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
	155290		08/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ELIZABETH HEALTHCARE CENTER	701 ARMORY RD DELPHI, IN 46923

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 28, 29, 30, 31, and August 3, 2015. Facility number: 000187 Provider number: 155290 AIM number: 100267300 Census bed type: SNF: 11 SNF/NF: 42 Total: 53 Census payor type: Medicare: 8 Medicaid: 23 Other: 22 Total: 53 These deficiencies reflect state findings cited in accordance with 410 IAC 16.3.1.	F 0000	St. Elizabeth Healthcare Center (the Provider) submits this Plan of Correction (POC) in accordance with specific regulator requirements. The submission of this POC does not indicate an admission by St. Elizabeth Healthcare Center that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of St. Elizabeth Healthcare Center. This POC shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests a desk review of the deficiencies noted.	
F 0356 SS=C Bldg. 00	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following			

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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	information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, interview and record review the facility failed to post the nurse staffing data on a daily basis. This deficient practice had the potential to affect 53 out of 53 residents. Findings include: During the initial tour of the facility on	F 0356	The daily staffing information was corrected during the time of the survey and posted at the nurses' station. No negative outcome was noted. All residents in the facility have the potential to be affected by the alleged deficiency. Re-education with the nursing scheduler was completed by Director of Health Services (Director of Nursing) to ensure	09/02/2015

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	7/28/2015 at 9:15 a.m., the staffing posted was dated 7/27/2015 with no staff hours listed. During an interview on 7/28/2015 at 9:18 a.m., with the Director of Nursing (DON), she indicated that staffing would be posted for 7/28/2015. Observation on 7/28/2015 at 9:30 a.m., indicated staffing posted for 7/28/2015 but no staff hours were listed. During an interview on 7/28/2015 at 9:55 a.m., with the DON and the Assistant Director of Nursing, the corrected staffing was received and posted . During an interview on 7/28/2015 at 10:15 a.m., with the DON, she indicated that staffing hours should have been posted for 7/27/2015 and 7/28/2015. .		the daily staffing information is posted accurately at the nurses station on a daily basis. DHS/designee will verify the nurse staffing data is posted daily at the nurses station 3 times per week for 3 months or until 100% substantial compliance is achieved. Audit results will be brought to monthly Quality Assurance (QA) meetings. QA Committee will review trends X 6 months or until 100% compliance is achieved.	
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY			

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	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, record review and interview, the facility failed to ensure foods that were expired were discarded, employees washed their hands between tasks, food temperature was tested prior to serving and employees wore hair-coverings while in the food preparation area. These deficient practices affected 53 of 53 residents who received food from 1 of 1 kitchen. Findings include: During a tour of the main kitchen on 7/28/15 at 8:30 a.m., the following were observed: 1. The cook's reach-in refrigerator had a container of fruit cocktail with a preparation date of 7/18, a container of cottage cheese with a preparation date of 7/24, a container of chopped onions with a preparation date of 7/15, a container of bread/butter pickles with a preparation date of 7/22 a container of cantaloupe, no date on the container, a container of watermelon, no date on the container, a container of strawberries, no date on the container.	F 0371	Alleged deficiencies related to hair and beard covering, handwashing and food temperature protocols were corrected during the time of the survey. No negative outcome was noted. All residents in the facility have the potential to be affected by the alleged deficiencies. Food in the reach-in refrigerator has been observed for proper dating and exposure. Corrections were made as identified. Proper handling of food during meal preparation was reviewed during the time of the survey by the Executive Director (ED) and Director of Food Services (DFS) with all dietary staff. This review/in-service included: hair and beard covering, handwashing and food temperature protocols. This in-service was repeated after the time of the survey. DFS or designee will in-service dietary staff on proper storage and dating of food in the reach-in refrigerator and proper handling of food during meal preparation. Staff will be in-serviced on hair and beard covering protocols. Audits will be conducted by DFS or designee for proper storage and labeling of food in the reach-in refrigerator 4X per week X 1 month, 3X per week X 1 month and weekly X 4	09/02/2015

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	A review of the policy on 7/30/15 at 3:10 p.m., titled "Food Labeling Guideline", no date, indicated " ...food must be date marked to assure that the food is either consumed or discarded within seven days... prepared leftover food items must be discarded within 3 days, including the day of preparation...." 2. During the kitchen observation, the cook was observed taking the temperature probe and testing the oil in the fryer, wiping the probe with cloth from a bucket that contained sanitizing solution and then going to the purée task without washing his hands. A review of the policy received from the Dietary Manager on 7/30/15 p.m., titled "Guidelines for Handwashing" dated 3/2013, indicated "...1. All healthcare workers shall wash their hands frequently and appropriately...b. before and after preparing/serving meals...." 3. During the kitchen observation on 7/28/15 at 11:45 a.m., the server was observed serving from the steam table without taking temperatures of the prepared food prior to serving. A review of the temperature logs for the month of July 2015, received from the		months. Audits will also be conducted by the DFS or designee for proper handling of food during meal preparation 5X per week at random mealtimes to include all meals X 1 month, 3X per week X 1 month and weekly X 4 months. Audit results will be brought to monthly Quality Assurance (QA) meetings. QA Committee will review trends X 6 months or until 100% compliance is achieved.	

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	Dietary Manager on 8/3/15 at 9:30 a.m., indicated there were 40 out of 89 completed temperatures logs for meals served. A review of the policy titled "Food Temperature Records "dated 1/08, "...the temperatures of all foods on the serving line will be measured prior to resident service and recorded at every meal." 4. During the kitchen observation, the maintenance man walked through the kitchen without hair or beard covering during food preparation time. A review of the policy titled " Dietary Hair Restraint Policy and Procedures" no date, received from Dietary Manager on 7/28/15 at 11:45 a.m., indicated "... all dining service employees will be required to wear hair restraints as required by the 2009 Federal Food Code...food employee shall wear hair restraints such as hats, hair coverings or nets, beard restraints...worn to effectively keep their hair from contacting food..." During an interview with the Executive Director and Dietary Manager on 7/28/15 at 2:00 p.m., the Dietary Manager indicated the cook should have washed his hands between tasks, she also indicated the temperatures should have			

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	been taken and logged prior to serving the prepared lunch. The Dietary Manager indicated the maintenance man should have worn hair/beard covering while in the kitchen. She indicated temperatures were taken prior to service but many times do not get documented as per policy. 3.1-21(i)(2)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, and interview, the facility failed to ensure a clean, sanitary, and home like environment related to 16 of 30 resident rooms, town square furniture and 2 handrails (Room's # 300, 400, 401, 405, 501, 502, 504, 505, 506, 510, 511, 512, 513, 514, 516, and 520). This deficient practice had the potential to affect 26 of 53 residents residing in the	F 0465	Solutions related to Observations #1, #2 and #3 were discussed during the time of the survey between the Executive Director (ED), Director Plant Operations (DPO), Home Office Plant Operations Support and Environment Services Director. No adverse effects were noted. All residents in the facility have the potential to be affected by the	09/02/2015

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	facility. Findings include; 1. During the initial tour on 7/28/2015 at 9:15 a.m., the following was observed: a.) A gouged and chipped hand rail outside room 400 and spa area. b.) A gouged and chipped hand rail between rooms 519 and 521. c.) 3 chairs in town square were marred, peeling and chipped. d.) 2 benches chipped, marred, peeling and gouged. 2. During resident room observations on 7/28/2015, 7/29/2015 and 7/30/2015, the following was observed: a.) Room 300 on 7/28/2015, at 12:00 p.m., the bathroom door, bedroom door, and doorway jams were gouged, marred, chipped and peeling. b.) Room 400 on 7/29/2015, at 10:15 a.m., the bathroom and bedroom walls were chipped, marred and peeling, the bedroom and bathroom doors were gouged, and the bed foot boards were gouged, chipped and peeling.		alleged deficiency. Rounds will be conducted to inspect furniture (including, but not limited to head- and footboards, closets, chairs, benches), handrails, walls, doorway jams and doors for gouges, chips and peels. Rounds will be conducted to inspect and identify areas with loose or peeling wallpaper. Areas identified that do not provide for a safe, functional, sanitary, and comfortable environment for residents, staff and the public will be repaired or replaced. DPO and Environmental staff will be in-serviced by the ED or designee on providing a safe, functional, sanitary, and comfortable environment for residents, staff and the public. DPO or designee will audit furniture (including, but not limited to head- and footboards, closets, chairs, benches), handrails, walls, doorway jams and doors for gouges, chips and peels. DPO or designee will inspect and identify areas with loose or peeling wallpaper. Said audits covering every aspect of this alleged deficiency(ies) will occur 3X a week X 1 month and weekly X 5 months. Audit results will be brought to monthly Quality Assurance (QA) meetings. QA Committee will review trends X 6 months or until 100% compliance is achieved.	

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	c.) Room 501 on 7/28/2015 at 11:56 a.m., the bathroom and bedroom walls were marred, chipped and peeling, the door jam needed repair, and the closet was chipped, gouged and peeling. d.) Room 520 on 7/28/2015 at 11:30 a.m., the walls and the closet were marred, chipped, gouged and peeling. 3. During the environmental tour with the Executive Director, Director of Plant Operations, and the Environmental Service Director, on 7/30/2015 at 1:45 p.m., the following was observed; a.) Rooms 401, 405, 502, 504, 505, 506, 510, 512, 513, 514, and 516, the bedroom door and door jams were gouged, chipped, and peeling. b.) Room 511 had wallpaper peeling from the edges of the ceiling. On 7/30/2015 at 2:30 p.m., the Executive Director(ED) indicated the facility had a reporting system for all staff to notify the Plant Department of facility needed repairs. The Director of Plant Operations indicated he was not aware of the facility needing these repairs.			

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	On 8/3/2015 at 3:00 p.m., " Work Order Procedures" were received from the ED. "Purpose of Work Orders... The use of the three part work order ticket provides a means to track maintenance requests by all campus residents and fellow employees...." On 8/3/2015 at 3:00 p.m., "Preventive Maintenance Procedure Campus Interiors" policy No. PM 06-2008, effective 1/1/2008 received from the ED, indicated floors, walls, ceilings, furniture, doors, windows and attic space are to be inspected monthly / quarterly. 3.1-19(f)			

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