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 05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD RIDGE ASSISTED LIVING	17650 GENERATIONS DR SOUTH BEND, IN 46635

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: May 19, 20 and 21, 2015 Facility Number: 001148 Provider Number: 001148 AIM Number: N/A Census bed type: Residential: 54 Total: 54 Sample: 7 These State Residential findings are cited in accordance with 410 IAC 16.2-5.	R 0000	Our facility strives to provide the best care possible. In accordance with that policy, we have addressed the following issue	
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on observation and interviews, the facility failed to follow their policy	R 0091	What corrective action(s) will beaccomplished for those residents found to have been	06/30/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	regarding medication storage for 1 of 1 multi-dose box of injectable medication. Finding includes: On 5/19/2015 at 2:30 P.M., a medication storage review indicated one multi-dose box of Copaxone 40 mg (milligrams), was stored in the medication refrigerator in the medication cart room, adjacent to the nurse's station. The Copaxone was not contained in a labeled and locked container marked specifically for medication. Other items stored in the medication refrigerator at that time included but were not limit to; unopened cans of juice, a cooked chicken leg, an opened package of zinger cupcakes, an opened can of pop, and an opened jar of applesauce. On 5/19/2015 at 2:30 P.M., an interview with QMA (Qualified Medication Aide) #16, indicated the applesauce belonged to a resident, and the remainder of the food belonged to employees. QMA #16 indicated injectable medications were routinely stored in this refrigerator along with juices for diabetic residents, and employees should not store food in the medication refrigerator. during an interview on 5/21/2015 at 11:15 A.M., the AD (Administrative		affected by the deficientpractice; No residents were affected -Howthe facility will identify other residents having the potential to be affectedby the same deficient practice and what corrective action will be taken; Noresidents were affected -Whatmeasures will be put into place or what systemic changes the facility will maketo ensure that the deficient practice does not recur; Facility identified and put into place arefrigerator designated only for medication storage. TheHealth Services Director will audit the refrigerator daily to ensure there isno food in the refrigerator designated for medications. -Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place;and TheAdministrator or his/her designee will audit the refrigerator and logs weeklyfor six months to ensure compliance findings will be reported to the QualityCommittee for review and recommendation to change in frequency based upon auditfindings.	

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	Director) indicated employees should not store personal food in the medication refrigerator. On 5/21/2015 at 11:30 A.M., the policy entitled Policy & Procedure, Food and Nutrition Services, dated December, 2009, was reviewed. The policy indicated, "...Medications may be stored in the refrigerator with food, if they are labeled and locked in a container marked specifically for medication...."			
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals			

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	and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on observation, interview and record review, the facility failed to document completion of fire drills. This has the potential to affect 54 out of 54 residents. Findings include: During an interview on 5/19/15 at 10:30 A.M., the Administrator indicated "the fire drills are not being done appropriately...." On 5/19/15 at 12:57 P.M., review of the fire drills documentation indicated that fire drills were not performed quarterly on each shift from July 2014 through March 2015. On 5/20/15 at 11:04 P.M., review of the current policy "Disaster and Emergency Plans" dated January, 2007 provided by the Administrator, indicated "Fire Drills will meet the regulations...."	R 0092	-What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice; No residents were affected -Howthe facility will identify other residents having the potential to be affectedby the same deficient practice and what corrective action will be taken; Noresidents were affected -Whatmeasures will be put into place or what systemic changes the facility will maketo ensure that the deficieny. FireMarshall present to conduct fire drill with Administrator to include thetransmission of a fire alarm signal and simulation of emergency conditions on5/26/15. Fire drills will be conducted quarterly on each shift as per regulation. -How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place; Fire drills willbe conducted monthly by the maintenance Director and followed up byadministrator to	06/12/2015

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			ensure fire drills are conducted on all three shifts every 6months. TheAdministrator or his/her designee will review fire drill records monthly forsix months to ensure fire drills are being conducted as per regulations.	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to ensure a specific policy and procedure was written and implemented for pre-employment reference checks for 2 of 10 employees. (CNA #11 and CNA #12) Finding includes: On 5-20-15 at 10:00 A.M., the employee records for CNA (Certified Nursing Assistant) #11 and CNA #12 were reviewed. There was no documentation of reference checks completed for either employees. On 5-20-15 at 1:11 P.M., the Administrator indicated they complete 2 reference checks for new employees.	R 0116	· What corrective action(s) will be accomplishedfor those residents found to have been affected by The deficient practice; Noresidents were affected. · How the facility will identify other residentshaving the potential to be affected by the same deficient practice and whatcorrective action will be taken; Noresidents were affected · What measures will be put into place or whatsystemic changes the facility will make to ensure that the deficient practicedoes not recur; The Administrator or his/her designee will review all new hireemployee folders before employee starts to ensure 2 reference checks arecompleted. A policy has been put in place to address pre-employment reference checks. · How the corrective action(s) will be	06/30/2015

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	On 5-20-15 at 1:20 P.M., the Regional Director indicated they did not have a policy related to reference checks.		monitoredto ensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place; The Administrator or his/her designee willreview new hire records monthly for six months to ensure pre-hiringrequirements including reference checks were completed and findings will bereported to the Quality Committee for review and recommendation to change infrequency based upon audit findings.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents			

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	effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on interview and record review, the facility failed to ensure 3 hours of dementia-specific training was completed annually for 5 of 10 employees. (LPN #9, CNA #10, CNA #11, LPN #14 and Dietary Manager) Finding includes: On 5-20-15 at 10:00 A.M., the employee records for LPN (Licensed Practical Nurse) #9, CNA (Certified Nursing Assistant), CNA #10, CNA #11, LPN #14 and the Dietary Manager were reviewed. There was no documentation of 3 hours of dementia inservicing completed in the last year. On 5-20-15 at 1:12 P.M., the Regional Director indicated they have not completed any dementia training since 11-8-2013. No policy related to dementia inservicing	R 0120	-What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice; No residents were affected -Howthe facility will identify other residents having the potential to be affectedby the same deficient practice and what corrective action will be taken; Dementiatraining will be completed upon hire and according to pre-scheduled dates in 2016 -Whatmeasures will be put into place or what systemic changes the facility will maketo ensure that the deficient practice does not recur;	06/12/2015

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	was provided by the facility.		Dementiatraining was pre-scheduled on the all staff in-service calendar. The Administrator or his/her designee willcomplete employee file audits and all staff sign in sheet audits to ensure 100%completion of Dementia training. Effective May 26 all current employees haveconcluded Dementia training -How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place; The Administratoror his/her designee will review new hire records monthly for six months toensure requirements including Dementia training were completed and findingswill be reported to the Quality Committee for review and recommendation tochange in frequency based upon audit findings	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident			

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	contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			
	Based on interview and record review, the facility failed to ensure a second step Mantoux testing was completed for 4 of	R 0121	What corrective action(s) will beaccomplished for those residents found to have been	06/12/2015

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	10 employees, documentation of a chest x-ray was completed for 1 of 10 employees and Mantoux testing was completed prior to or within 1 month of an employee starting work for 1 of 10 employees. (Cook #8, CNA #12, Dietary Aide #13, HSC, LPN #9 and CNA #11). Finding includes: On 5-20-15 at 10:00 A.M., the employee records for Cook #8, CNA (Certified Nursing Assistant) #12, Dietary Aide #13, HSC (Health Service Coordinator), LPN #9, and CNA #11 were reviewed. In the file for Cook #8, CNA #12, Dietary Aide #13 and HSC there was no documentation of a second step Mantoux test completed. In the file for LPN #9 there was no documentation of a chest x-ray completed upon hire when ordered. In the file for CNA #11, hire date 11-21-14, the only Mantoux test completed was dated 1-18-15. On 5-20-15 at 1:10 P.M., the Regional Director indicated they were missing a lot of second step Mantoux testing documentation. On 5-20-15 at 1:11 P.M., the Administrator indicated the Mantoux testing should be done upon hire.		affected by the deficientpractice; No residents were affected -Howthe facility will identify other residents having the potential to be affectedby the same deficient practice and what corrective action will be taken; Noresidents were affected. All staff PPDare updated and complete Chestx-rays are complete on all necessary employees. -Whatmeasures will be put into place or what systemic changes the facility will maketo ensure that the deficient practice does not recur; TheAdministrator or his/her designee will review all new hires information beforestarting his/or shift. TB test tracking forms were put in place to identifyemployees needing a TB test or chest x-ray. -How the correctiveaction(s) will be monitored to ensure the	

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	On 5-21-15 at 9:28 A.M., the Administrator indicated she could not find a chest x-ray for LPN #9 and they did not have a policy specific to Mantoux testing.		deficient practice will not recur,i.e., what quality assurance program will be put into place; The Administratoror his/her designee will review records and TB test tracking forms monthly forsix months to ensure and findings will be reported to the Quality Committee forreview and recommendation to change in frequency based upon audit findings.	
R 0122 Bldg. 00	410 IAC 16.2-5-1.4(g) Personnel - Deficiency (g) The facility must prohibit employees with communicable disease or infected skin lesions from direct contact with residents or their food if direct contact will transmit the disease. An employee with signs and symptoms of communicable disease, including, but not limited to, an infected or draining skin lesion, shall be handled according to a facility's policy regarding direct contact with residents, their food, or resident care items until the condition is resolved. Persons with suspected or proven active tuberculosis will not be permitted to work until determined to be noninfectious and documentation is provided for the employee record. Based on interview and record review, the facility failed to ensure a pre-screening health status was completed for 6 of 10 employees. (Cook #8, CNA #10, CNA #11, CNA #12,	R 0122	· What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected · How the facility will identify other	06/12/2015

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	Dietary Aide #13 and LPN #14) Finding includes: On 5-20-15 at 10:00 A.M., the employee records for Cook #8, CNA (Certified Nursing Assistant) #10, CNA #11, CNA #12, Dietary Aide #13, and LPN (Licensed Practical Nurse) #14 were reviewed. There was no documentation of completion of a pre-screening health status report done. On 5-20-15 at 1:11 P.M., the Administrator indicated "we send the new employees to [name of local clinic]...." On 5-20-15 at 1:20 P.M., the Regional Director indicated they did not have a policy related to pre-screening of new employees.		residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All new hire staff will report to Administrator for location to complete physical What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Administrator or his/her designee will review all new hire information before starting his/or shift. All new hires are required to complete a physical at the designated location provided by the facility prior to reporting to work on a designated employer form. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Administrator or his/her designee will review new hire records monthly for six months to ensure pre-hiring requirements including physicals are completed and findings will be reported to the Quality Committee for review and recommendation to change in frequency based upon audit findings.	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.			

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	Bases on observation and interview, the facility failed to ensure equipment was clean and in good repair related to the ice machine in 1 of 1 kitchens. Finding includes: On 5/19/15 at 10:45 A.M., an observation of the ice machine indicated the machine was constantly dripping water, a milky film was across the front, and a white and brown crusty build up was underneath by the dispensing area. The DM (Dietary Manger) indicated at this time "we clean it weekly on Mondays... that is just hard water build up on it...." During an interview on 5/20/15 at 2:10 P.M., the Administrator indicated maintenance is responsible for the cleaning of the ice machine every two weeks. Maintenance takes it apart and cleans inside of it and dietary wipes down the outside of daily. "We don't have a policy on cleaning of the ice machine...."	R 0154	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Daily cleaning log put into place What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Company contracted to repair and descale ice machine quarterly How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Administrator or his/her designee will review company cleaning records and recommendations for twelve months to ensure ice machine clean and in good repair. Findings will be reported to the Quality Committee for review and recommendation to change infrequency based upon audit findings.	06/12/2015
R 0192 Bldg. 00	410 IAC 16.2-5-1.6(p) Physical Plant Standards - Nonconformance (p) The facility shall have a janitor's closet conveniently located on each resident occupied floor of the facility. The janitor's			

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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
	closet shall contain a sink or floor receptacle and storage for cleaning supplies. The door to the janitor's closet shall be equipped with a lock and shall be locked when hazardous materials are stored in the closet. Based on observation and interview, the facility failed to ensure the janitor's closet door was closed in 1 of 1 kitchens. Finding includes: On 5/19/15 at 10:20 A.M., during the initial kitchen tour with the DM (Dietary Manager) an observation was made of the Janitor's closet. The door to the closet was observed to be open at that time with chemicals stored on the shelves of the closet. A sign on the door read "Please Keep Door Closed at All Times." The DM indicated, "yes, it should be closed...." On 5/19/15 at 2:26 P.M., review of the current policy, "Food and Nutrition Services," dated December 2009, provided by the Administrator, indicated, "... 2. Medication, biological, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods...." During an interview on 5/20/15 at 2:10 P.M., the Administrator indicated "... the door to the Janitors closet in the kitchen should be closed all the time...."	R 0192	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected -How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Dietary staff was educated to ensure the janitors close stays closed -What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Administrator or his/her designee will audit the kitchen area to ensure the janitor's closet is closed. Findings will immediately be reported to the Dietary Manager -How the corrective action(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place; The Administrator or his/her designee will conduct random audits monthly for six months to ensure janitors closet is closed. Findings will be reported the Quality Committee for review and recommendation to change in frequency based upon audit findings.	06/12/2015

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R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to ensure a self medication administration assessment was updated for 1 of 1 residents reviewed for self medication. (Resident #2) Finding includes: On 5-19-15 at 2:30 P.M., the record for Resident #2 was reviewed. Resident #2 was admitted on 6-2-12. Physician orders indicated the resident self medicates. A "Interview & Assessment for Medication Self-Management" indicated it was completed on 12-4-12.	R 0216	•□□□□□□□□What corrective action(s) will be accomplishedfor those residents found to have been affected by The deficient practice; Noresidents were affected. •□□□□□□□□How the facility will identify other residentshaving the potential to be affected by the same deficient practice and whatcorrective action will be taken; Allcharts were audited to ensure if resident self-medicates a self-medicationassessment is completed quarterly •□□□□□□□□What measures will	06/12/2015

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	On 5-19-15 at 3:45 P.M., the Regional Director indicated the self-medication assessments should be updated quarterly. On 5-19-15 at 3:50 P.M., the Administrator indicated the self-medication assessments should be updated twice a year. On 5-20-15 at 9:39 A.M., review of the "Self-Administration of Medication" policy, dated 2006, received from the Administrator at this time, indicated "...4. Determine the ability of the resident to self administer medications using the Medication Self Administrator Interview form...7. Complete or update a resident's assessment and service plan reflecting the resident's ability to self administer medications and the service provided by the community...."		be put into place or whatsystemic changes the facility will make to ensure that the deficient practicedoes not recur; The Health ServicesDirector completed chart audits on May 29th to ensure 100%completion of self-medication assessments. The Health Services Director orhis/her designee will complete chart audits to ensure 100% completion ofself-medication assessments every quarter •□□□□□□□□How the corrective action(s) will be monitoredto ensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place; Administrator/designeewill choose 5 random charts monthly and conduct an audit for updatedself-medication audits. The Administrator or his/her designee will review chartaudit records monthly for six months to ensure self-medication assessments areupdated including quarterly and findings will be reported to the QualityCommittee for review and recommendation to change in frequency based upon auditfindings.	
R 0272 Bldg. 00	410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature. Based on observation, interview and record review, the facility failed to ensure	R 0272	•□□□□□□□□Whatcorrective action(s) will be accomplished	06/12/2015

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	food and milk was served at appropriate temperatures. This had the potential to affect 52 of 54 residents that received food and milk from 1 of 1 kitchens. Finding includes: On 5/19/15 at 12:00 P.M., during food temping with the DM (Dietary Manager) a glass of milk was temped at 51.8 degrees. The DM indicated at this time "milk should be below 41 degrees F [Fahrenheit]...." On 5/19/15 at 12:05 P.M., a glass of milk was observed sitting on the dining room table waiting for resident to come down for lunch. An interview with employee # 4 at this time indicated, "I place all the milks on the table for the residents that drink milk at 11:45 A.M., that way they are there when they come down... I place the extra's back on the counter in case someone else wants one or wants another glass...." At this time the DM temped the glass of milk on the table at 56.1 degrees F. The DM indicated at this time "No this is too warm to be served ... the milk has been sitting out at least 20 minutes...." On 5/19/15 at 12:30 P.M., review of the undated FPO (Food Production Order Form) and temperature logs provided by the DM indicated that hot food		for those residents found to havebeen affected by the deficient practice; Noresidents were affected •□□□□□□□□Howthe facility will identify other residents having the potential to be affectedby the same deficient practice and what corrective action will be taken; No residents were affected •□□□□□□□□Whatmeasures will be put into place or what systemic changes the facility will maketo ensure that the deficient practice does not recur; a. Staffwill pour and serve milk when residents arrive at table. b. DietaryManager was educated on FPO acronyms and what temperature logs mean c. Newtemp logs were put into place to include that date and milk temps are taken	

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	temperatures ranged from 47 degrees F to 165 degrees F. On 5/19/15 at 2:26 P.M., review of the current policy "Food and Nutrition Services" dated December 2009, provided by the Administrator, indicated "... Potentially hazardous food such as meat, milk ... shall be kept at 45 degrees F or below or at 140 degrees F or above... reheated foods must be hated [sic] to a minimum of 164 degrees F or above...." During an interview on 5/21/15 at 10:15 A.M., the DM indicated "... I don't know what the acronyms on the FPO and temperature logs mean... milk should be between 35 and 41 degrees...we don't temp milk so it's not on the temperature log...hot foods should be kept at 145 degrees or hotter... if it's not at 145 degrees we throw it out and make new...." During an interview on 5/21/15 at 10:34 A.M., Cook #3 indicated "...hot foods should be held at 145 degrees... if they aren't at 145 degrees they then reheat the food to the proper temperature... I don't temp milk...cold food should be 41 or below...I don't know what the FPO and temperature log acronyms mean... I just put the food temps in...."		•□□□□□□□□Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; TheAdministrator or his/her designee will review temperature logs. Monitor meal service and temp milk poured attable to ensure milk served at appropriate temperatures.	

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	During an interview on 5/20/15 at 2:20 P.M., the Administrator indicated "we don't have a policy on FPO and temperature logs... yes the FPO and temperature logs should have a date on them and be organized in a book."			
R 0273 Bldg. 00	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, interview and record review, the facility failed to to store and serve food under sanitary conditions, regarding covering and dating of food and handwashing in 1 of 1 kitchens. Findings include: On 5/19/15 between 10:15 A.M., and 10:50 A.M., a kitchen tour was conducted with the DM (Dietary Manager) the following was observed: At 10:17 A.M., in the reach in cooler: an open, undated 1/4 pound of butter and 20	R 0273	· What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; No residents were affected · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; a. Dietary Manager was educated on importance of dating and labeling all open items in cooler. DM will audit coolers to ensure staff are dating and	06/12/2015

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	individual garden salads with no date. The DM indicated "yes, they should be dated...." At 10:25 A.M., on the bread rack: an open, undated, package of hamburger buns containing 5 buns. An open, undated, package of hot dog buns containing 7 buns. The DM indicated "yes, they should be dated...." At 10: 28 A.M., in the walk in cooler: 24 glasses of lemonade, 12 glasses of cranberry juice and 11 glasses of milk, uncovered and undated. During an interview at 10:35 A.M., the DM indicated "I don't send back dented cans... I use them first...because it may be open...." On 5/19/15 at 11:55 A.M., Cook # 3 was observed washing her hands for 7 seconds then prepared food. On 5/19/15 at 2:26 P.M., review of the current policy titled "Food and Nutritional Services," dated December 2009, provided by the Administrator, indicated "... 11. Food stored in refrigerators/freezers shall be covered, dated, and labeled...." On 5/20/15 at 2:08 P.M., review of the		labeling all open items in the cooler. b. DM was educated on importance of dating all opened bread. Milk temps were added to the temperature log. DM will audit bread rack to ensure staff is dating all opened bread. c. DM was educated on the importance and ability of returning dented cans to vendor for credit.d. All staff were re-educated on hand washing. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; a. The Administrator or his/her designee will review bread racks to ensure staff is dating all opened items in the cooler. b. The Administrator or his/her designee will review bread racks to ensure staff is dating all opened bread. c. The Administrator or his/her designee will review all food deliveries and ensure there are no dented cans delivered. If dented cans are delivered the Administrator and his/her designee will ensure dented cans are returned to vendor and not used in the facility per policy.d. Dietician to monitor and ensure staff are washing hands as per policy	

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	undated policy titled "Infection Control Hand Washing," provided by the Administrator, indicated, "Staff will wash hands... Procedure... 5... for at least 20 seconds...."			