

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/10/2015
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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN RD NEW ALBANY, IN 47150
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: April 6, 7, 8, 9, and 10, 2015</p> <p>Facility number: 001144 Provider number: 155668 AIM number: 200256980</p> <p>Census bed type: SNF: 66 SNF/NF: 70 Residential: 4 Total: 140</p> <p>Census payor type: Medicare: 36 Medicaid: 57 Private: 43 Total: 136</p> <p>Residential sample: 4</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000		
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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 371 SS=E Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>Based on observation and record review, the facility failed to provide the sanitary handling of food and utensils for 11 of 36 residents observed for meal service in the East and North dining rooms during 2 of 2 lunch observations. (Residents #8, #32, #35, #42, #77, #84, #97, #100, #135, #148, and #167).</p> <p>Findings include:</p> <p>During the lunch observation of the East dining room on 04/06/15 at 12:49 p.m., the following was observed:</p> <p>1. The Qualified Medication Aide (QMA) #5 removed a piece of half consumed bread, with her bare hands, from Resident #42's hand, then proceeded to assist Resident #49 and Resident #6 with their meals. QMA #5 did not wash her hands or use hand sanitizer before assisting Resident #49 and Resident #6.</p> <p>During the lunch observation of the</p>	F 371	<p>This plan of correction constitutes Diversicare of Providence's credible allegation of compliance for the cited deficiency Nothing in this plan of correction should be construed as admission by the facility of any violation of state and federal statues, regulations or standards of care This plan of correction is to demonstrate compliance of the state of and federal requirements cited during an annual survey 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility is unable to go back and correct for resident # 8, #32, #35, #42, #77, #84, #97, #100, #135, #148 and #167 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken Any resident requiring any type of assistance with their meal set up or feeding has the potential to be affected Facility staff will be in-serviced on providing proper sanitary handling of food and</p>	05/07/2015

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	<p>North dining room on 04/07/15, between 12:10 p.m. and 12:35 p.m., the following was observed:</p> <p>2. CNA (Certified Nursing Assistant) # 1 held the corn muffin in place with her bare fingers for Resident # 32 and applied butter with the resident's knife. She then held another corn muffin in place with her bare fingers for Resident # 97 and applied butter with the resident's knife.</p> <p>3. CNA # 2 applied butter to the corn muffin with a knife for Resident # 148, holding the muffin in place with her bare fingers.</p> <p>During the dining observation in the East dining room on 04/07/15 at 12:52 p.m., the following was observed:</p> <p>4. The Certified Nurse Assistant (CNA) #11 removed Resident #8's bread from the wrapper with her bare hands and placed it on Resident #8's plate.</p> <p>5. The Registered Nurse (RN) #5, picked up Resident #8's used napkin, then proceeded to assist Resident #53 with eating, the RN did not wash her hands or use hand sanitizer in between assisting the residents.</p>		<p>utensils 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Facility staff will be in-serviced on providing proper sanitary handling of food and utensils Director of Nursing or Designee will monitor dining rooms for proper sanitary handling of food and utensils for all three meals for one week, then weekly for one month, then monthly for three months and then quarterly for the remainder of the year 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place Director of Nursing or Designee will monitor dining rooms for proper sanitary handling of food and utensils for all three meals for one week, then weekly for one month, then monthly for three months and then quarterly thereafter. Findings will be reported to the QA committee</p>		

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	<p>During an observation in the East dining room on 4/7/15, between 12:30 p.m. and 1:25 p.m., the following was observed:</p> <p>6. CNA #10 reached in and grabbed a slice of bread with her bare hands, removed it from the wrapper and placed it on Resident #84's tray.</p> <p>7. CNA #11 was observed to sprinkle seasoning into her bare hand and then sprinkled it onto the food, for Residents' #135, #77 and #100.</p> <p>8. CNA #11 was observed touching her hair and then alternating feeding Residents #135, #77 and #100. CNA # 11 did not sanitize her hands between residents. The CNA was observed to touch all 3 residents' hands, arms and straighten their clothing while feeding them without handwashing or applying hand gel.</p> <p>9. At 1:10 p.m., CNA #10 was observed picking up a piece of Resident #84's peach shortcake with her bare hand and placed it back onto the plate for the resident to consume.</p> <p>Observation of the East dining room on 04/07/15, between 1:00 p.m. and 1:25 p.m., the following was observed:</p>			

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R 000 Bldg. 00	<p>10. QMA # 1 was observed assisting three Residents (#167, #35 and #146) with their lunch. The QMA picked up the used eating utensil for Resident # 167 and handed it to the resident. She then turned and picked up Resident #146's used eating utensil and handed it to the resident. She did this multiple times throughout the lunch observation. The QMA picked up the used cup of Resident # 35 and placed it in the resident's hand. The QMA used hand sanitizer only on one occasion during the observation, which she kept in the pocket of her uniform.</p> <p>During an interview with the Dietary Manager (DM) on 04/07/15 at 2:05 p.m., the DM indicated there was not a policy regarding staff handling of the residents utensils and food.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>Diversicare of Providence was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R 000		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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