of Nursing or designee, and the CDM will determine the individual needs of a resident and implement interventions if appropriate. Dietary and Nursing will meet weekly for a Nutrition At Risk (NAR) meeting and ensure weekly weights are current and that there are no weight discrepancies exceeding a 5 lb difference which has not been reviewed or intervened upon as necessary. The QA/QI (Quality Assurance and Quality Improvement) Committee will oversee the NAR committee, monthly, to ensure the NAR committee is meeting weekly and to ensure residents' weights do not reflect any 5 lb or greater discrepancies without a Nursing Director and CDM review and intervention. Weight Staff will be educated regarding the new policy addendum and "5 lb Rule". Training will be completed by 3/16/14 (See Exhibit C) .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>2/4/14.</p> <p>A "Mini Nutritional Assessment" dated 1/23/14 by the Dietitian, included, but was not limited to, the following: "Mild dementia, BMI (body mass index) 23 or greater, score of 12." This form indicated a score of 12 was "normal nutritional status."</p> <p>A "Progress Note", dated 1/29/14 at 5:25 P.M. from the FSM (Food Service Manager) included, but was not limited to, the following: "Ht (height) of 5'10" (70 inches) and weight of 166 lb...intake ranges at 50-75%...will be at risk and we will monitor intake and weight."</p> <p>A "Progress Note" dated 2/4/14 at 11:22 A.M., from the FSM, indicated the following: "Review done...with intake of 50-75%...will continue to be at risk and we will continue to monitor intake and weight."</p> <p>On 2/11/14 at 2:22 P.M., the "Progress Notes" were reviewed from 1/23/14 to 2/11/14 and included, but were not limited to, the following: On 1/23/14 Dietary documented a BMI (body mass index) of 23 or greater. The total score for the "Mini</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>"Nutritional Assessment" was 12 points. The form indicated 12 - 14 points was normal nutritional status. The Dietitian documented on 1/23/14 the resident was on a regular diet, with a weight of 166 lbs and a BMI of 25.</p> <p>On 1/28/14 at 6:30 A.M., the Nursing notes indicated resident eats without difficulty and staff assist.</p> <p>On 1/29/14 at 5:25 P.M., the Food Service Manager (FSM) documented the following: "Height of 5'10" (70 inches) and weight of 166 lb...intake ranges 50-75% and fluid intake is fair...will be at risk and we will monitor intake and weight."</p> <p>A plan of care, dated 1/29/14, addressed the following: "Resident is at risk for altered intake and weight...also needs ast (assistance) with meal set up, cueing during meals." The Goal was "...will eat at least 50% of meals served so not to have a significant weight change noted..will maintain weight at 165# +/-5%." Interventions included, but were not limited to, "...monitor intake and weight."</p> <p>On 2/3/14 at 8:03 A.M., Nursing documented "...eats and drinks 50% of food and fluids..."</p> <p>On 2/4/14 at 11:22 A.M., the FSM</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>documented "...cont on regular diet, no chewing and/or swallowing problems... able to feed self fair with tray set-up and cueing with reminders to finish meal served...intake of 50-75%...will continue to be at risk and we will continue to monitor intake and weight..."</p> <p>On 2/6/14 at 2:02 P.M., Nursing documented "...Consumes 50-100% regular diet..."</p> <p>On 2/7/14 at 2:31 P.M., Nursing documented "...requires feeding by either staff or family."</p> <p>On 2/8/14 at 6:13 A.M., Nursing documented "...consumes 50-100% regular diet..."</p> <p>On 2/9/14 at 11:14 A.M., Nursing documented "...staff assist with meals-usually eats 50%..."</p> <p>On 2/11/14 at 4:09 A.M., Nursing documented "consumes 50-100% regular diet...requires feeding/cueing at meals."</p> <p>On 2/12/14 at 2:30 P.M., LPN #14 was interviewed. She indicated the resident ate 50 % of her meal today and was currently didn't receive a supplement.</p> <p>On 2/13/14 at 2:40 P.M., the "Food/Fluid Intake Record" was reviewed for February 2014. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>following totals of intake were documented from 2/1/14 - 2/13/14: Breakfast intake documented 1 intake of 75%, 12 intakes were 50%; Lunch intake documented 8 times of 25% and 5 times of 50%; Dinner intake documented as 12 meals of 25% intake (this meal had not yet been served on 2/13/14).</p> <p>On 2/13/14 at 2:40 P.M. the Monthly Vital Sheet was reviewed. This form included, but was not limited to, the following: Ideal Body weight and Height were left blank on the form; 1/22/14 an initial weight of 166 lbs was documented on admission but the weight was crossed out and had the numbers "126" written above the 166 lb. The initials "LF" were also documented by the 126. The next weight was documented as 2/11/14 with a weight of 122 (lbs).</p> <p>At this time, the weekly weight form was also reviewed and indicated the following: and initial weight on 1/22/14 was documented as 166 lb. and this had been crossed out with "re-weight 126" written above it. The next weight was documented as 2/3/14 of 122 (lbs) and 2/11/14 with a weight of 123 (lbs).</p> <p>On 2/13/14 at 1:40 P.M., the FSM</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>and Dietitian were interviewed. They indicated the resident had been admitted on 1/22/14 and had an admission weight of 166 lb. The FSM and Dietician indicated by reviewing their notes, the resident had an admission weight of 166 lbs. and a height of 5 ft 10 inches (70 inches). The FSM indicated the weight logs included in the clinical records were monthly weights and the weight logs contained the weekly weights. They indicated the resident was on a regular diet. At the time, the Dietitian indicated she finds the resident's admission weight on the Face Sheet and the Nursing Admission Assessment. At the time, the Dietitian indicated in the current clinical record, the resident's documented weight on the Face sheet and the Nursing Admission Assessment both documented a weight of 166 lb and a height of 5'8" (68 inches). The Dietitian indicated she looks at the face sheet and the nursing admission assessment for the initial weight.</p> <p>At the time, the FSM and Dietitian were made aware of the weights on the Monthly Vital Sheet and the Weekly Weight Form. The Dietician indicated she and the FSM would not have looked at the resident's</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>monthly weights yet, as staff were in the process of doing obtaining monthly weights at the time. The Dietician indicated the resident's ideal body weight range would be 135 lbs. - 165 lbs. The FSM indicated he developed the Nutrition Care Plan for the resident and this care plan was based on the documented weight of 166 pounds.</p> <p>At the time, the Dietitian indicated she did an initial Nutrition Assessment on 1/23/14 and the resident's BMI was 25. The Dietician indicated the normal range for a BMI was 19 - 25. She indicated the resident's BMI was on the high end of normal. The Dietitian indicated the resident's BMI of 25 was calculated using the documented admission weight of 166 pounds. The FSM indicated he saw the resident on 1/29/14 and 2/4/14.</p> <p>The Dietitian indicated after a resident was admitted, the facility let her know who needed to have a nutritional assessment. The Dietitian indicated she was at the facility once a week. She indicated this resident had not been seen by the NAR (Nutritional At Risk) team yet as the resident "was too new." The Dietitian indicated the NAR</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>team met monthly.</p> <p>On 2/13/14 at 1:55 P.M., the FSM was interviewed. He indicated the facility was to obtain weekly weights on a resident after admission. The FSM indicated if the resident was weighed on 1/22/14, her next weekly weight should have been on 1/29/14. He indicated the nursing staff initiated the weekly weight sheets. The FSM indicated he was aware of the initial weight of the resident of 166 lbs. He indicated he documents the initial care plan within the first 5 - 14 days from the resident's admission. He indicated this resident had not yet been reviewed in the NAR meeting and the next NAR meeting was to be the next week. The FSM indicated the resident's meal intakes, were in the range of 50-75%. The FSM indicated he was not aware of the documented weight of the resident of 126 lbs and he also indicated the weight of 126 lbs. would have been a significant drop. The FSM indicated if he would have been aware of this weight, the resident's care plan would have been changed and indicated the BMI would have been affected. He indicated for a resident with a low BMI, a supplement would have been</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805			
(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>started and the facility would monitor the weight of the resident closely. The FSM indicated as a new admission, the resident was on weekly weights for 4 weeks to monitor her and the the resident would be monitored at the NAR meeting. The FSM indicated at the time, the resident's care plans will be revised.</p> <p>On 2/13/14 at 2:15 P.M., CNA #3 was interviewed. She indicated when a resident was admitted who was in a wheelchair (wc), the facility weighs the wc empty and then that specific wc was what the resident was weighed in on admission. CNA #3 indicated the Restorative CNA is the staff that usually weighs the residents but that she is also aware how to weigh residents. CNA #3 indicated an empty wc usually weights "about 48 lbs."</p> <p>On 2/13/14 at 2:25 P.M., the ADON (Assistant Director of Nursing) was interviewed. She indicated newly admitted residents were weighed weekly x 4 weeks, and then monthly. The ADON indicated the resident should have been weighed again on 1/29/14 but wasn't weighed until 2/3/14. At the time, the ADON reviewed the Monthly Vital Sheet</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>and the Weekly Weight form. She was unsure the date the resident's weight was changed to from 166 lb on admission to 126 lb. She indicated documentation was lacking on the clinical record of the date the revision was made to the resident's weight (from 166 lbs to 126 lbs) and if the weight was with or without a wheelchair. The ADON indicated the care plan was generated from the admission weight. She indicated the original care plan was done by the FSM. The ADON indicated the restorative aide obtained the resident's weights. At the time, the ADON indicated the resident's family helps to feed her and the family also brings in shakes for this resident.</p> <p>On 2/13/14 at 2:40 P.M., the ADON provided a current copy of the facility policy and procedure which addressed monitoring of weights. The portion of the provided policy did not contain a title to the policy but was dated 12/04. The policy included, but was not limited to, the following: "...following initial admission, weights will be obtained and monitored weekly x 4 weeks....Nursing will obtain all weights..."</p> <p>On 2/13/14 at 3 P.M., the ADON</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>provided a copy of the Dietitian's progress note, dated 2/13/14. This note included the following: "Weekly wt (weight) sheets indicate that admission wt of 166# may have been incorrect and a weight of 126# was entered. Weekly wts following this have wts at 122# and 123#. Monthly wt is 122#. BMI is 17.6-low weight. Will ask for 4 oz healthshakes bid (twice a day). Will also add magic cups to lunch and supper trays for added calories. Will monitor."</p> <p>On 2/13/14 at 3:02 P.M., the ADON provided a copy of the current facility policy and procedure for "Balance Scale and Weigh Residents." This policy and procedure was undated and included, but was not limited to, the following: "Wheelchair scale - move resident in wheelchair onto scale and lock wheels...record weight..." Documentation was lacking in the policy and procedure regarding inclusion and/or exclusion of the wheelchair in regards to the documented weight of the resident.</p> <p>On 2/14/14 at 9:23 A.M., the Dietitian was interviewed. She indicated if she would have known the resident weighed 122 lb., the Resident would have been started</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>on a supplement. The Dietician indicated at the time, that she (the Dietitian) was not notified of the weight change.</p> <p>On 2/14/14 at 9:45 A.M., the FSM was interviewed. He indicated the care plan for this resident had been updated. He provided a copy at the time. The revised care plan, dated 2/13/14, included, but was not limited to, the following: "Resident is at risk for altered intake and weight...has a low BMI...will gain 1 to 5# per month...offer supplements as planned and/or ordered...monitor intake and weight."</p> <p>3.1-46(a)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805		
(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	
F000364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on observation, interview and record review the facility failed to ensure hot soup was served and held at the appropriate temperature during 2 of 2 meal observations in 1 of 3 dining rooms potentially affecting 20 to 24 residents of 20 to 24 residents who ate their meals in the Skilled Unit dining room.</p> <p>Findings include:</p> <p>1. During an observation of the lunch meal on 2/12/14 in the Skilled Unit dining room, the following was observed:</p> <ul style="list-style-type: none"> - At 11:07 a.m., Certified Nursing Assistant (CNA) #1, was observed dishing up tomato soup into individual bowls from the soup tureen on the counter in the Diet Kitchen in the Skilled Unit. She placed the dished bowls onto a service tray. - At 11:11 a.m., CNA #1, was 	F000364	<p>F364 It is the practice of Woodview-A Waters Community to obtain a hot food temperature prior to service. (See policy # 304-Exhibit K). No residents were affected by the deficient practice. The facility has since stopped the practice of having a soup urn on the unit. Instead, dietary will serve any individuals who desire soup, directly from the kitchen, where a serving temperature will be obtained prior to service by dietary staff. Food temperatures will be recorded by dietary staff prior to service and documented on a food temp log. To ensure compliance, the QA/QI Committee will oversee temperature logs (See Exhibit F) and require the CDM to submit food temperature logs monthly for review.</p>	03/16/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>observed to carry the service tray containing the dished bowls of tomato soup from the Diet Kitchen into the dining room. One bowl of soup was given to a resident from the service tray. The service tray containing the remaining dished bowls of tomato soup were placed on the counter in the dining room. The bowls of soup were not placed on a heating element to keep them at the appropriate temperature.</p> <p>- At 11:18 a.m., the service tray containing the dished bowls of tomato soup remained on the counter. The bowls of soup were not on a heating element to keep them at the appropriate temperature.</p> <p>- At 11:25 a.m., the service tray containing the dished bowls of soup remained on the counter in the Skilled Unit dining room. The bowls of soup were not on a heating element to keep them at the appropriate temperature. CNA #2 was observed going from table to table offering the resident's bowls of soup.</p> <p>- At 11:32 a.m., CNA #3 was observed to serve a bowl of the tomato soup to a resident and began feeding him. The bowl of tomato</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>soup had been on the service tray on the counter since 11:11 a.m. The bowls of soup were not on a heating element to keep them at the appropriate temperature.</p> <p>2. During an observation of the lunch meal 2/13/14 at 10:26 a.m., Dietary #4 was observed pushing a open cart from the facility kitchen to the diet kitchen in the Skilled Unit. The cart contained trays of covered soup bowls and a covered stainless steel stock pot containing cream of mushroom soup. Dietary #4 was then observed to plug the soup tureen into the electrical outlet which was on the counter in the Diet Kitchen, add water to the bottom of the tureen, and place the stainless steel stock pot of soup into the tureen. She was not observed to check the temperature of the soup after placing it in the tureen. A tour of the Diet Kitchen did not produce a temperature log or a food thermometer.</p> <p>CNA #3 and CNA #5 were interviewed on 2/13/14 at 12:30 p.m. During the interview they indicated residents were offered soup at lunch and were provided with a bowl of soup if they requested. They also</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>indicated they did not take the temperature of the soup prior to service to the residents. They further indicated the dietary staff who brought the soup from the kitchen to the Diet Kitchen in the Skilled Unit took the temperature of the soup.</p> <p>The Registered Dietitian was interviewed on 2/13/14 at 2:34 p.m. During the interview she indicated the temperature of the soup was taken in the facility kitchen, but had not been taken after the soup was delivered to the Diet Kitchen in the Skilled Unit.</p> <p>The Certified Dietary Manager (CDM) was interviewed on 2/13/14 at 2:14 p.m. During the interview he indicated the soup for the Skilled Unit was taken from the facility kitchen to the Diet Kitchen between 10:15 a.m. and 10:30 a.m. He also indicated the temperature of the soup was taken prior to the soup leaving the kitchen, but was not taken again after the soup was placed in the soup tureen in the Diet Kitchen. He further indicated the soup should only be dished into the soup bowls right before service to the residents if they requested soup. The bowls of soup should be kept</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805		
(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>hot until served.</p> <p>A current undated facility policy "Food Temperatures", provided by the CDM on 2/13/14 at 3:25 p.m., indicated "...The temperatures of the food items will be taken and properly recorded for each meal...Hot food items may not fall below 135 (degrees) F (Fahrenheit) after cooking...Temperatures should be taken periodically to ensure hot foods stay above 135 (degrees) F...during the portioning, transporting and delivery process until received by the individual recipient...."</p> <p>3.1-21(a)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805			
(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			
F000371 SS=E	<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 ensure staff washed their hands for the recommended amount of time and after touching soiled surfaces and failed to ensure staff did not touch residents food during 3 noon meal observations in the South dining room which had the potential to affect all of the 18-24 residents who ate their meals in the South dining room.</p> <p>Findings include:</p> <p>1. On 12-10-2014, the following observations were made in the South dining room: -12:03 p.m., CNA #6 washed her hands and touched the trash can lid with her hand when disposing of the paper towel and served a resident her meal tray. -12:05 p.m., CNA #7 washed her hands and touched the trash can lid with her hand when disposing of the paper towel and served a resident</p>	F000371	F371 It is the policy of Woodview-A Waters Community, to ensure food is served in a sanitary manner. No residents were affected by the deficient practice. Woodview –A Waters Community will replace dining room trash cans, with foot operated trash cans, to prevent staff from contaminating their hands when disposing of their paper-towels after washing hands. Staff training will be completed by 3/16/2014 (See Exhibit I) and include Bare hands/food handling and Proper Handwashing. Staff providing meal services will be observed for compliance at least 2 times weekly, by assigned nursing managers (See Exhibit J), to ensure proper bare food handling and hand-washing. The Nursing managers will be responsible for ensuring staff compliance and immediately addressing non-compliance issues and reporting any non-compliances and training interventions to the QA/QI committee. The QA/QI Committee will oversee the nurse managers for compliance in monitoring staff (See Exhibit F)	03/16/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805			
(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>her meal tray.</p> <p>-12:06 p.m., CNA #6 removed a resident's bread from the wrapper with her bare hand, held the bread in her hand while buttering the bread and laid the buttered bread on the resident's plate.</p> <p>-12:08 p.m., CNA #6 removed a resident's bread from the wrapper with bare hand, held the bread in her hand while buttering the bread and laid the buttered bread on the resident's plate.</p> <p>-12:13 p.m., CNA #7 was feeding a resident her meal. CNA #7 got up and obtained a clothing protector by opening a cabinet door with her hand, placed the clothing protector on the resident and began feeding the resident without washing hands or using hand hygiene.</p> <p>2. On 2-11-2014, the following observations were made in the South dining room:</p> <p>-11:59 a.m., CNA #8 washed her hands and touched the trash can lid with her hand when disposing of the paper towel and proceeded to serve residents their meal.</p> <p>-12:02 p.m., CNA #9 removed a resident's bread from the wrapper with her bare hand and placed the bread on the resident's plate.</p> <p>-12:09 p.m., CNA #6 removed a</p>		<p>during dining room meal service, for proper handling of food and hand-washing for at least 6 months, at which time the QA/QI will review the need for continuation and determine necessity of continued monitoring</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>resident's bread from the wrapper with her bare hand, held the bread in her hand while buttering the bread and laid the bread on the resident's plate.</p> <p>-12:10 p.m., CNA #6 removed a resident's bread from the wrapper with her bare hand, held the bread in her hand while buttering the bread and laid the bread on the resident's plate.</p> <p>3. On 2-13-2014, the following observations were made in the South dining room:</p> <p>-12:00 p.m., CNA #10 moved a resident's wheelchair by grasping handles of wheelchair with her hands and began feeding another resident their meal without washing hands or using hand hygiene.</p> <p>-12:02 p.m., CNA #6 touched 2 rolling chairs with her hands, adjusted her glasses and began feeding a resident her meal without washing her hands or using hand hygiene.</p> <p>-12:04 p.m., CNA #7 got up from feeding a resident her lunch, went to a cabinet and opened the cabinet door with her hand, left the dining room, returned to the dining room and began feeding 2 residents their meal without washing her hands or using hand hygiene. CNA #7</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014	
NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805			
(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>adjusted one resident's clothing protector and without washing hands or performing hand hygiene, she resumed feeding another resident their meal.</p> <p>-12:07 p.m., CNA #11 washed her hands for 10 seconds and began feeding a resident her lunch.</p> <p>An interview with the CDM (Certified Dietary Manager) on 2-13-2014 at 2:24 p.m., indicated staff should wash their hands for 20 seconds prior to serving residents their meal and perform hand hygiene or handwashing after touching a person or object (such as a chair or glasses) prior to serving or feeding residents their meals. In addition, the CDM indicated staff should not touch bread with their bare hands.</p> <p>A policy "Handwashing" dated 8-22-2012 and provided by the CDM on 2-13-2014 at 3:25 p.m., indicated "...how to wash hands...turn on the faucet using a paper towel to avoid contaminating the faucet...wet hands and forearms with warm water...apply antibacterial soap...scrub well...for a minimum of 10-15 seconds within the 20-second hand washing procedure..." The policy included "when to wash</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>hands" and indicated the following "...clean hands and exposed portions of arms...immediately before engaging in food preparation including working with exposed food...after touching bare human body parts...after handling soiled equipment...after engaging in other activities that contaminate the hands...."</p> <p>A policy "Ready to Eat Foods" dated 8-21-2012 and provided by the CDM on 2-13-2014 at 3:25 p.m., indicated "...the employee may not contact exposed, ready to eat food with their bare hands...."</p> <p>An undated document posted by the sink in the South dining room titled "Please Wash Your Hands" was provided by the DON (Director of Nursing) on 2-14-2014 at 12:12 p.m., indicated the following "handwashing procedure...4. Wash Hands for at least 20 seconds...."</p> <p>3.1-21(i)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805		
(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	
F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to</p>	F000441	F441 It is the practice of Woodview-A Waters Community	03/16/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>ensure clean linens were transported in a manner to prevent infection which had the potential to affect 102 of 102 residents who resided in the facility.</p> <p>Findings include:</p> <p>1. On 2/11/14 at 10:35 a.m., Laundry Staff #13 was observed carrying a stack of clean white towels balanced between her right arm and shoulder and up against her uniform while she pulled the covered laundry cart behind her with her left hand. The Laundry Staff #13 transported the uncovered clean towels approximately 20 feet, from the linen closet in the Nurse's Station on the Rehabilitation Unit to resident's room 308.</p> <p>2. An observation on 2-10-2014 at 2:50 p.m., indicated Laundry Staff</p>		<p>to ensure personnel handle, store, and transport linens in a way to prevent the spread of infection. No residents were affected by the deficient practice. To prevent a re-occurrence, all laundry staff will be in-serviced regarding facility policy on handling of, storing, processing, and transporting of linens (See Exhibit G). Upon completion of training, each laundry employee will be required to perform a return demonstration of correct technique. Training will be completed by 3/16/14. The Laundry Supervisor will be responsible for ensuring correct technique is followed by laundry aides and will address performance issues individually and provide training and disciplinary action as needed for non-compliances. The Infection Control Nurse will be responsible for overseeing the Laundry Departments compliance with proper technique by inspection. The infection Control Nurse will perform random audits (See Exhibit H), at least 2 times a week. The Infection Control Nurse will report any laundry staff non-compliance to the Laundry Supervisor. The Infection control nurse will audit activity and Laundry compliance to the Quality Assurance Committee who will oversee the compliance with Audits (See Exhibit F)</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>#12 carried clean linens in her arms and held the linens against her uniform from the linen closet at the ICF (Intermediate Care Facility) nurse's station down the hall to a resident's room in the Rehabilitation hall.</p> <p>3. An observation on 2-11-2014 at 11:53 a.m., indicated Laundry Staff #13 carried bed linens in her arms against her uniform down the South hall to a resident's room.</p> <p>4. An observation on 2-12-2014 at 9:38 a.m., indicated Laundry Staff #13 unloaded a clean linen cart with folded resident gowns. The Laundry Staff #13 stacked the clean gowns in her arms, against her uniform and placed the gowns into the clean linen closet.</p> <p>An interview with the Director of Environmental Services on 2-14-2014 at 9:46 a.m., indicated staff should deliver clean laundry to the clean areas with the clean laundry covered and when placed in the clean linen area or resident room, the clean linens should be carried away from the body.</p> <p>A policy "Handling Clean Linens" dated 12-12-2009 and provided by</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805
---	---

(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>the Director of Environmental Services on 2-14-2014 at 10:15 a.m., indicated "...all linens shall be carried away from your body and clothing...."</p> <p>3.1-19(g)(2)</p>			