STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BEND NURSING AND REHABILITATION	4600 W WASHINGTON AVE SOUTH BEND, IN 46619

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00191900. Complaint IN00191900 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: February 11, 12, 15, 16, and 17, 2016 Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420 Census bed type: SNF/NF: 86 Total: 86 Census Payor type: Medicare: 13 Medicaid: 61 Other: 12 Total: 86 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed by 14454 on February 19, 2016.	F 0000	**Thecreation and submission of this plan of correction does not constitute anadmission by this provider of any conclusion set forth in the statement ofdeficiencies, or of any violation of regulation.** **Dueto the relative low scope and severity of this survey, the facilityrespectfully requests a desk review in lieu of a post-survey revisit on orafter 3/17/16.**	

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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F 0371 SS=E Bldg. 00	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 a staff member changed gloves or washed hands after touching soiled items, and before filling plates, for 16 of 16 room trays observed for preparation of the 86 residents that received food from the kitchen. (Employee #4) Finding includes: On 2-11-2016 during a kitchen tour from 10:45 A.M. to 12:10 P.M., Employee #4 was observed filling resident plates for room trays. The employee was wearing gloves when she went to the first tray to be filled. She picked up the resident's meal ticket to read, first with the gloved right hand, then passed it to the gloved left hand, then set it back down on the resident's tray. Then Employee #4 picked up a cup of pudding from the first tray by grasping it over the top, with fingers	F 0371	**F371– Food Procure, Store/Prepare/Serve - Sanitary** It is the practice of this provider that all food isstored, prepared and served under sanitary conditions. **Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:** Facility meals are being prepared, distributed and served to all residentsusing sanitary conditions. None of the residents were negatively affectedby this finding. The staff members identified in this finding have receivedre-education and training regarding food preparation and distribution. **Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken:** All residents have the potential to	03/17/2016

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	resting along the cup lip, and moved it to the other side of the tray. Then the employee picked up an empty plate by grasping it with the same gloved right hand, with the thumb of the right hand latched over rim of the plate, and transferred the plate to left hand. The left hand still in the original glove, grasped the plate with the left thumb hooked over the rim of the plate as she filled the plate with the resident's requested foods. Employee #4 continued to fill 15 more plates without washing hands or changing gloves, as the thumb of the right hand and the thumb of the left hand continued to grasp each plate with the thumbs hooked over the rims and onto the surface of the plates. Employee #4 did not wash her hands or change her gloves at any time during the observation. On 2/16/2016 at 11:19 A.M., an interview with Employee #6, indicated kitchen and dining staff should always handle dinner plates from the bottom surface only, when food is being dished, and the thumb should never be on the rim of the plate or on the surface of the plate. On 2/16/2016 at 12:18 P.M., the ED (Executive Director) provided the Food Handling Policy, dated 01-2014, and		be affected by this finding. Dietary staff responsible for cooking, foodpreparation and food distribution is utilizing proper technique and infectioncontrol practices during the meal preparation and meal service process. The ED/DM/designee will be responsible formeal preparation and meal service observations no less than five times per weekto ensure safe, sanitary practices are in place during the meal serviceprocess. A Dietary staff in-service willbe conducted on or before 3/17/16 by the ED/DM/designee. This in-service will include review of thepolicy related to General Food Preparation and Handling as well as proper useof gloves, proper hand washing during food distribution and proper handplacement when food is being plated for service to the residents. **Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:** A Dietary staff in-service will be conducted on or before 3/17/16by the ED/DM/designee. This in-servicewill include review of the policy related to General Food Preparation andHandling as well as proper use of gloves, proper hand washing during fooddistribution and proper hand placement when food is being plated for service tothe residents.	

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	indicated it was the policy currently used by the facility. The policy indicated, "...Food employees (any individual working with food, food equipment or utensils, or food contact surfaces) will clean their hands and exposed portions of their arms:...After handling soiled surfaces, equipment, or utensils;...during food handling, as often as necessary to remove soil and contaminations and to prevent cross-contamination when changing tasks...." 3.1-21(i)(1)		The ED/DM/designee willbe responsible for meal preparation and meal service observations no less thanfive times per week to ensure safe, sanitary practices are in place during themeal service process. **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:** To ensure ongoing compliance with this corrective action, the ED/DM/designeewill be responsible for completion of the CQI Audit tool titled, "FoodPreparation and Meal Service" for every meal for 30 days and weekly thereafterfor at least 6 months. If threshold of90% is not met, an action plan will be developed. Findings will be submitted to the CQICommittee for review and follow up. **Bywhat date the systemic changes will be completed:** Compliance Date:3/17/16	
F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of			

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	all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview and record review, the facility failed to ensure a medication cart was kept locked when not in use. This deficiency affected 1 of 1 observed medication cart. (2nd floor West Hall) Finding includes: On 2-11-16 at 3:20 P.M., a medication cart in the West Hall of the 2nd floor was noted to be unlocked with resident	F 0431	**F431– Drug, Records, Label/Store Drugs & Biologicals** It is the practice of this provider that all drugsand biologicals are stored in locked compartments under proper temperaturecontrols, with only authorized personnel permitted to have access to the keys. **Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice:**	03/17/2016

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	medications inside. No nurse was attending the medication cart. Between 3:20 P.M. and 3:45 P.M., several staff members and residents walked by the unlocked medication cart. At 3:45 P.M., RN (Registered Nurse) #3 returned to his medication cart and pushed it down the West Hall. On 2-17-16 at 10:56 A.M., during an interview, the DON (Director of Nursing) indicated nurses should keep their medication carts locked when they are not using them. On 2-17-16 at 11:36 A.M., review of the current "Medication Pass Procedure" skills checklist, received at this time by the DON, indicated "...Medication cart locked when unattended...." 3.1-25(m)		All facility medication carts are being properlylocked and stored when unattended and not in use by authorized personnel. No residents were negatively affected by thisfinding. **Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected bythis finding. Authorized personnel areusing proper procedure and safe practices during the medication pass procedureand all medication carts are being properly locked and stored when unattendedand not in use. A Nursing In-service will beconducted on or before 3/17/16 by the DNS/designee. This in-service will include review of thepolicy related to the medication pass procedure and safe practices regarding properlocking and storage of medication carts when unattended by authorized personneland not in use. **Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:** Nursing Rounds are completed by the DNS/Charge Nurse/Designee everyshift to ensure that medication carts are being locked and properly stored whennot in use. A Nursing In-service will beconducted on or	

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			before 3/17/16 by the DNS/designee. This in-service will include review of thepolicy related to the medication pass procedure and safe practices regardingproper locking and storage of medication carts when unattended by authorizedpersonnel and not in use. **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:** This corrective action will be monitored through thefacility CQI Program. The DNS/designeewill be responsible for completion of the CQI Audit Tool titled, "EnvironmentalSafety" daily for 4 weeks and weekly thereafter for at least six months. If threshold of 90% is notmet, an action plan will be developed. Findings will be submitted to the CQI Committee for review and followup. **Bywhat date the systemic changes will be completed:** Compliance Date: 3/17/16	
F 0441 SS=D Bldg. 00	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			

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	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 record review, the facility failed to ensure staff followed infection control procedures during dressing changes related to application of wound treatments and handling of sterile dressings. This had the potential to affect 1 of 1 residents observed for dressing changes. (Resident #52). Findings include:	F 0441	**F441– Infection Control, Prevent Spread, Linens** It is the practice of this provider to establish andmaintain an Infection Control Program designed to provide a safe, sanitary andcomfortable environment and to help prevent the development and transmission ofdisease and infection. **Whatcorrective action(s) will be accomplished for those**	03/17/2016

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	On 2-17-16 at 9:00 A.M., during an observation of wound care for Resident #52, employee #5 was observed to open a package of sterile gauze pads by tearing the package across the top. Employee #5 was observed to apply There Honey (a wound treatment ointment) to the wound bed by using a gloved finger. Employee #5 then was then observed to, open a package of Opti Foam dressing (wound covering) by tearing the package across the top, drop the package of Opti Foam dressing on the floor, pick it up with her gloved hand, remove the dressing from the package and apply it to Resident #52's heel wound. During an interview on 2-17-16 at 10:58 A.M., the DON (Director of Nursing) indicated "... best way to open the dressing packages is to pull it apart at the top... if a dressing package falls on the floor it should be thrown out ... it should not be used.... application of ointments should be done with tongue depressor or a applicator...." On 2-17-16 at 11:30 A.M., review of the current policy titled "Dressing Change [Incision or Wound]," last updated on 9/2012, and provided by the DON at this time, did not indicate how to open sterile dressings or how to apply ointments.		**residents found to havebeen affected by the deficient practice:** Resident #52's wound treatments and dressing changesare being administered per policy using proper infection controlprocedures. The physician and family areaware of the status of this resident's wound and treatment orders. This resident experienced no negative outcomeas a result of this finding. Employee #5 received one on one training andeducation including infection control practices and proper technique related toapplication of wound treatments and handling of sterile dressings. **Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken:** All residents with orders for dressing changes havethe potential to be affected by this finding. An audit will be completed by the DNS/designee to identify all residentswith orders for treatments and dressing changes. Physician orders will be reviewed and verifiedto ensure all wound treatments and dressing changes are being administered perphysician's order. In addition, theDNS/CEC and/or designee will be responsible for completing skills validations andreturn demonstrations related to dressing changes on all licensed	

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	3.1-18(a)		nurses. These skills validations will includeobservations of infection control practices, application of wound treatmentsand handling of sterile dressings during physician ordered dressing changes. **Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:** A Nursing In-service will be conducted on or before 3/17/16 by theDNS/designee. This in-service willinclude review of the policy related to use of infection controlpractices, application of wound treatments and handling of sterile dressingsduring physician ordered dressing changes. Each licensed nurse will be validated and required to complete returndemonstrations for dressing changes and wound treatments. Skills validations are completed on all licensedstaff upon hire, when specific needs are identified and at least annually. **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:** To ensure ongoing compliance with this corrective action, theDNS/CEC/designee will be responsible for completion of the CQI Audit tooltitled, “Dressing Changes” weekly for at least 6 months. If threshold of 90% is not met, an actionplan will be	

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			developed. Findings will besubmitted to the CQI Committee for review and follow up. **Bywhat date the systemic changes will be completed:** Compliance Date:3/17/16	