

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993
---	---

(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. This visit included the investigation of complaint numbers IN00147165 and IN00148553.</p> <p>Complaint number IN00147165-Substantiated, No deficiencies related to the allegations are cited.</p> <p>Complaint number IN00148553-Unsubstantiated, No deficiencies related to the allegations are cited.</p> <p>Survey Dates: July 13, 14, 15, 16, &17, 2014</p> <p>Facility Number: 000449 Provider Number: 155568 AIM Number: 100290350</p> <p>Survey Team: Mary Weyls RN TC Megan Burgess RN Laura Brashear RN (July 14, 15, 16, & 17, 2014)</p> <p>Census Bed Type: SNF/NF: 68 Total: 68</p> <p>Census Payor Type:</p>	F000000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider or any conclusion set forth in the statement of deficiencies, or any violation of regulation. Provider desires that the 2567 plan of correction be considered the letter of credible compliance and requests a desk review certification of compliance on or after 08-15-2014.</p> <p>James D. Sizemore, HFAExecutive Director</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993
---	---

(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
F000164 SS=D	<p>Medicare: 13 Medicaid: 45 Other: 10 Total: 68</p> <p>These deficiencies also reflects state findings in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 7/24/14 by Brenda Marshall, RN.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993
---	---

(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>methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and record, review the facility failed to maintain personal privacy for 1 of 1 random observation of a resident receiving personal care, (Resident #6)</p> <p>Findings include:</p> <p>1. On 7/16/14 at 10:00 a.m., Room #104, a three bed room, was entered. Resident #150 was seated in a recliner in the middle of the room. CNA #4 was observed providing incontinence care to the resident the third bed in the room (Resident 6). The CNA stated "giving care" and held up a soiled incontinence brief. The privacy curtain between the resident in the recliner in the room and Resident #6 was not pulled.</p> <p>Resident #6's clinical record was reviewed on 7/17/14 at 3:30 p.m. A Minimum Data Set (MDS) assessment dated 5/27/14 coded the resident as requiring extensive assistance of two for bed mobility, transfers, toileting, always incontinent of bowel and bladder.</p> <p>Review of a facility policy, undated, received from the Administrator on 7/17/14 at 12:28 p.m., titled "(e) Privacy</p>	F000164	<p>F164 483.10(e) Personal Privacy/Confidentiality of Records The Resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and Resident groups, but this does not require the facility to provide a private room for each Resident. Except as provided in paragraph (e) (3) of this section, the Resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The Resident's right to refuse release of personal and clinical records does not apply when the Resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the Residents records, regardless of the form or storage methods, expect when release is required by transfer to another healthcare institution; law; third party contract; or the Resident. What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient</p>	08/15/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993
---	---

(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
	and confidentiality", documentation indicated "(1) Personal privacy includes accommodations, medical treatment, written and telephones communications, personal care" 3.1-3(p)(4)		practice? 1.) Resident #6 had no negative adverse effects2.) Privacy curtain will be pulled while doing any care or treatment on Resident #6 How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken? 1.) All Residents have the potential to be affected 2.) No other Residents was identified or affected 3.) All nursing staff was re-educated on privacy on 08-01-2014 by Executive Director What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? 1.) C.N.A#4 was re-educated on privacy during patient care on 07/17/2014 2.) All nursing staff was re-educated on privacy on 08/01/2014 by Executive Director 3.) Director of Nursing Services (DNS) or designee will make rounds daily on all shifts to ensure privacy is being provided How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1.) DNS or designee will randomly audit for privacy being provided on all shifts weekly for 4 weeks, bi-weekly for 4 weeks and then monthly thereafter for 6 months. 2.) Upon discovering privacy not being provided	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2014
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993		
(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	
F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.		correctly, DNS or designee will correct and provide 1:1 re-education to those staff members 3.) DNS or designee will then provide and present information of the privacy rounds during monthly Continuous Quality Improvement (CQI) meetings. If found below 95% threshold DNS or designee will put in place a plan of action to correct any deficient practice 4.) To ensure compliance, the DNS/Designee is responsible for the completion of the Resident care rounds CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Date systemic changes will be completed Completion date: August 15, 2014		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2014	
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993			
(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>Based on interview and record review, the facility failed to ensure residents preferences for showering was maintained for 2 of 3 residents reviewed who met the criteria for choices. (Resident #99 and #101)</p> <p>Findings include:</p> <p>1. On 7/14/14 at 10:54 a.m., Resident #99 was interviewed. The resident indicated she had not been asked how many times she would prefer to take a shower. The resident indicated she didn't think she had a shower but may not be able to due to hip fracture. The resident indicated she had not been asked if she preferred showers, tub baths or bed baths and that she washes up in the bathroom.</p> <p>The resident's clinical record was reviewed on 7/17/14 at 12:27 p.m. An Admission MDS (Minimum Data Set) assessment dated 7/3/14, coded the resident with moderate cognitive impairment and total dependence of two for bathing.</p> <p>A plan of care dated 7/9/14, included, but was not limited to, provide shower two times a week, partial bath in between. Encourage resident to make choices in care such as clothing, shower time, preference, etc.</p>	F000242	<p>F242 483.15(b) Self-Determination – Right to Make Choices The Resident has the right to choose, activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the Resident. What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice? 1.) Resident #99 had no negative adverse reactions 2.) Resident #101 had no negative adverse reaction 3.) All Residents including resident 99 and 101 will have showers per their preference How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken? 1.) All Residents have the potential to be affected 2.) No other Resident was identified or affected 3.) All Residents will be interviewed on bathing preferences by the Activities Director (AD) and Social Services Director(SSD) and documented on the Residents care plan and Resident assignment sheets. All residents will have showers per their preference. What measures will be put into place or what</p>	08/15/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2014	
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993			
(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 Activities Director (AD) was interviewed on 7/17/14 at 12:27 p.m. The AD indicated she interviews residents and/or representative for preferences for daily routines upon admission and with each assessment. It is then given to nursing and the facility had started incorporating the information in to all charts.</p> <p>On 7/17/14 at 12:30 p.m., the AD provided a form titled, "Preferences for Daily Customary Routines," which included, but was not limited to, "Do you have a preference as to what time or how often you bathe?" Resident #99's response was documented as "yes." The assessment tool indicated the resident preferred evening showers and did not address the number of showers preferred weekly. The AD indicated she usually included that information on the assessment.</p> <p>The CNA assignment sheet, provided by the Administrator on 7/17/14 at 1:54 p.m., included documentation for the Day Shift to provide showers on Monday and Thursdays.</p> <p>2. During interview of Resident #101 on 7/15/14 at 10:20 a.m., the resident indicated "they give me a shower two times a week, but would love one every</p>		<p>systemic changes will be made to ensure that the deficient practice does not recur? 1.) Activity Director and all nursing staff was re-educated on the preferences of daily routines by the Executive Director on 08-01-2014 2.) Activity Director or designee will complete the preferences for daily customary routines worksheet upon admission of a new Resident, quarterly and upon significant change of a Resident. 3.) Activity Director or designee will review the preferences with the interdisciplinary team so each department can address the Resident's preferences. Preferences will be brought to morning meeting after the preferences are obtained and shared with the IDT, care plans and care assignment sheets will be updated at this time. Once the IDT has reviewed the preferences preference sheets will be set at each nurse's station in order for the staff to get to know their preferences. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1.) Activity Director or designee will provide a copy of the preferences to the Executive Director upon completion of the preferences weekly for 4 weeks, bi-weekly for 4 weeks, for 6 months then quarterly thereafter. 2.) Social Services Director or</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2014
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993		
(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>day. I guess that's just how they do that here."</p> <p>Resident #101's clinical record was reviewed on 7/17/14 at 11:44 a.m. An admission date was noted of 7/7/14. An admission MDS (minimum data set), dated 7/14/14, indicated the resident as cognitively intact and requiring extensive assist of two with personal hygiene.</p> <p>During interview of RN #1 and LPN #5, on 7/17/14 at 11 a.m., concerning how the nurses determined when residents take showers. The nurse's indicated "we get a pre-printed report as to what days the residents are to receive showers.</p> <p>Review of an "Activity Assessment" for resident #101, received from the Activity Director on 7/17/14 at 12:30 p.m., the assessment indicated the resident preferred morning showers daily.</p> <p>Review of the resident's CNA assignment sheet, received from the Administrator on 7/17/14 at 12:58 p.m., the assignment sheet indicated the resident was to receive a daily shower.</p> <p>The Activities Director (AD) was interviewed on 7/17/14 at 12:27 p.m. The AD indicated she interviewed residents and/or representative for</p>		<p>designee will audit preferences monthly for 6 months and quarterly thereafter using the preferences CQI tool. If any Resident identified their preferences are not being followed SSD or designee will meet with the IDT and corrections be made immediately. 3.) Audits will reviewed during monthly CQI meetings and if preferences fall below 95% threshold a plan of action will be initiated and corrections made immediately to achieve compliance. To ensure compliance, the DNS/Designee is responsible for the completion of the accommodation of needs CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Date systemic changes will be completed Completion Date: August 15, 2014</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993
---	---

(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=D	<p>preferences for daily routines upon admission and with each assessment. It was then given to nursing and the facility started incorporating the information in to all charts.</p> <p>During interview of the Administrator on 7/17/14 at 12:58 p.m., the Administrator indicated the resident wasn't receiving daily showers, and indicated the CNA's must have been looking at a different resident on the assignment sheet, in that the resident above Resident #101's name on the assignment sheet, indicated that resident was to receive a shower two times a day.</p> <p>3.1-3(u)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure adequate hand sanitation during food distribution to 3 of 45 residents in the main dining room, for 1 of 2 dining room observations. (Residents #1 and #15).</p>	F000371	F371 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 What corrective	08/15/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2014	
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993			
(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>Findings include:</p> <p>On 7/13/2014 from 12:00 p.m. to 12:12 p.m., during the lunch dining observation, RN #1 was observed to wash her hands for 9 seconds and then served Resident #15 her meal tray. RN #2 was observed to hand wash for 8 seconds and then served Resident #82 her lunch while passing meal trays.</p> <p>During an interview on 7/17/2014 at 12:45 p.m., the DON indicated facility policy stated staff should hand wash for 20 to 45 seconds..</p> <p>The "Hand Washing" policy dated May 2006 was provided by the Administrator on 7/17/2014 at 12:41 p.m. This current policy indicated the following: " PROCEDURE: ...wet hands and forearms with warm water and apply an antibacterial soapwash for at least 20 seconds "</p> <p>3.1-21(i)(3)</p>		<p>action(s) will be accomplished for those Residents found to have been affected by the deficient practice? 1.) Resident #15 had no negative adverse reaction 2.) Resident #82 had no negative adverse reaction 3.) Residents will be served their meal after staff have adequately washed their hands How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken? 1.) All Residents have the potential to be affected 2.) No other Resident was identified or affected 3.) All staff was re-education on hand washing 08-01-2014 by the Executive Director What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? 1.) RN#1 and RN#2 were re-education on hand washing by the DNS on 07-18-2014 2.) All staff was re-education on hand washing 08-01-2014 by the Executive Director 3.) Meal managers will conduct meal observations during each meal to ensure staff wash their hands per policy What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? 1.) Meal managers will use hand washing skills check off tools to observe employee hand washing</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2014
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993		
(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	
			per policy during meal service daily for 30-days, weekly for 30-days, and monthly thereafter for 6 months to ensure staff is washing hands per policy. 2.) Meal managers will re-educate staff immediately if hand washing is not occurring for 20 seconds. 3.) Meal managers will bring their findings to the monthly CQI meetings for review, if hand washing is below 95% threshold corrections will be made immediately and a plan of action will be initiated to achieve compliance. <i>Date systemic changes will be completed</i> Completion Date: 08-15-2014		