

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155616	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/10/2016
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NAME OF PROVIDER OR SUPPLIER ROBERT E LEE	STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN 47150
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00195157.</p> <p>This visit was in conjunction with a Recertification and State Licensure Survey.</p> <p>Complaint IN00195157 - Substantiated. Federal deficiencies related to the allegations are cited at F241.</p> <p>Survey date: March 2,3,4,7,8,9, and 10, 2016</p> <p>Facility number: 001145 Provider number: 155616 AIM number: 200120200</p> <p>Census bed type: SNF/NF: 84 Total: 84</p> <p>Census payor type: Medicare: 9 Medicaid: 50 Other: 25 Total: 84</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC</p>	F 0000		

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.

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F 0241 SS=E Bldg. 00	<p>16.2-3.1.</p> <p>Quality review completed by 30576 on March 16, 2016.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident's dignity was maintained during meal observation for 6 of 14 residents in the 4 Hall Dining Room and 7 of 11 residents in the 1-2-3 Hall Dining Room. (Residents # E, F, G, H, I, J, K, L, M, N, O, P, and Q).</p> <p>A. On 03/02/2016 at 12:06:41 p.m., during the initial tour, Resident # P, Resident M, and Resident # N was observed in Hall 4 Dining Room waiting for ten to fifteen minutes before receiving lunch service. Residents at the same table were already eating and finishing up lunch.</p> <p>On 03/03/2016 at 12:25:22 p.m., during</p>	F 0241	<p>1.A. Meal Service will be reviewed and revised to ensure the residents affected (M,N,O,P,F,Q,G,H,E,L,K,I and J) will receive their meal trays in a systematic and timely manner.</p> <p>B. Resident #92 has expired</p> <p>2.A. As all residents may have the potential to be affected the policy for meal service will be reviewed and revised to ensure all residents are served their mealtrays in a systemic and timely manner.</p> <p>B. No other Residents were affected</p> <p>3.A. The meal service policy/procedure has been revised to ensure a systematic and timely tray delivery process is in place. The dietary staff and Nursing staff will be in-serviced on the new dining policy and the importance of.</p>	04/08/2016

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	<p>an observation, Resident # M, # Resident # N, and Resident # O was observed sitting at a table in the Hall 4 Dining Room waiting for their lunch trays at 12:00 p.m. Resident # M received the lunch tray at 12:26 p.m. Resident # M indicated "I am sitting here waiting on my tray and I don't know why it's not here yet". Resident # N received the lunch tray at 12:27 p.m., and Resident # O received the lunch tray at 12:29 p.m. Several residents were observed finishing up their meal.</p> <p>On 03/07/2016 at 12:49 p.m, Resident # P was observed sitting in a wheelchair at the lunch table, with head laying on the table, waiting for the lunch tray at 11:50 a.m. Resident # P received the lunch tray at 1:11 p.m.</p> <p>On 03/07/2016 at 12:54 p.m., Resident # O indicated, " I have been out here since 12:00 p.m., waiting on my tray. I just sit here and watch all of these people. I don't know why it's not here yet." During an observation in the Hall 4 Dining Room the staff started serving the lunch trays at 12:50 p.m.</p> <p>On 03/07/2016 at 1:00 p.m., Resident # Q indicated to the ADON (Assistant Director of Nursing) " I have sit here all day and you are finally going to feed me."</p>		<p>B. The nursing staff have been in-serviced on providing privacy and dignity when providing care.</p> <p>1. A. A department manager will be assigned to the individual dining rooms during 2 random meals Monday – Friday to ensure compliance daily x2 weeks, weekly x4 and monthly x4. Any areas of concern will be addressed immediately. The QA monitoring tool will be reviewed in the daily AM management meeting and forwarded to the QA committee to review for compliance, the need for further policy/procedure revisions and/or staff education.</p> <p>B. The DON and/or Designee will make 2 random rounds daily Monday - Friday to ensure privacy is being provided during care daily x2 weeks, weekly x4 and monthly x4. Any areas of concern will be addressed immediately. The QA monitoring tool will be reviewed daily during the AM management meeting and forwarded to the QA committee to review for compliance, the need for further policy/procedure revisions and/or staff education</p>		

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	<p>The ADON was providing the resident with a clothing protector at this time.</p> <p>B. During lunch observations of the 1-2-3 Dining Room on 3/2, 3/3, 3/4, 3/5 and 3/7/16, the following was observed:</p> <p>1. Initial dining room observation on 3/2/16 between 12:00 Noon and 12:45 p.m.:</p> <ul style="list-style-type: none"> - trays were not being served consecutively in that one table was not completed before moving onto the next table. Resident #L sat for 22 minutes before being served while others received their trays. Resident # L was observed to be looking around at the other tables and his tablemates who were eating while he waited. Trays were also being taken to resident rooms on the hall while the dining room was served. <p>2. On 3/3/16 between 12:00 p.m., Noon and 12:30 p.m.:</p> <ul style="list-style-type: none"> - 1st tray was taken to Resident # K at Noon, second tray to Resident # I at 12:02 p.m., Resident # L received his tray at 12:07 p.m., and Resident # J received his tray at 12:12 p.m.; both were looking around at their tablemates while they waited on their tray. - All 3 residents at Resident # F's table received their trays at Noon except her. She then received her tray at 12:07 p.m. Resident # F was observed to be looking 			

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	<p>at her tablemates while she waited on her tray. The CNAs (Certified Nursing Assistants) were observed to be taking trays to resident rooms in between serving the dining room tables.</p> <p>3. During interviews with Residents # L and # J on 3/4/16 at 8:45 a.m., Resident # L indicated "I am always the last one served at meals - I have no clue as to why. Hate sitting there watching while everyone else eats." Resident # J also indicated "This happens to us a lot - they are so disorganized. I also have to wait on my meal while the others at my table are eating and then you have to ask for condiments; there is no order as to who gets their tray."</p> <p>4. On 3/5/16 at 12:25 p.m., Resident # L was observed sitting at his table waiting on his food tray - all 3 of his tablemates were eating their meals. Resident # I was observed to give Resident # L his roll while he waited. Staff were observed fixing trays for residents at other tables and taking trays to residents who were eating in their rooms before Resident # L received his tray at 12:35 p.m.</p> <p>In an interview with LPN #1 at 12:45 p.m., she indicated "There really is no order to when the trays come up on the food cart, sometimes they may be in</p>				

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	<p>room order and then other times they are mixed."</p> <p>5. During an interview with Cook #1, the Dietary Manager and Dietary Aide #1 on 3/7/16 at 11:50 a.m., the Cook indicated "The dining room carts are fixed first, then the next cart is the hall trays. The 1-2-3 dining room cart is fixed and sent out, then 1-2-3 Hall cart is fixed and then sent out. Hall 4 dining room and hall carts are done the same way. They are also fixed according to tables - all one table is to be served before moving on to next table."</p> <p>6. On 3/7/16 at 12:20 p.m., the hall trays were observed being served at the same time as the dining room trays.</p> <ul style="list-style-type: none"> - Resident # I received his tray at 12:20 p.m., Resident # J received his at 12:21 p.m., Resident # K received his at 12:25 p.m. Resident # K was observed to give Resident # L his mighty shake while everyone else at the table was eating and he was waiting on his tray. At 12:35 p.m., Resident # L received his food tray which was on the second cart of trays. - In an interview at 12:38 p.m., CNA #2 indicated "There is no specific order when the trays come up from the kitchen. I personally like to serve the men first as they can be more impatient than the others. We are supposed to serve the 			

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	<p>whole table first before moving on to the next table and complete the dining room before moving to the hall trays."</p> <p>On 3/8/16 at 1:08 p.m., the Dietary Manager presented a copy of the facility's current policy titled "Meal Service". Review of this policy at this time included, but was not limited to: "Meal Service: Purpose: to ensure each resident is provided with the daily menu choices and have their meals served in a location of their choice....5. Meals trays will be served in the dining rooms first and then the room trays will be delivered..."</p> <p>C. On 03/03/16 between 11:48 a.m., and 12:30 p.m., the observation of the 1-2-3 Hall Dining Room lunch service, indicated the meal cart to arrive at 11:58 a.m., with 11 residents present. The food was uncovered at 12:00 p.m., for Resident # E and placed on the table. The resident was not present in the dining room at this time. At 12:20 p.m., the resident was notified of the lunch meal service, after the Nurses Aide student # 1 was asked whose plate was at the table. The resident arrived within a minute of being told of the meal service. The Nurses Aide student was told the food was probably cold and the student requested for Nurses Aide student # 2 to return the food to the kitchen for a warm</p>			

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	<p>tray. The resident left the dining room when the cold food was returned to the kitchen. The resident returned to the dining room and the Nurses Aide student # 2, returned with a tray at 12:27 p.m.</p> <p>On 03/07/16 at 12:20 p.m., the lunch meal service began in the 1, 2, 3 Hall Dining Room. At 12:27 p.m. 3 of 4 residents were served by an unknown Nurses Aide student # 3 at the same table. Resident # F was at this table and waited until 12:33 p.m. to be served the lunch tray. At another table at 12:27 p.m., an unknown resident was served, then another resident at this table was served at 12:32 p.m. Resident # G at this table was served at 12:39 p.m. At 12:37 p.m., Resident # H left the lunchroom when the lunch tray wasn't served and 6 other residents were served at the same table. The resident returned to the dining room 2 minutes later and waited until 12:43 p.m. to be served the meal tray.</p> <p>This Federal tag relates to complaint # IN00195157.</p> <p>3.1-3(t)</p>			