

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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
--------------------	--	---------------	---	----------------------

R000000	<p>This visit was for a State Licensure Survey.</p> <p>Survey dates: May 13 &amp; 14, 2013</p> <p>Facility number: 011804 Provider number: 011804 AIM number: N/A</p> <p>Survey team: Angela Strass, RN, TC Sue Brooker, RD Julie Call, RN Virginia Terveer, RN</p> <p>Census bed type: Residential: 103 Total: 103</p> <p>Census payor type: Other: 103 Total: 103</p> <p>Sample: 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 17, 2013 by Randy Fry RN.</p>	R000000		
---------	--	---------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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
R000029	<p>410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, interview and record review the facility failed to ensure 2 of 29 Residents of Keepsake Village South (Memory Unit) who ate their meals in the dining room were treated with respect and dignity. (Resident #9 and Resident #10)</p> <p>Findings include:</p> <p>1. A continuous observation of Resident #9 during lunch on 5-13-13 from 12:00 p.m. to 1:35 p.m. in the Keepsake South Dining Room indicated the following:</p> <p>-At 11:50 a.m., beverage service began for the residents in the Keepsake South dining room.</p> <p>-At 12:00 p.m., Resident #9 was observed being wheeled into the dining room in her DES (Dyn-Ergo Scoot) Chair, which was low to the floor and tilted back to reduce the risk of falls. The resident was wheeled up to the table with 2 other residents for lunch. The tabletop height was above the resident's visual level.</p>	R000029	<p>1. Resident#9 and #10 show no adverse affect due to the alleged deficient practice, asevidenced by no significant weight loss.</p> <p>2.</p> <p>3. Allresidents have been assessed and care planned for their individual needsregarding table height and the ability to reach their meal and beverages whenplaced on the dining table.</p> <p>4.</p> <p>5. Facilitysystems have been reviewed and changed so that residents are given two beveragesof choice at each meal service, and offered a dessert in accordance with theirdiet orders. Monthly menus will beposted in each Village, as well as daily menus made readily available. Staff will be assigned to those residentsidentified as needing dining assistance as determined by the service plan. Adjustable height table(s) will be placed inthe</p>	06/14/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
	<p>-At 12:15 p.m., Resident #9 was served water, no other beverages were offered to Resident #9. The Resident was sleeping in her chair and was not awakened or offered the water that was served. The glass of water was not within the Resident's reach. Lunch service began at 12:20 p.m. for the residents in the dining room.</p> <p>-At 12:45 p.m., Resident #9 was awakened by CNA #7 by saying, "Here is your lunch, here is a green bean for you." Then CNA #7 placed the plate of food on the table above resident's eye level and CNA #7 handed her a single green bean to eat, and then left Resident #9 and served meals to the other residents.</p> <p>-At 12:46 p.m., Resident #9 finished eating the single green bean, then reached up and over the table top for more food from the plate. She could not see her plate and tapped on the tabletop to find her plate, her fingertips pushed the plate further out of reach. Then she also tried to reach the disposable plastic glass of water, she could only touch the glass with her fingertips, but not grasp it.</p> <p>-From 12:46 p.m. to 1:26 p.m., Resident #9's plate and water glass</p>		<p>dining room to accommodate those residents exhibiting difficulty with the standard height table. Staff will be in-serviced by Food Services Director and Keepsake Village Wellness Director, and/or designees on Dining Services in a dementia unit, which includes information on resident dignity and choices, food portions, menus, serving procedures, use of correct serving utensils, mealtime assistance, and cueing procedures.</p> <p>6.</p> <p>7. The Keepsake Village Wellness Director and/or designee will conduct sample audits of meal service at least weekly to ensure that facility procedures are being followed. Results of these audits will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
	<p>were still out of her reach and the resident received no assistance from staff to eat her meal. Resident #9 continued periodic tapping on the table and numerous staff members passed by her and did not assist her with her food or drink. Resident #9 then crossed her arms hugged herself and mumbled to herself.</p> <p>-At 1:15 p.m., CNA # 7 asked Resident #9 if her food was good but did not assist Resident #9 with any of her food or water.</p> <p>-At 1:26 p.m., CNA # 19 handed Resident #9 her glass of water. Resident was able to take sips of water while she held the cup and continued to take sips of the water. She put the glass of water on the edge of the table and then reached and tapped on the table for her plate again.</p> <p>-At 1:32 p.m., QMA #10 placed 1/4 of the sandwich into the Resident #9's hand and she ate a few small bites, then held the sandwich tightly and squeezed it in one hand to her mouth. The Resident then tried to reach for the water glass and knocked the glass over and spilled the remaining water onto the table. QMA #10 wiped up the spill and cleared away the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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
	<p>plate of food and water glass.</p> <p>-At 1:35 p.m., CNA # 7 asked Resident #9 if she was ready for a nap and wheeled her out of the dining room. The Resident was never offered the baked apples during lunch.</p> <p>Review of clinical record for Resident #9 on 5-13-13 at 3:00 p.m., indicated she had diagnoses including but not limited to dementia, degenerative joint disease, scoliosis, glaucoma, osteoporosis, depression and history of falls. The Resident was admitted to Hospice Services on 12-28-12.</p> <p>On 5-13-13 at 3:00 p.m., the clinical record of Resident #9 was reviewed. The Assessment and Service Plan dated 3-8-13 indicated the Resident required assist with dining, needed food cut up, prompting, encouragement, special utensils or tools.</p> <p>An interview with LPN #17, Keepsake North and South Unit Manager, on 5-13-13 at 4:10 p.m., indicated Resident # 9 was in a low speciality chair provided by Hospice to prevent future falls. She indicated they did not consider the dining table height a problem for this resident.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
	<p>2. A continuous observation of Resident #10 during lunch on 5-13-13 from 12:00 p.m. to 1:45 p.m. in the Keepsake South Dining Room, indicated the following:</p> <p>-At 12:00 p.m., Resident #10 was seated at a table with 2 other residents. He was seated in a high back wheelchair, with his eyes closed.</p> <p>-At 12:45 p.m., Resident # 10's plate was put in front of him by CNA #19. CNA #19 placed 1/4 of a fish sandwich in his hand and said, "Here is your sandwich." and left him to serve another plate. Resident #10 held the sandwich in his hand, his eyes remained shut and he did not attempt to eat his sandwich.</p> <p>-At 12:58 p.m. Resident dropped the sandwich on the floor.</p> <p>-At 12:59 p.m. CNA #19 placed another 1/4 of the fish sandwich in Resident #10's hand, told him, "Here is your fish sandwich." and walked away. Resident #10 attempted several times to take a bite of the sandwich but could not get the sandwich up to his mouth, then held the sandwich in his lap.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
	<p>-At 1:06 p.m., Resident #10 dropped the sandwich onto the floor when he tried to place it on the table.</p> <p>-At 1:20 p.m. QMA #10 talked with Resident #10, asked resident if he was going to eat, then she placed 1/4 of the sandwich in his hand, she encouraged him to take a bite, but he did not take a bite.</p> <p>-At 1:38 p.m., an unidentified CNA placed a cooked carrot in Resident #10's hand, and lifted his hand up to his mouth. The Resident held the carrot in his mouth and sucked on it for several minutes.</p> <p>-At 1:45 p.m., Resident #10 was wheeled out of dining room. He was never offered the any fluids during lunch or the baked apples.</p> <p>Review of clinical record for Resident #10 on 5-14-13 at 10:00 a.m., indicated he had diagnoses including but not limited to dementia, depression, gastroesophageal reflux disease, benign prostatic hyperplasia, insomnia, hypothyroidism, constipation. The Resident received Hospice Services.</p> <p>Resident #10's Assessment and</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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
	<p>Service Plan dated 3-8-13, indicated the Resident required assist with dining, needed food cut up, prompting, encouragement, special utensils or tools.</p> <p>An interview with LPN #17, Keepsake North and South Unit Manager, on 5-14-13 at 1:30 p.m., indicated Resident # 10's family had hired a caregiver to assist resident with eating his evening meal, personal care and supervision daily from 4 p.m. to 8 p.m.</p> <p>An interview with CNA #19 on 5-13-13 at 1:10 p.m., indicated that both Resident #9 and Resident #10 do not eat much and they were given foods that can be held in their hands. CNA #19 indicated Resident #9 usually only ate a few bites or spits out her food.</p> <p>Review of the facility's current policy for Meal-Time Assistance, dated 9/27/11, provided by Keepsake's Unit Manager, indicated,"...Assistance will be provided in a way that maintains the dignity and self-esteem of each resident...."</p> <p>Review of the facility's current policy for Resident Rights, dated 9/7/11, provided by Keepsake's Unit</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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
	Manager, indicated, "...Our resident have the right to...be treated with dignity and respect...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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
R000121	<p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
	<p>Based on interview and record review, the facility failed to administer a tuberculin skin test for 1 of 10 employees reviewed for tuberculin skin test administration at hire (QMA #11); the facility failed to ensure a tuberculin skin test was performed annually for 1 of 10 employees reviewed for annual tuberculin skin tests (Cook #12); and the facility failed to ensure a tuberculin skin test was administered and read prior to starting work for 1 of 10 employees reviewed for tuberculin test administration done at hire. (QMA #2)</p> <p>Findings include:</p> <p>1. The personnel record review on 5-13-2013 at 4:20 p.m., indicated QMA #11 did not have a tuberculin skin test performed and read at the hire date of 1-15-2013.</p> <p>An interview with the Administrator on 5-13-2013 at 4:20 p.m., indicated QMA #11 was working fulltime at another facility when she began employment at this facility on 1-15-2013. The Administrator provided a tuberculin skin test dated 6-23-2012 from the other facility.</p> <p>An interview with the Administrator on 5-14-2013 at 10:15 a.m., indicated</p>	R000121	<p>1. QMA#2, and Cook #12 employee files have been reviewed and corrected in accordance with state regulations. QMA #11 is no longer employed with Hearth Management.</p> <p>2.</p> <p>3. All employee records have been reviewed to identify any employees who have not received the tuberculin skin test(s). Tuberculin skin tests have been scheduled for those staff members on or before June 14th, 2013.</p> <p>4.</p> <p>5. Facility systems have been reviewed and changed so that employees will have the required tuberculin skin test(s) prior to being placed on the staff schedule. Business Office Manager was in-serviced on May 29th, 2013 on the policy and procedure of tuberculin skin test by Executive Director.</p> <p>6.</p> <p>7. The Business Office Manager and/or designee will conduct audits of employee tuberculin skin test records at least monthly to</p>	06/14/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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
	<p>since QMA #11 was employed fulltime at another facility where she received annual tuberculin skin tests, a tuberculin skin test was not given when she was hired for this facility on 1-15-2013.</p> <p>2. The personnel record review on 5-14-2013 at 10:15 a.m., indicated Cook #12 did not have an annual tuberculin skin test performed since 7-6-2011.</p> <p>An interview with the Administrator on 5-14-2013 at 10:20 a.m., indicated the tuberculin skin test documentation was not present in the employee's record.</p> <p>3. The personnel record review on 5-14-2013 at 10:20 a.m., indicated QMA #2 had a hire date of 12-18-2012. The initial tuberculin skin test was performed on 12-18-2012 and read on 12-21-2012, 3 days after QMA #2 started work.</p> <p>A policy titled "Mantoux Testing" (tuberculin skin test) and dated 9-27-2011 was provided by LPN #18 on 5-14-2013 at 11:16 a.m. The policy indicated "all communities will follow their State Guidelines regarding Mantoux Testing."</p>		ensure that facility procedures are being followed. Results of these audits will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
	An interview with LPN #18 on 5-14-2013 at 11:16 a.m., indicated this was the policy used for employees also, per the Administrator.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
R000123	<p>410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation.</p> <p>Based on interview and record review, the facility failed to ensure signed job descriptions were included in the personnel records for 4 of 10 records reviewed for current and accurate contents. (CNA #13, Housekeeper #14, LPN #15, and CNA #16.</p> <p>1. During the personnel records review which began on 5-13-2013 at 3 p.m., the records for CNA #13, Housekeeper #14, LPN #15 and CNA #16 lacked a signed job description.</p>	R000123	<p>1. C.N.A.#13, Housekeeper #14, LPN #15, and C.N.A. #16 employee files have been reviewed and job descriptions have been completed. 2. All employee records have been reviewed to identify any employees who do not have assigned job description. Appointments have been made with those staff members to review and sign job descriptions on or before June 14th, 2013. 4. Facility systems have been changed so that the facility shall maintain current and accurate personnel records for employees. Business Office Manager was in-serviced on May</p>	06/14/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
	<p>An interview with the Administrator on 5-13-2013 at 4:05 p.m., indicated there were no job descriptions in the personnel records for CNA #13, Housekeeper #14, LPN #15 and CNA #16.</p> <p>An interview with the Administrator on 5-13-2013 at 4:30 p.m., indicated the facility did not have a policy for personnel record contents.</p>		<p>29 th , 2013 oncorresponding facility policies and procedures by the Executive Director. 6. 7. The Business Office Manager and/or designee will conduct sample audits of employeerecords at least monthly to ensure that facility procedures are beingfollowed. Results of these audits willbe reviewed by the QA committee, who will establish the threshold of complianceand make further recommendations accordingly.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
R000270	<p>410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room.</p> <p>Based on observation, interview and record review the facility failed to provide an adequate serving of baked apples as defined on the weekly menu potentially affecting 29 of 29 residents who ate their meals in the Keepsake Village South dining room. The facility also failed to provide beverages as menued and provide additional beverages to 1 resident (Resident #14) who continually attempted to drink from a glass with no liquid, and the facility further failed to provide adequate assistance or cueing to eat for 2 Residents during lunch services. (Resident #9 and Resident #10)</p> <p>Findings include:</p> <p>1. During an observation of the Keepsake Village South dining room on 5/13/13 at 1:02 p.m., CNA (Certified Nursing Assistant) #1 was observed to dish up the baked apples</p>	R000270	<p>1. Resident#9 and #10, and #14 showed no adverse affect due to the alleged deficientpractice, as evidenced by no significant weight loss or signs of dehydration.</p> <p>2.</p> <p>3. Facilitysystems have been changed so that all Keepsake Village residents are given twobeverages of choice at each meal service, and offered a dessert in accordancewith their diet orders. Monthly menuswill be posted in each Village, as well as daily menus made readily available. Staff will be assigned to those residentsidentified as needing dining assistance as determined by the service plan. Adjustable height table(s) will be placed inthe dining room to accommodate those residents exhibiting difficulty with thestandard</p>	06/14/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
	<p>into individual dessert bowls. She was observed to use a green handled scoop, or a # 12 scoop, which provided 1/3 cup of baked apples.</p> <p>A review of the facility menu, approved by the Consultant Registered Dietitian, indicated the serving size for the baked apples for the lunch menu on 5/13/13 was 1/2 cup.</p> <p>The Dietary Manager was interviewed on 5/13/13 at 3:45 p.m. During the interview he indicated staff were to use a # 8 scoop (the scoop with a grey handle) for the baked apples which provided 1/2 cup and not a # 12 scoop (the scoop with a green handle) for the baked apples which provided 1/3 cup. He also indicated the facility menus were to be followed.</p> <p>QMA #2 was interviewed on 5/14/13 at 10:50 a.m. During the interview she indicated serving utensils for the meals on the unit were sent from the kitchen. She also indicated the staff used their judgement on what utensil to use on what items, like tongs for meat and scoops with holes in the bottom for vegetables. She further indicated there were no written instructions provided by the kitchen</p>		<p>height table. Staff will be in-serviced by Food Services Director and Keepsake Village Wellness Director, and/or designees on Dining Services in adementia unit, which includes information on resident dignity and choices, food portions, menus, serving procedures, use of correct serving utensils, mealtime assistance, and cueing procedures.</p> <p>4. The Keepsake Village Wellness Director and/or designee will conduct sample audits of meal service at least weekly to ensure that facility procedures are being followed. Results of these audits will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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
	<p>matching up the correct serving utensils with the correct food items, but if there were any questions they would contact the Dietary Manager.</p> <p>2. During a continuous observation of the Keepsake Village South dining room on 5/13/13 from 12:15 p.m through 1:05 p.m., Resident #14 was observed seated at a dining table with 2 other residents. He had received and already consumed a small glass of juice. During the meal he placed pieces of his food into the small glass and attempted to drink from the glass, although there was no liquid in the glass. After numerous attempts to drink from the small glass filled with his food, he was observed to pick the pieces of food out of the glass and consume them. He then continually brought the empty glass up to his mouth to drink.</p> <p>Numerous facility staff who were working the dining room, walked right past his table, but did not offer Resident #14 anything else to drink.</p> <p>The Dietary Manager was interviewed on 5/13/13 at 9:15 a.m. During the interview he indicated the facility did not offer any modified or therapeutic diets.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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
	<p>The Service Plan for Resident #14, dated 3/8/13, indicated he was to receive assistance with dining.</p> <p>A review of the facility menu, approved by the Consultant Registered Dietitian, indicated an 8 ounce glass of milk and a beverage of choice were to be provided to each resident during the noon meal on 5/13/13.</p> <p>3. A continuous observation of Resident #9 during lunch on 5-13-13 from 12:00 p.m. to 1:35 p.m. in the Keepsake South Dining Room indicated the following:</p> <p>-At 11:50 a.m., beverage service began for the residents in the Keepsake South dining room.</p> <p>-At 12:00 p.m., Resident #9 was observed being wheeled into the dining room in her DES (Dyn-Ergo Scoot) Chair, which was low to the floor and tilted back to reduce the risk of falls. The resident was wheeled up to the table with 2 other residents for lunch. The tabletop height was above</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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
	<p>the resident's visual level.</p> <p>-At 12:15 p.m., Resident #9 was served water, no other beverages were offered to Resident #9. The Resident was sleeping in her chair and was not awakened or offered the water that was served. The glass of water was not within the Resident's reach. Lunch service began at 12:20 p.m. for the residents in the dining room.</p> <p>-At 12:45 p.m., Resident #9 was awakened by CNA #7 by saying, "Here is your lunch, here is a green bean for you." Then CNA #7 placed the plate of food on the table above resident's eye level and CNA #7 handed her a single green bean to eat, and then left Resident #9 and served meals to the other residents.</p> <p>-At 12:46 p.m., Resident #9 finished eating the single green bean, then reached up and over the table top for more food from the plate. She could not see her plate and tapped on the tabletop to find her plate, her fingertips pushed the plate further out of reach. Then she also tried to reach the disposable plastic glass of water, she could only touch the glass with her fingertips, but not grasp it.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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
	<p>-From 12:46 p.m. to 1:26 p.m., Resident #9's plate and water glass were still out of her reach and the resident received no assistance from staff to eat her meal. Resident #9 continued periodic tapping on the table and numerous staff members passed by her and did not assist her with her food or drink. Resident #9 then crossed her arms hugged herself and mumbled to herself.</p> <p>-At 1:15 p.m., CNA # 7 asked Resident #9 if her food was good but did not assist Resident #9 with any of her food or water.</p> <p>-At 1:26 p.m., CNA # 19 handed Resident #9 her glass of water. Resident was able to take sips of water while she held the cup and continued to take sips of the water. She put the glass of water on the edge of the table and then reached and tapped on the table for her plate again.</p> <p>-At 1:32 p.m., QMA #10 placed 1/4 of the sandwich into the Resident #9's hand and she ate a few small bites, then held the sandwich tightly and squeezed it in one hand to her mouth. The Resident then tried to reach for the water glass and knocked the glass over and spilled the remaining</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
	<p>water onto the table. QMA #10 wiped up the spill and cleared away the plate of food and water glass.</p> <p>-At 1:35 p.m., CNA # 7 asked Resident #9 if she was ready for a nap and wheeled her out of the dining room. The Resident was never offered the baked apples during lunch.</p> <p>Review of clinical record for Resident #9 on 5-13-13 at 3:00 p.m., indicated she had diagnoses including but not limited to dementia, degenerative joint disease, scoliosis, glaucoma, osteoporosis, depression and history of falls. The Resident was admitted to Hospice Services on 12-28-12.</p> <p>On 5-13-13 at 3:00 p.m., the clinical record of Resident #9 was reviewed. The Assessment and Service Plan dated 3-8-13 indicated the Resident required assist with dining, needed food cut up, prompting, encouragement, special utensils or tools.</p> <p>An interview with LPN #17, Keepsake North and South Unit Manager, on 5-13-13 at 4:10 p.m., indicated Resident # 9 was in a low speciality chair provided by Hospice to prevent future falls. She indicated they did</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
	<p>not consider the dining table height a problem for this resident.</p> <p>4. A continuous observation of Resident #10 during lunch on 5-13-13 from 12:00 p.m. to 1:45 p.m. in the Keepsake South Dining Room, indicated the following:</p> <p>-At 12:00 p.m., Resident #10 was seated at a table with 2 other residents. He was seated in a high back wheelchair, with his eyes closed.</p> <p>-At 12:45 p.m., Resident # 10's plate was put in front of him by CNA #19. CNA #19 placed 1/4 of a fish sandwich in his hand and said, "Here is your sandwich." and left him to serve another plate. Resident #10 held the sandwich in his hand, his eyes remained shut and he did not attempt to eat his sandwich.</p> <p>-At 12:58 p.m. Resident dropped the sandwich on the floor.</p> <p>-At 12:59 p.m. CNA #19 placed another 1/4 of the fish sandwich in Resident #10's hand, told him, "Here is your fish sandwich." and walked away. Resident #10 attempted several times to take a bite of the sandwich but could not get the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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
	<p>sandwich up to his mouth, then held the sandwich in his lap.</p> <p>-At 1:06 p.m., Resident #10 dropped the sandwich onto the floor when he tried to place it on the table.</p> <p>-At 1:20 p.m. QMA #10 talked with Resident #10, asked resident if he was going to eat, then she placed 1/4 of the sandwich in his hand, she encouraged him to take a bite, but he did not take a bite.</p> <p>-At 1:38 p.m., an unidentified CNA placed a cooked carrot in Resident #10's hand, and lifted his hand up to his mouth. The Resident held the carrot in his mouth and sucked on it for several minutes.</p> <p>-At 1:45 p.m., Resident #10 was wheeled out of dining room. He was never offered the any fluids during lunch or the baked apples.</p> <p>Review of clinical record for Resident #10 on 5-14-13 at 10:00 a.m., indicated he had diagnoses including but not limited to dementia, depression, gastroesophageal reflux disease, benign prostatic hyperplasia, insomnia, hypothyroidism, constipation. The Resident received Hospice Services.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
	<p>Resident #10's Assessment and Service Plan dated 3-8-13, indicated the Resident required assist with dining, needed food cut up, prompting, encouragement, special utensils or tools.</p> <p>An interview with LPN #17, Keepsake North and South Unit Manager, on 5-14-13 at 1:30 p.m., indicated Resident # 10's family had hired a caregiver to assist resident with eating his evening meal, personal care and supervision daily from 4 p.m. to 8 p.m.</p> <p>An interview with CNA #19 on 5-13-13 at 1:10 p.m., indicated that both Resident #9 and Resident #10 do not eat much and they were given foods that can be held in their hands. CNA #19 indicated Resident #9 usually only ate a few bites or spits out her food.</p> <p>An interview with the Coporate Nurse Consulant on 5-13-13 at 4:00 p.m. during the daily exit conference, indicated the facility staff does not feed the residents but the staff is able to assist the residents by encouraging, cueing, providing hand over hand to assist residents in eating or mirroring by sitting down and</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
	<p>eating with residents and talking with them.</p> <p>During observations made at lunch services on 5-13-13, in Keepsake South dining room, no staff were observed to sit down with Resident #9 or Resident #10 to encourage, cue or mirror them to eat.</p> <p>Review of the facility's current policy for Meal-Time Assistance, dated 9/27/11, provided by Keepsake's Unit Manager, indicated, "...Assistance will be provided in a way that maintains the dignity and self-esteem of each resident...."</p> <p>Review of the facility's current policy for Resident Rights, dated 9/7/11, provided by Keepsake's Unit Manager, indicated, "...Our resident have the right to...be treated with dignity and respect...."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
R000272	<p>410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature.</p> <p>Based on observation, interview and record review the facility failed to ensure the temperatures of hot food and cold food were taken at the time of service in the Keepsake Village North affecting 17 of 17 residents who ate their meals in the Keepsake Village North dining room and at the time of service in the Keepsake Village South affecting 29 of 29 residents who ate their meals in the Keepsake Village South dining room.</p> <p>Findings include:</p> <p>1. During an observation of the facility kitchen on 5/13/13 at 9:15 a.m., the Food Service Director indicated food for the Keepsake Village North and for the Keepsake Village South were sent from the kitchen in steam table pans which were then placed in the portable steam table units in each of the unit kitchens. He also indicated the food temperatures were taken prior to the food being delivered to the units.</p> <p>2. During an observation of the Keepsake Village North on 5/13/13 at 11:40 a.m., residents were being seated at the dining tables. Pitchers of milk and juices were</p>	R000272	<p>1. No adverse affect occurred as a result of the alleged deficient practice.</p> <p>2.</p> <p>3. Facility systems have been changed so that temperature log books are kept in the kitchen area of both Keepsake Village units. Beverages are kept on ice to ensure proper temperature. Food temperatures are taken at the point of service by the staff member serving food to ensure proper temperatures as defined by the revised facility policy. Additional thermometers were purchased to ensure staff access at each meal. Staff will be in-serviced by Food Service Director or designee on corresponding facility temperature procedures on or before June 14 th , 2013.</p> <p>4.</p> <p>5. The Food Services Director and/or designee will conduct sample audits of meal service at least monthly to ensure that corresponding facility</p>	06/14/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
	<p>observed on the counter of the unit kitchen and residents were being offered drinks. No temperatures were taken of the milk and juices prior to the start of service to ensure they were at the appropriate temperature and the pitchers were not placed on ice to keep them cold. At 12:00 p.m., a cart containing steam table pans with the lunch meal was transported from the facility kitchen to the kitchen on the unit. The steam table pans were placed into the wells of the portable steam table units and the lunch service was started. No temperatures of the hot food were taken prior to the start of service to ensure they were at the appropriate temperature.</p> <p>3. During an observation of the Keepsake Village South on 5/13/13 at 12:15 p.m., residents were seated at the dining tables. Pitchers of milk and juices were observed on the counter of the unit kitchen and residents were being offered drinks. No temperatures were taken of the milk and juices prior to the start of service to ensure they were at the appropriate temperature and the pitchers were not placed on ice to keep them cold. The cart containing steam table pans with the lunch meal from the kitchen was already in the unit kitchen. At 12:35 p.m., the steam table pans were placed into the wells of the portable steam table units and</p>		<p>procedures are being followed. Results of these audits will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
	<p>the lunch service was started. No temperatures of the hot food were taken prior to the start of service to ensure they were at the appropriate temperature.</p> <p>The Consultant Registered Dietitian was interviewed on 5/13/13 at 3:15 p.m. During the interview she indicated the facility was not taking the temperatures of the hot and cold food prior to service in the Keepsake Village North and the Keepsake Village South. She also indicated temperatures should be taken at the time of service.</p> <p>A current facility policy "Food Temperatures", dated 9/27/11 and provided by the Administrator on 5/14/13 at 8:30 a.m., indicated "...Hot foods should be maintained at a minimum of 140 degrees F...Cold foods should be maintained at a maximum of 41 degrees F...."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
R000273	<p>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.</p> <p>Based on observation, interview and record review the facility failed to protect silverware and a steam table pan from contamination, failed to protect food from potential contamination, failed to wash hands appropriately and for the appropriate amount of time, potentially affecting 103 of 103 residents who ate meals in the main dining room., the Keepsake Village North dining room, and the Keepsake Village South dining room.</p> <p>Findings include:</p> <p>1. During an observation of the facility kitchen on 5/13/13 at 9:30 a.m., an open cart containing a bin of wrapped silverware, with silverware exposed, and a dishmachine caddy containing soup spoons with the bowls of the spoons exposed at the top of the caddy, was transported from the facility kitchen through two common hallways to the main dining room by Server #3. The bin and the caddy were not covered.</p> <p>2. During an observation of the Keepsake</p>	R000273	No adverse affect occurred as a result of the alleged deficient practice. Facility systems have been changed so that silverware, utensils, and serving dishes transported from kitchen to dining rooms are properly covered. The facility hand washing procedure has been revised in accordance with state regulations. Staff will be in-serviced by Wellness Directors and/or designees on facility handwashing procedures on or before June 14 th , 2013. The Wellness Directors and/or designee will conduct sample audits of meal service at least monthly to ensure that facility procedures are being followed. Results of these audits will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly.	06/14/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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
	<p>Village North on 5/13/13 at 12:05 p.m., a large steam table pan of fish was delivered in the food cart. Determining all the hot food could not be placed in the steam table due to the size of the pan holding the fish, CNA #4 left the unit and brought a small steam table pan to the unit kitchen through common hallways. The steam table pan was not covered to protect the inside from contamination. QMA #5 immediately transferred the fish from the large steam table pan to the small pan, placed the small pan into the well of the steam table and began meal service.</p> <p>3. During an observation of the Keepsake Village South on 5/13/13 from 12:30 p.m. to 1:05 p.m., the following was observed:</p> <ul style="list-style-type: none"> <li>- At 12:30 p.m., CNA #1 was observed to wash her hands for only 4 seconds. She then proceeded to don a pair of disposable gloves and continue dishing lunch plates for residents.</li> <li>- At 12:32 p.m., CNA #6 was observed to wash her hands for only 4 seconds. She did not use a paper towel as a protective barrier to turn off the water faucet. She then proceeded to don a pair of disposable gloves and continue serving lunch plates to residents.</li> </ul>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814			
(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			
	<p>- At 12:34 p.m., CNA #7 was observed to wash her hands for only 7 seconds. She then proceeded to don a pair of disposable gloves and continue serving lunch plates to residents.</p> <p>- At 12:35 p.m., CNA #6 was observed to rinse off a soiled plate. She then removed her disposable gloves and was observed to wash her hands for only 3 seconds. She did not use a paper towel as a protective barrier to turn off the water faucet. She then proceeded to don a pair of disposable gloves and remove clean dinner plates from the cabinet.</p> <p>- At 12:40 p.m., CNA #6 was observed to wash her hands for only 2 seconds. She then proceeded to don a pair of disposable gloves and continue serving lunch plates to residents.</p> <p>- At 12:42 p.m., CNA #6 was observed to wash her hands for only 6 seconds and Activities #7 was observed to wash her hands for only 7 seconds. Both proceeded to don disposable gloves and continue serving lunch plates to residents.</p> <p>- At 12:45 p.m., CNA #1 was observed to wash her hands for only 4 seconds. She proceeded to don a pair of disposable gloves and opened a can of pop. She then proceeded to remove her disposable</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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
	<p>gloves, use sanitizing solution, and don a new pair of disposable gloves. She then was observed to remove a loaf of bread from the cabinet. She again was observed to remove her disposable gloves, use sanitizing solution, and don a new pair of disposable gloves. She then removed 4 slices of bread from the loaf with her gloved hands to make 2 fish sandwiches. CNA #9 then took the plates containing the fish sandwiches and handled them with her gloved hands to cut the sandwiches in half.</p> <p>- At 1:00 p.m., QMA #10 was observed to wash her hands for only 7 seconds. She did not use a paper towel as a barrier to turn off the water faucet.</p> <p>- At 1:02 p.m., CNA #6 was observed to wash her hands for only 6 seconds. She then proceeded to don a pair of disposable gloves to pass bowls of baked apples to residents. She was observed to carry the bowls with her gloved hands touching the rims.</p> <p>The Consultant Registered Dietitian was interviewed on 5/13/13 at 3:15 p.m. During the interview she indicated all items coming from the facility kitchen need to be covered when transported through the hallways. She also indicated dietary staff were to wash their hands for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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
	<p>20 seconds.</p> <p>A current facility policy "Hand washing", dated 9/27/11 and provided by the Administrator on 5/14/13 at 8:30 a.m., indicated "...Turn on water and wash hands with soap...Wash you palm, fingers, between fingers, under fingernails, wrists, and forearms...For routine washing, wash the hands for 15-30 seconds...Rinse hand and wrists well removing all soap and dirt...Dry the hands with a clean paper towel...Using the paper towel, turn off the faucet...(Don't use your hands to turn off the water as they are clean and the faucet is contaminated...."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
--	---

(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