STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155654	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGLEWOOD HEALTH & REHABILITATION CENTER	2237 ENGLE RD FORT WAYNE, IN 46809

(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
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: December 4, 5, 6, 7 & 10, 2012 Facility number: 000498 Provider number: 155654 AIM number: 100266110 Survey team: Angela Strass, RN TC Sue Brooker, RD Julie Call, RN Virginia Terveer, RN Census bed type: SNF/NF: 58 Total: 58 Census payor type: Medicare: 4 Medicaid: 43 Other: 11 Total: 58 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 12/13/12 by Randy Fry RN.	F0000	***The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law.***	

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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F0272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.			
	Based on observation, interview and record review, the facility failed to accurately assess 2 of 3 residents reviewed for vision out 16 residents who met the criteria for vision.	F0272	1. Resident #72 and #38 were reassessed for vision. Both residents care plans were reviewed and revised to reflect current vision assessment.2. All residents have the potential to be	01/09/2013

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	(Residents #38 and #72) Findings include: 1. On 12-4-2012 at 12:30 p.m., Resident #38 was observed feeding himself from his meal tray and made eye contact with spouse while she visited. Resident #38 was observed earlier as he pointed to his pillow and picked it up to show the area where he lived. Resident #38 commented about the computer used. On 12-6-2012 at 12:30 p.m., Resident #38 was observed to acknowledge people when they walked into his room. The resident was observed as he fed himself from his meal tray. On 12-6-2012 at 2:31 p.m., Resident #38 was observed as he waved to people in the hall who were standing about 12 feet away from him. Resident #38 moved from his bed to his rocking chair and picked up his shoes from the floor, put them on his feet and tied them. An interview with LPN #5 on 12-6-2012 at 9:51 a.m., indicated Resident #38 had not had glasses since admitted earlier this year (6-8-2012). LPN #5 indicated		affected by the alleged deficient practice. 3. Social Service in-service to be completed 12/28/12 related to comprehensive assessments and care plan updating or implementing to accurately reflect the vision assessment outcome. All current resident vision assessments and care plans will be reviewed to identify and correct any concerns.4. Social Service staff or Designee will complete vision assessments and care plans accurately. Social Service or designee will review 3 vision assessments per week for 4 weeks then monthly thereafter to ensure accuracy. Results will be forwarded monthly to the Quality Assurance Committee Meeting.5. Date Certain: January 9, 2013.	

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	Resident #38 was able to read the menu when placed in front of him. LPN #5 was not aware of any vision changes in the resident since admission. An interview with Resident #38's spouse on 12-6-2012 at 12:30 p.m., indicated the resident had cataract surgery about 4 years ago and had no current problems with his vision. Resident #38's spouse indicated "he would not wear his glasses because he said he can see so well." The spouse indicated she did not feel he had any trouble seeing the TV or eating his meals. Resident #38's spouse indicated the facility contacted her about making an appointment for an eye exam on this date. An interview with CNA #6 on 12-6-2012 at 2:08 p.m., indicated Resident #38 had no difficulty with vision. CNA #6 indicated Resident #38 required supervision/assistance for ambulation because the resident was a fall risk and not due to vision problems. The record review for Resident #38 began on 12-6-2012 at 9:00 a.m. Resident #38's diagnoses included, but were not limited to, constipation,			

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	abnormality of gait, pain in joint-hand, dysphagia oral phase (swallowing problem), polyarthropathy (arthritis in multiple areas), HTN (hypertension-high blood pressure), Alzheimer's disease, hypercholesterolemia, depression, CAD (coronary artery disease) and GERD (gastroesophageal reflux disease). A review of the MDS (Minimum Data Set, an assessment tool) significant change assessment dated 10-30-2012, indicated the resident had vision that was moderately impaired and had no corrective lenses. A review of care plans indicated there was not a care plan developed for vision impairment. The prior quarterly MDS assessment completed on 8-28-2012, indicated Resident #38 was able to see in adequate light (with glasses or other visual appliance) and had corrective lenses. The Social Services Assessment on 8-28-2012 indicated "no glasses or hearing aids needed at this time." A review of Resident #38's inventory			

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	sheet dated 6-28-2012 and located in the clinical record indicated the resident did not have eyewear marked on the list at admission. On 12-6-2012 at 11:00 a.m., the MDS coordinator provided CAA (Care Area Assessment) worksheets for 10-30-2012 for Resident #38 and it indicated the following: "Blindness" was marked on the form. Functional limitations related to vision problems that were marked indicated "peripheral vision or other visual problem that impedes ability to eat, walk, or interact with others", "difficulty negotiating the environment due to vision problem", "ability to recognize staff limited by vision problem", and "difficulty seeing television, reading material of interest or participating in activities of interest because of vision problem". There was not a care plan developed as the "resident does not show impairment on daily functioning related to vision." This information was completed by Social Services on 10-29-2012. An interview with the MDS Coordinator on 12-10-2012 at 3:05 p.m., indicated "Blindness" marked on the CAA Worksheet dated 10-30-2012 was not correct.			

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	2. Review of the clinical record for Resident #72 on 12-6-12 at 11:43 a.m., indicated the following: diagnoses included, but were not limited to, cardiomyopathy, ventricular septal defect, convulsions, atrial fibrillation, dementia, chronic kidney disease, muscle weakness and difficulty walking. Resident #72's Social Services assessment on 10-30-12 of physical condition indicated, "...resident does not have glasses, hearing aids or dentures. He does not participate in any assessment of effectiveness but shows no impairments...." During record review on 12-6-12 at 11:43 a.m., of Resident #72's Social Service assessment on 11/16/12 of physical condition indicated, "...resident has impaired vision			

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	without glasses, reports having glasses but chooses not to wear as he is able to read large print...." An interview with MDS Coordinator on 12-6-12 at 11:43 a.m. indicated Social Services was responsible to assess the resident's vision for the MDS. A record review on 12-6-12 at 2:20 p.m. of MDS Assessments indicated the Admission Assessment on 11/1/12 for vision and corrective lenses was not answered. The MDS quarterly assessment review on 11/16/12 for vision indicated, "...1. Impaired-sees large print, but not regular print in newspapers/books...." and assessment for corrective lenses indicated, "...1. No...." Interview on 12/10/12 at 3:55 p.m. with Regional Director of Quality Assurance indicated there is not a facility policy for assessment of resident's vision. The facility uses the CMS's (Centers of Medicare and Medicaid) RAI (Resident Assessment Instrument) Version 3.0 manual as a guideline for assessment. Page 4-20 of RAI manual indicated, "...3. Visual Function...a decreased ability to focus on close objects or to see small print, a reduced capacity to adjust to changes in light and dark and			

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	diminished ability to discriminate colors. The safety and quality consequences of vision loss are wide ranging and can seriously affect physical safety, self image and participation in social, personal, self-care and rehabilitation activities...." 3.1(d)(3)			

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review the facility failed to develop a plan of care for 1 of 3 residents reviewed in a sample of 16 who met the criteria for lack of corrective action for visual problems. (Resident #72) Findings include: Review of the clinical record for Resident #72 on 12-6-12 at 11:43 a.m., indicated the following: diagnoses included, but were not limited to, cardiomyopathy, ventricular	F0279	1. Resident #72 and #38 were reassessed for vision. Both residents care plans were reviewed and revised to reflect current vision assessment. 2. All residents with a visual impairment have the potential to be affected by the alleged deficient practice. 3. Social Service in-service to be complete 12/28/12 related to comprehensive assessments for vision and care plan updating or implementing to accurately reflect the assessment outcome. All current resident vision assessments and care plans will be reviewed to	01/09/2013

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	septal defect, convulsions, atrial fibrillation, dementia, chronic kidney disease, muscle weakness and difficulty walking. A record review on 12-6-12 at 11:43 a.m., of Resident #72's Social Service Assessment on 11/16/12 of physical condition indicated, "...Resident #72 has impaired vision without glasses, reports having glasses but chooses not to wear as he is able to read large print...." Interview with MDS (Minimum Date Set, an assessment tool) Coordinator on 12-6-12 at 11:43 a.m. indicated Social Services was responsible to assess the resident's vision for the MDS. A record review on 12-6-12 at 2:20 p.m. of MDS Assessments indicated the Admission Assessment on 11/1/12 for Vision and Corrective Lenses was not answered. The MDS quarterly assessment review on 11/16/12 for vision indicated, "...1. Impaired-sees large print, but not regular print in newspapers/books...." and assessment for corrective lenses indicated, "...1. No...." A record review on 12-6-12 at 2:30 p.m. of Resident # 72's care plans		identify and correct any concerns. For all residents identified with a visual impairment Social Service will review and/or initiate a care plan with appropriate interventions to address any identified concerns. 4. Social Service staff or Designee will complete vision assessments and care plans accurately. Social Service or designee will review 3 vision assessments and care plans per week for 4 weeks then monthly thereafter to ensure accuracy. Results will be forwarded monthly to the Quality Assurance Committee Meeting. 5. Date Certain: January 9, 2013.	

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	indicated there was no care plan for resident's visual impairment or that he needed large print to read. An interview with MDS Coordinator on 12/10/12 at 3:10 p.m., indicated Social Services should have developed a care plan for Resident #72 for impaired vision when it was discovered on 11/16/12. The care plan should have included Resident # 72's need for large print to be able to read. Social Service should have also notified Nursing of Resident # 72's visual impairment so Nursing could care plan for Resident #72's needs. Social Services should have also notified the Activities Director of vision needs. Interview on 12/10/12 at 3:55 p.m. with Regional Director of Quality Assurance indicated there was not a facility policy for assessment and care plan of resident's vision. The facility uses the CMS's RAI Version 3.0 manual as a guideline for assessment. Copy of page 4-20 of RAI manual indicated, "...3. Visual Function...The next step is to develop and individualized care plan based directly on these conclusions. The focus of the care plan should be to prevent decline when possible and to enhance vision to the extent possible			

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	when reversal of visual impairment is not possible...." 3.1-35(a) 3.1-35(b)(1) 3.1-25(b)(2)			

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F0323 SS=E	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 the environment was free of accident hazards in the secured unit affecting 2 of 24 residents on the unit, (residents #30 and #51) with the potential to affect 17 independently mobile residents of 24 residents on the unit. Findings include: On 12-10-2012 at 10:48 a.m., a bottle of Gel Rite Instant Hand Sanitizer with Vitamin E was observed on top of an unattended med cart in the secured unit. No staff were observed in the vicinity of the medication cart. Another observation on 12-10-2012 at 11:10 a.m., indicated the bottle of Gel Rite Instant Hand Sanitizer with Vitamin E remained out on top of the medication cart and without staff presence. An observation on 12-10-2012 at 11:25 a.m., indicated the hand gel	F0323	1. Corrective action cannot be taken as alleged deficiency occurred in the past. 2. All residents have the potential to be affected by the alleged deficiency. 3. All individual hand sanitizer bottles have been placed out of resident reach. All staff in-service conducted 12/20/12 related to proper storage of hand sanitizer gel. 4. Director of Nursing or Designee shall do facility rounds 5 times per week for 4 weeks then monthly thereafter to ensure compliance. Results will be forwarded monthly to the Quality Assurance Committee Meeting. 5. Date Certain: January 9, 2013.	01/09/2013

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	remained out on top of the medication cart. An interview with LPN #5 on 12-10-2012 at 11:25 a.m., indicated she was unaware that the hand gel was out on top of the medication cart. LPN #5 indicated the hand gel was not usually kept out on top of the medication cart because of the residents in the secured unit. On 12-10-2012 at 11:28 a.m., Resident #30 was observed trying to get items out of the overflow medication cart as LPN #5 was in the cart. LPN #5 had to physically shield the resident from the cart to prevent Resident #30 from getting items from the cart. On 12-10-2012 at 11:33 a.m., Resident #51 was observed trying to get into the locked medication cart. An interview with the ADON (Assistant Director of Nursing) on 12-10-2012 at 11:41 a.m., indicated there were 17 independantly mobile residents in the secured unit which has a total of 24 residents. A label review of the Gel Rite Instant Hand Sanitizer with vitamin E, 4 ounce bottle, reorder #00104			

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	indicated the gel was for handwashing to decrease bacteria on the skin. The label information indicated, but was not limited to, the following: "Warnings: for external use only. Avoid contact with eyes. Flammable, keep away from heat or flame. Keep out of reach of children. In case of accidental ingestion contact a physician or Poison Control Center right away." 3.1-45(a)(1)			

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NAME OF PROVIDER OR SUPPLIER ENGLEWOOD HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2237 ENGLE RD FORT WAYNE, IN 46809	

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F0371 SS=E	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 prevent potential contamination of food by transporting room trays with food and beverages uncovered to 4 resident rooms in 2 of 2 hallways and failed to ensure staff washed hands for the appropiate amount of time while serving meals in the main and secured dining rooms. This had the potential to affect 57 of 58 residents who eat their meals in the facility. Findings include: 1. During an observation of the lunch meal on 12/4/12 at 12:28 p.m., the food cart for the 100 Hall was placed between Room 110 and the therapy room. Room trays were carried from that location through the hallway to Room 111 and Room 112 by the Director of Nursing and Certified Nursing Assistant (CNA) #1. Bowls of fruit and gelatin salad were not covered.	F0371	1. Corrective action cannot be taken as alleged deficiency occurred in the past.2. All residents have the potential to be affected by the alleged deficiency.3. All staff in service conducted 12/20/12 related to proper handling and delivery of resident's food and hand washing. Laminated signs reminding staff of the proper hand washing technique have been placed above the sinks in the dining rooms. All food items placed on hall cart trays shall be covered.4. Director of Nursing or Designee shall monitor staff 5 times per week for 4 weeks then 2 times per week for 2 weeks then monthly thereafter. Results will be forwarded monthly to the Quality Assurance Committee Meeting. 5. Date Certain: January 9, 2013.	01/09/2013

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	During the same observation of the lunch meal on 12/4/12 at 12:34 p.m., the food cart for the 100 Hall was pushed from its location between Room 110 and the therapy room in front of Room 104. A room tray was carried through the hallway by CNA #1 to Room 111. The bowls of fruit and gelatin salad were not covered. During the same observation of the lunch meal on 12/4/12 at 12:38 p.m., the food cart for the 200 Hall was placed in front of Room 212. A room tray was carried through the hallway by CNA #2. The bowl of gelatin salad was not covered. 2. During an observation of the breakfast meal on 12/7/12 at 8:35 a.m., RN #3, was observed carrying a room tray from the kitchen, through part of the dining room, through the 200 Hall to Room 211. A bowl of dry cereal and a glass of tomato juice was not covered. The Certified Dietary Manager was interviewed on 12/10/12 at 8:35 a.m. During the interview she indicated the food cart should be moved from room to room when delivering room trays. She also indicated any food or beverages carried through the			

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	hallways should be completely covered. A current facility policy "Transporting Drink and Food Items to Satellite Dining Room", dated 8/2011, indicated "...All prepared drinks, portioned foods, and prepared foods to be served shall be transported through Common Areas in enclosed carts or with proper coverings...." 3. During an observation of dining services on 12-4-12 from 12:00 p.m. until 12:45 p.m. in main dining room, Administrative Manager washed her hands in the sink for 10 seconds and then began to serve resident meals. Housekeeping Supervisor washed her hands in sink the first time for 6 seconds and began to serve resident meals. During her 2nd handwashing, she washed her hands for 5 seconds and then continued to serve resident meals. 4. An observation during lunch on 12-4-2012 at 12:14 p.m., indicated LPN #5 and CNA #8 washed their hands for 10 seconds at the sink in the secured unit dining area and proceeded to serve residents their meal.			

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	An observation during lunch on 12-4-2012 at 12:17 p.m., indicated the ADON washed her hands for 10 seconds at the sink in the secured unit dining area and proceeded to feed a resident their meal. An observation during lunch on 12-4-2012 at 12:18 p.m., indicated LPN #5 washed her hands for 10 seconds and proceeded to serve a resident their meal. An interview with the Certified Dietary Manager on 12-10-2012 at 8:58 a.m., indicated staff were expected to wash their hands for 20 seconds prior to serving meal trays to residents. An interview with Certified Dietary Manager on 12-10-2012 at 9:04 a.m., indicated there was not a separate dietary policy for handwashing and they use the facility handwashing policy. On 12-10-2012 at 9:05 a.m., the Certified Dietary Manager presented a "Food Safety Wash your Hands" laminated poster which indicated but was not limited to the following "Rinse hands and exposed portions of arms under clean, warm, running water. Apply soap and rub hands and fingers			

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	together vigorously for at least 20 seconds, including under fingernails, between fingers/fingertips, and on surfaces of the hands and arms. Rinse again with clean, warm running water...." An observation on 12-10-2012 at 9:08 a.m., indicated a copy of the "Food Safety Wash your Hands" poster was taped on the cabinet next to and above the sink in the secured unit of the facility. A policy for "Hand Washing" was obtained from the Regional Director of Quality Assurance on 12-10-2012 at 8:30 a.m. and indicated but was not limited to the following: "Policy: To ensure proper hand washing before and after procedures and/or resident care to prevent the spread of infection. Procedure: 1. Wet hands with water. Leave water running. 2. Apply soap. Using friction, rub hands together, cleaning under nails and between fingers thoroughly and up to wrist for 20 seconds....." 3.1-21(i)(2) 3.1-21(i)(3)			

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and	F0441	1. Corrective action cannot be taken due to the alleged	01/09/2013

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	record review the facility failed to handle and transport clean linen in a manner to prevent contamination in the main dining room potentially affecting 25 of 57 residents who eat their meals in the main dining room. Findings include: 1. During an observation of the main dining room 12/5/12 at 9:50 a.m., Housekeeping #4, was observed to retrieve a stack of 8 clean tablecloths from a cabinet in the main dining room and carry them closely against her arm and her uniform. She was then observed to place the tablecloths on the dining room tables in the main dining room. 2. During an observation of the main dining room on 12/6/12 at 2:15 p.m., Housekeeping #4, was observed to retrieve a stack of 8 clean tablecloths from a cabinet in the main dining room and carry them closely against her arm and her uniform. She was then observed to place the tablecloths on the dining room table in the main dining room. The Housekeeping/Laundry Supervisor, was interviewed on 12/10/12 at 8:23 a.m. During the interview she indicated clean linen should be carried away from one's		deficiency occurred in the past. 2. All residents have the potential to be affected by the alleged deficiency. 3. Housekeeping staff in-service completed 12/7/12 and all staff in-service completed 12/20/12 related to facility policy on handling and transporting clean linens. 4. Director of Nursing or Designee shall monitor staff handling clean linens 5 times per week for 4 weeks then 2 times per week for 2 weeks then monthly thereafter. Results will be forwarded monthly to the Quality Assurance Committee Meeting. 5. Date Certain: January 9, 2013.	

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	body and not touch any clothing. A current undated facility policy "Laundry Guidelines", provided by the Regional Director of Quality Assurance on 12/10/12 at 9:00 a.m., indicated "All personnel will handle, store, process and transport linen so as to prevent the spread of infection...clean linen will be held away from employee's uniform...." 3.1-19 (g)(1)(2)(3)			