STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155675	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC	950 N LAKEVIEW DR GREENSBURG, IN 47240

(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 a State Residential Licensure Survey. Survey dates: June 22, 23, 24, 25, 26, and 29, 2015 Facility number: 011039 Provider number: 155675 AIM number: 200299100 Census bed type: SNF/NF: 52 Residential: 21 Total: 73 Census payor type: Medicare: 9 Medicaid: 24 Other: 19 Total: 52 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		
F 0371	483.35(i)			

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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SS=E Bldg. 00	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 distribute and/or serve food under sanitary conditions in that proper hand washing was not performed when hands became contaminated (unclean) while serving meals for 7 of 63 residents who ate meals in the facility dining rooms, during 2 of 4 dining observations, for 1 of 2 dining rooms observed. (Residents #6, #18, #20, #23, #43, #88, #91) Findings include: 1. During an observation of the Main Dining Room on 06/22/2015 at 12:14 P.M., LPN (Licensed Practical Nurse) #1 picked up two glasses of milk from the serving window and spilled some of the milk onto the floor. She turned around and placed the glasses of milk back on the serving window ledge and then used a towel to wipe the floor. After wiping the floor, LPN #1 picked up one glass of milk and a individual container of orange ice cream and served them to Resident	F 0371	**F 371 Kitchen Sanitation** **Corrective action for affected resident:** Nurses notes reviewed for residents #6, #18, #20, #23, #43, #88 and #91 and no change of condition noted related to infection control **Identification of others at risk**: All residents have potential for risk. Nurses notes reviewed for residents and no change of condition noted related to insufficient infection control practices	07/24/2015

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	155675		06/29/2015

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	#91. No hand washing or hand sanitizing was observed throughout the observation. During an interview on 06/29/2015 at 1:04 P.M., LPN #1 indicated proper hand washing during dining included hand washing with soap and water or hand sanitizing with gel between every resident and "definitely after touching a resident". 2. An observation of the Main Dining Room was conducted on 06/22/2015 at 12:29 P.M. LPN #1 reached inside her scrub top and touched her left shoulder, adjusted her stethoscope around her neck, served a plate of food to Resident #43, pulled her scissors out of her right pocket, cut a packet of mustard open with the scissors, returned the scissors to her pocket, squirted mustard on Resident #43's hot dog, and then patted the resident's back. LPN #1 then cut up Resident #18's food and moved his wheelchair forward. LPN#1 touched Resident #88's back, then delivered ice cream to Resident #23. No hand washing or hand sanitizing was performed during this observation. LPN #1's scissors were not observed being cleaned before or after use. 3. An observation of the Main Dining Room was conducted on 06/25/2015 at		**Measures to ensure this deficient** **practice does not recur:** Staff re-educated on proper hand washing procedures **Monitoring of corrective action:** The Director of Nursing (DON) or designee will observe hand washing during meal service 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, 1 time weekly for 3 months, and then 1 time monthly for 3 months. The results of the audits will be reviewed during morning clinical meeting and forwarded to the Quality Assurance Committee monthly for recommendations.	

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NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC		STREET ADDRESS, CITY, STATE, ZIP CODE 950 N LAKEVIEW DR GREENSBURG, IN 47240	

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	12:12 P.M. Staff #3 reached under her scrub top and touched her shoulder, served Resident #20 a plate of food, served Resident #6 a plate of food, then used hand sanitizer. During an interview with the Dietary Manager on 06/26/2015 at 11:05 A.M., she indicated staff must wash their hands if they touch any person or the inside of any dish or cup. During an interview on 06/26/2015 at 11:09 A.M., the Administrator indicated she sanitized her hands after each tray was served in the dining room. She further indicated staff was inserviced on hand washing upon hire, annually, and as needed. Record review of the current "HANDWASHING AND USE OF GLOVES" policy, provided by the ADON (Assistant Director of Nursing) on 06/26/2015 at 11:13 A.M., indicated, "Hand hygiene will be performed before and after resident care is rendered and after handling contaminated articles." Record review of the current "HAND WASHING" policy, provided by the Administrator on 06/26/2015 at 11:30 A.M., indicated hands should be washed "...After touching bare human body parts			

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	other than clean hands and clean, exposed portions of arms ..." and "...After handling soiled equipment or utensils ...". 3.1-21(i)(2) 3.1-21(i)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 21 Sample: 12 These State findings are cited in accordance with 410 IAC 16.2-5.	R 0000		
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure infection control practices and safe food handling were maintained related to hand washing and hand sanitizing for 4 of 21 residents, during 1 of 4 dining observations for 1 of 2 dining rooms	R 0273	**F 273 Kitchen Sanitation** **Corrective action for affected resident:**	07/24/2015

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	observed. (Residents #8, #10, #11, #12) Findings include: During an observation of the Main Dining Room on 06/22/2015 at 12:14 P.M., LPN (Licensed Practical Nurse) #1 picked up Resident #8's bread out of a bread basket with her bare hands and placed the bread on the resident's plate. She then served Resident #10 a plate of food. After LPN #1 placed Resident #10's plate on the table, she repositioned the resident by placing her hands under the resident's arms, then served Resident #11 a plate of food. While walking back to the serving window, LPN #1 scratched her head, then picked up a plate of food and served it to Resident #12. No hand washing or hand sanitizing was performed by LPN #1 throughout the observation. During an interview with the Dietary Manager on 06/26/2015 at 11:05 A.M., she indicated staff must wash their hands if they touch any person or the inside of any dish or cup. During an interview on 06/26/2015 at 11:09 A.M., the Administrator indicated she sanitized her hands after each tray was served in the dining room. She further indicated staff were inserviced on		Nurses notes reviewed for residents #8,#10,#11 and #12 and no change of condition noted related to infection control **Identification of others at risk**: All residents have potential for risk. Nurses notes reviewed for residents and no change of condition noted related to insufficient infection control practices **Measures to ensure this deficient** **practice does not recur:** Staff re-educated on proper hand washing procedures **Monitoring of corrective action:**	

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	hand washing upon hire, annually and as needed. During an interview on 06/29/2015 at 1:04 P.M., LPN #1 indicated proper hand washing during dining included hand washing with soap and water or hand sanitizing with gel between every resident and "definitely after touching a resident". Record review of the current "HANDWASHING AND USE OF GLOVES" policy, provided by the ADON (Assistant Director of Nursing) on 06/26/2015 at 11:13 A.M., indicated, "Hand hygiene will be performed before and after resident care is rendered and after handling contaminated articles." Record review of the current "HAND WASHING" policy, provided by the Administrator on 06/26/2015 at 11:30 A.M., indicated hands should be washed "...After touching bare human body parts other than clean hands and clean, exposed portions of arms..." and "...After handling soiled equipment or utensils...". 5-5.1(f)		The Director of Nursing (DON) or designee will observe hand washing during meal service 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, 1 time weekly for 3 months, and then 1 time monthly for 3 months. The results of the audits will be reviewed during morning clinical meeting and forwarded to the Quality Assurance Committee monthly for recommendations.	