STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155471	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEASONS RETIREMENT CENTER	1901 TAYLOR RD COLUMBUS, IN 47203

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F000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00139708. Complaint IN00139708 - Substantiated. No deficiencies related to the allegation are cited. Survey Dates: December 16, 17, 18, 19, and 20, 2013. Facility number: 000543 Provider number: 155471 AIM number: NA Survey Team: Diana Sidell RN, TC Jennifer Carr RN Sunny Jungclaus RN Gloria Reisert MSW (December 16, 17, and 18, 2013) Caitlin Lewis RN Paula Igou RN (December 16, 17, 19, and 20, 2013) Julie Dover RN (December 19, and 20, 2013) Census bed type: SNF: 18	F000000	Plan of Correction of F-0000Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiencies cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement, that the allegations made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Four Seasons requests that compliance with Federal and State rules be determined through paper review.	

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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	Residential: 99 NCC: 44 Total: 161 Census payor type: Medicare: 13 Other: 148 Total: 161 Sample: Residential: 7 NCC: 7 NCC supplemental sample: 1 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on december 30, 2013 by Cheryl Fielden RN.			
F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement their policy for abuse in that written statements were not	F000226	Four Seasons respectfully requests an Informal Dispute Resolution for this deficiency, as we believe there has been a misunderstanding about the terms "written" and "handwritten."	01/19/2014

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	obtained from staff who witnessed incidences of alleged abuse. This affected 3 of 3 residents reviewed for 2 investigations of alleged abuse. (Residents #143, 144, and 146) Findings include: On 12/19/13 at 2:22 p.m., the Director of Nursing (DoN) provided two reportable abuse incidents. An incident dated 2/12/13, indicated an incident between Resident #143 and Resident #146. The incident was reported to ISDH and investigated, but the investigative documentations lacked written statements from CNA # 6 who had observed the incident. An incident dated 6/30/13, indicated an incident between Resident #144, and a family member. The incident was reported to ISDH, but the investigative documentations lacked written statements from LPN # 7 and RN # 8 who had observed the incident, only a summary typed by the DoN. During an interview with the DoN, on 12/19/2013 at 1:45 p.m., the DoN indicated that she did not obtain handwritten statements from the		IDR 226 We dispute the deficiency cited here. There seems to be confusion regarding the terms "written" and "hand written." Four Seasons Abuse policy as it existed on the date of the Survey, stated that 'written statements' are to be provided when investigating an Incident that has been turned in to ISDH. Four Seasons Policies, as they existed on the date of the survey, do not say that statements are to be handwritten, as the Surveyors have erroneously cited in their statement of deficiency -- they added the word "hand" in error, to change "written" to "handwritten." We believe that written statements (but not handwritten) were provided, collected, and filed appropriately, per the Four Seasons policy. We believe that the difference between written and hand written would be that a written statement could still be typed, and that saying 'written' is to help contrast between 'writing' as opposed to 'oral' or 'verbal'. Four Seasons policy, as it existed on the date of the survey, was followed -- written statements were obtained.	

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	staff that witnessed the two separate incidents, and indicated that she just typed a summary of the events. She indicated that the policy states that handwritten statements are required. On 12/16/13 at 12:32 p.m., the DoN provided a policy and procedure for "Abuse, Investigation of /Protection of Resident" The policy indicated, but was not limited to: "Policy: It shall be the policy of Four Seasons that upon the allegation or identification of abuse, neglect, or misappropriation of resident property, Four Seasons shall immediately undertake an investigation of the allegation or event. It shall be the policy of Four Seasons to assure the safety of the resident involved during and after any such allegation. Procedure...f. Written statements are obtained by the Administrator and/or designee from all involved parties including the suspended staff member. g. Upon receipt of all statements, Administrator and/or designee reviews statements for validation of alleged concern...." 3.1-28(a)		Plan of Correction for F226 Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiencies cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement, that the allegations made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Four Seasons requests that compliance with Federal and State rules be determined through paper review.	

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			These two self-reported incidents, which the Surveyors refer to, were thoroughly investigated and documented – one in conjunction with the office of State Ombudsman on September 23, 2013 (Resident #144) – and appropriately reported to the ISDH, per Four Seasons policies and state regulations.	

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			Regarding the Incident on June 26 between Resident #144 and a family member: The LPN's written (typed) version of what had happened was in the 'Reportable' Notebook with the same investigative information that was supplied to the surveyors. The RN's written (typed) version of what had happened was in the	

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			RN's file that the Director of Nursing keeps on each staff member in a locked file in her office, and had not been placed in the 'Reportable' notebook with the rest of the investigation. It has now been placed there with the rest of the investigation information.	

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			Regarding the second alleged abuse that was also self reported by Four Seasons (involving Residents #143 and #146), the typed version of the CNA report to the DON was also in the CNA's file that is kept in the Director of Nursing's office. It too, has been placed in the Reportable book with the rest of the investigation.	

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			Corrective actions taken.	

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			Four Seasons Abuse policy has been changed to use the phrase hand written instead of written, as follows: "f. Hand written statements are obtained by the Administrator and /or designee from all involved parties including the suspended staff member if applicable. Each statement will be signed with a written signature by the person submitting the statement." (Exhibit A Revised Abuse Policy)	

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			All handwritten copies written by witnesses to a state reportable incident will be placed in the Reportable Book along with copies of all investigation.	

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			Measures and systemic changes to prevent recurrence. All staff have been re-educated as to the changes in the Four Seasons Abuse policy, regarding the changes in the method in which they turn in their handwritten version of what they witness during an incident. Education was done on January 10th, 2014. (Exhibit B Abuse In-service Sign In)	

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			Monitoring corrective actions. The Director of Nursing will be responsible for making sure the policy is followed by all staff. A check list has been developed as to what documents need to be kept together with the State Reportable information. (Exhibit C Abuse Checklist). All changes will be reported at the Quarterly QAA	

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			meeting in January. Future reportable incidents will be reviewed by the DON, and reported at QAA meetings.	

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			Systemic changes identified in this Plan of Correction will be completed by January 19, 2014.	
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			

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	Based on record review and interview the facility failed to develop care plans for 1 resident who received an antidepressant and an anticoagulant. This affected 1 of 22 residents reviewed for care planning. (Resident #73) Findings include: Review of the clinical record of Resident #73 on 12/18/2013 at 11:30 a.m., indicated the resident had the diagnosis that included, but not limited to, double knee replacement, thyroid disorder, arthritis, osteoporosis, anxiety disorder and depression. Resident #73's Physician's orders, dated 12/9/13, indicated she was prescribed citalopram (an antidepressant medication) 20 milligrams (mg) once per day for depression, with a start date of 12/9/13, and enoxaparin (a low molecular weight heparin) 30 mg subcutaneously every 12 hours for ten days for double joint replacement, with a start date of 12/9/13. Documentation was lacking of a care plan for an antidepressant and	F000279	The reason for requesting an Informal Dispute Resolution for this deficiency is that Four Seasons believes there has been a misunderstanding of the time frames involved in moving from our Interim/Initial Care Plans to the Comprehensive Care Plan for this resident. IDR 279 We dispute the deficiency cited here. Four Seasons' "Interim/Initial Care Plan Policy" states that the Interim/Initial Care Plan is to be completed by the Licensed Nurse within 24 hours of admission. (Exhibit D Initial Care Plan Policy) The Interim/Initial Care Plan is a primary care plan used to initiate the resident's care, and includes anything that has to do with the admission. For example, late loss ADL's, observing for falls, communication, nutrition problems, use of side rails, bed mobility and pressure ulcers. The MDS Coordinator reviews the Interim/Initial Care Plan within 14 daysof admission to update and /or add additional elements. The MDS Coordinator reviews the resident's chart, and applies more specific care plans with updates as needed. This follows our Interim/Initial Care Plan Policy and Procedure.	01/19/2014

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	an anticoagulant. A behavior sheet labeled December 2013 indicated the resident was being monitored for anxiety behaviors and for side effects of her antianxiety medication. Her depression and side effects of her antidepressant were not listed on this behavior sheet. Documentation was lacking of monitoring of her antidepressant medication. During an interview with LPN #5 on 12/20/2013 at 11:02 a.m., she indicated she was not aware of any care planning for enoxaprin. A policy and procedure for "Care Planning/Assessments" was provided by the DoN on 12/19/13 at 1:42 p.m. The policy indicated but was not limited to: "Complete initial care plan within 24 hours of admission...revise as appropriate with physician order changes and resident/family request...." 3.1-35(a)		For tag F279: Resident # 73 was admitted on 12/09/2013, and the survey questions were asked on 12/18/2013. This was 9 days later; Four Seasons was still within the 14 days, and the MDS Coordinator still had 5 days left before the review was required to be updated. There is not an Interim care plan for the anticoagulants, but that would have been addressed by the MDS Coordinator within the 14 day deadline. There is an Interim Care Plan for antipsychotics (Exhibit E Example Care Plan) which would have included the antidepressant, but it too, would have been addressed by the MDS Coordinator prior to the 14 day deadline. Lovenox and monitoring for side effects: Residents on any type of blood thinner are observed for low blood pressure, and we automatically observe the skin for any significant increase in bleeding, and good clinical nursing judgment would lead a nurse to contact the MD in the event of a noticed bleeding event. Tracking of Lovenox (enoxaparin): Very few physicians	

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			order PT/INR's to track Lovenox, because one of the luxuries of being on Lovenox is that it does not have to be monitored by labs. Generally, orders for Lovenox are short term, no more than one to two weeks, so we do not receive lab orders to monitor. Therefore, we do not have a policy to track Lovenox. Once in a great while, a doctor will order a PT/INR, but it is rare. If a person was on Lovenox therapeutically, the MD could order a CBC at periodic intervals, but our residents are only on Lovenox short term. The only other lab that is ever used for low molecular Heparin (Lovenox) is Anti – Xa, which is used for morbidly obese people or pregnant women, but not for elderly residents. Our residents are usually off of Lovenox when they are admitted to our facility, and at that point they are on Coumadin. This resident was an exception, because she had bilateral knee surgery. Plan of Correction for F279 Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the	

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			deficiencies cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement, that the allegations made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Four Seasons requests that compliance with Federal and State rules be determined through paper review. Corrective actions for F279. Review the Interim/Initial Care Plan Policy with the Nurse Management Team and update/change any policies if needed by January 15th. If changes are made, then re-educate the entire Nursing Staff on any changes, no later than January 17th. Measures and systemic changes to prevent recurrence. We will review with our medical team to see if there is any updated	

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			information that is available regarding monitoring Lovenox. If there is, then we will educate our staff and create a policy to coincide with any labs or monitoring by January 17th. Four Seasons will educate our nurses by January 17th regarding any side effects from Lovenox and the need to document appropriately to prevent any new admissions being admitted on Lovenox to not have side effects monitored. Residents on Lovenox will be charted on for signs and symptoms of any side effects daily, and documentation will be entered in Nurses Notes. Charts will be audited and reported on at QAA meeting x 2. (Six months) Monitoring of corrective actions and systemic changes. Audits will be performed on Admissions to see if the appropriate Interim Care Plans are being entered and will be reported to our QAA committee at our quarterly meetings which will be in January. (Exhibit F Admission Paperwork Audit)	

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FOUR SEASONS RETIREMENT CENTER	1901 TAYLOR RD COLUMBUS, IN 47203

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			These systemic changes will be completed by January 19th, 2014.	
F000314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review and interview, the facility failed to ensure that a resident with a pressure ulcer received necessary treatment and services to promote healing. This affected 1 of 3 residents reviewed for pressure ulcers. (Resident #35) Findings include: Review of the clinical record of Resident #35 on 12/18/2013 at 9:41 a.m., indicated the resident had diagnosis that included, but not limited to, traumatic brain injury, diabetes mellitus and hypertension.	F000314	Plan of Correction for F314 Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiencies cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement, that the allegations made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Four Seasons requests that compliance with Federal and State rules be determined through paper review.	01/19/2014

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	During an interview with LPN #3 on 12/18/2013 at 12:15 p.m., she indicated the Resident #35 was admitted to the facility with a stage two pressure ulcer to his coccyx. She indicated the area had "gotten worse" since the resident had been admitted to the facility on 10/31/2013. The dressing order for the pressure ulcer on his coccyx had not been changed since admission. The dressing was changed every three days and measured weekly. The area had gotten larger, so there was a new order on 12/17/2013 for Foley catheter placement. During an interview with LPN #3 on 12/19/2013 at 10:53 a.m., she indicated if the pressure ulcer on Resident #35's coccyx began to improve, with the new Foley catheter placement, that they would keep the same dressing as ordered. A care plan dated 11/15/2013 indicated Resident #35 had the problems of alteration in skin integrity related to a pressure ulcer on his coccyx and potential for pressure ulcers related to impaired and decline in mobility due to subdural hemorrhage with craniectomy. The goal dated		Resident 35 was admitted to Four Seasons on 10/31/2013 with a Stage 2 pressure ulcer on the buttock/coccyx area, measuring 3.25x4x<0.5cm. All measures were put in place to prevent the ulcer from getting worse. Resident 35 was placed on an air mattress; heels were floated, turned and repositioned every two hours. Optifoam was ordered to be placed every 3 days and PRN. Pressure ulcer was to be assessed and measured every week. All these measures were carried out as ordered. Resident 35's healing ability was compromised by his nutrition intake, although he was being monitored weight wise by the facility dietician, further complicated by the fact that he was totally dependent on us to reposition him. In addition to being assessed and measured by the staff nurse, the pressure ulcer was also being monitored by an LPN who keeps track of all wounds and pressure ulcers. (Exhibit G Treatment timeline.) When a wound isn't healing properly, a Physical Therapists is asked to look at the wounds and provide an opinion of what changes need to be made. After one month, Resident 35's pressure ulcer measured 1.5x0.8x< 0.1cm. This was a vast improvement. The order for the Optifoam was continued due to	

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	12/27/2013 indicated the resident will be free of open areas on any pressure points as evidenced by intact, warm, supple skin. The interventions included, but were not limited to, treatment per MD order, assist in changing position at least every 2 hours, pressure-reducing mattress in place on bed and wheelchair and review medications and assess need for multivitamins with minerals, zinc and or vitamin C. A care plan dated 11/15/2013 indicated the resident had potential for alteration in skin integrity related to bladder and bowel incontinence. The goal indicated the resident would be clean and dry and the skin would be free of rashes, irritations, excoriations or open lesions related to bowel and bladder incontinence. The goal was dated 12/27/2013. The interventions included, but were not limited to, observe resident for frequency of voiding, distention, and discomfort, notify MD of any skin breakdown and observe resident's skin integrity and chart any signs of rash or redness. Physician's orders, dated 10/31/2013, indicated an order was written for Optifoam (an absorbent dressing) to area on coccyx, change		per the measurements, the wound was healing well. On December 4, 2013, the wound size increased to 4.2x4.4x<0.1. Nurses were verbally educated at the time on how the wound was measured (from one end of the area to the other, rather than just the wound itself) due to the increase in size from one week to the next. On 12/11/2013, the wound measured 2.1x2x<0.1. On 12/13/2013, a fax was sent to the doctor asking for an order to place a Foley catheter. The doctor did not respond until 12/17/2013 and the Foley catheter was placed per orders. On 12/18/2013 one of the nurses measured the wound erroneously (the depth) which made it look as if the wound was getting worse. This nurse was asked to re-measure it, and the measurement documentation was corrected. In the nurse's notes on 12/18 and 12/20, after the Foley catheter was placed, there is documentation (exhibit H follow up documentation) showing this additional documentation on the condition of the wound. Plan of Correction: Corrective actions taken. All nursing staff will be re-educated regarding the correct way to measure and document pressure ulcers by January 15, 2014. Also,	

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	every 3 days and as needed for soilage. Reassess and measure area every week. Physician's orders, dated 12/17/2013, indicated an order was written to place a Foley catheter until the pressure ulcer was healed. The wound/ skin healing record dated 10/31/2013, indicated the resident was admitted with a stage two pressure ulcer on his coccyx. The area measured 3.25 c.m. X 4 c.m. with the depth of less than 0.5 c.m. The wound/skin healing record dated 11/6/2013 indicated the resident's pressure ulcer measured to be 2.3 c.m. X 2.1 c.m. with the depth of 0.1 c.m. The wound/skin healing record dated 11/13/2013, indicated the resident's pressure ulcer measured 2.5 c.m. X 2.5 c.m. with the depth of less than 0.1 c.m. The wound/skin healing record dated 11/20/2013, indicated the resident's pressure ulcer measured 1.6 c.m. X 0.8 c.m. with the depth of less than 0.1 c.m. The wound/skin healing record dated 11/27/2013, indicated the resident's pressure ulcer measured 1.5 c.m. X 0.8 c.m. with the depth of less than 0.1 c.m. The wound/skin healing record dated 12/15/2013, indicated the resident's pressure ulcer measured		staff will be in-serviced on implementation of new interventions if/when wounds are not improving. Measures and systemic changes, and monitoring of corrective actions. Pressure ulcer documentation (including measurements) will be audited and reported on in quarterly QAA until 100% compliance is met, and intermittently afterwards. At bi-weekly SOC meetings, condition of pressure ulcers and status of wounds will be discussed, and appropriate new interventions will be discussed with the Management Nurses and implemented. These systemic changes will be completed by January 19, 2014. LPN #3 was observed changing the dressing on resident # 35's coccyx and was observed to remove her gloves, and put them on the resident's bedside table prior to throwing them away and then proceed to wash her hands and walk out of the room without sterilizing the table. Four Seasons Policy "Skin Conditions, Prevention of Pressure Ulcers" indicates that the purpose of the policy is to prevent skin breakdown. (Exhibit I Skin Conditions, Prevention of	

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	2.1 c.m. X 2.0 c.m. and the depth was less than 0.1 c.m. The wound/ skin healing record dated 12/18/2013, indicated the resident's pressure ulcer measured 2.75 c.m. X 3.0 c.m. and the depth was less than 0.5 c.m. During an interview with LPN #4 on 12/20/2013 at 10:45 a.m., she indicated the nurse who had documented the measurements of the pressure area on 12/18/2013 was asked to measure the area again. She provided a timeline of the Resident #35's pressure ulcer measurements at this time. The timeline document of Resident #35's pressure ulcer provided by LPN #4 indicated, "12/20/13 (LPN #3) who measured area on 12/18/13 asked to re-measure wound due to depth change documented from prior assessment to <0.5cm on the 18th. Nurse indicated she thought the depth increase was an error on her part. Current measurement (after remeasured): 2.75X3.75X<0.1 cm." On 12/18/2013 at 12:20 p.m., LPN #3 was observed performing a dressing change to Resident #35's coccyx area for a stage 2 pressure		Pressure Ulcers) LPN # 3 has provided a written statement that diputes the Surveyor's observation. She states that she would never put her gloves on the bedside table. (Exhibit J Nurse's hand written statement) She states that her standard procedure for changing a clean non sterile dressing is to put the trash can close to the bed with her foot, to easily facilitate its use and put the bedside table close to her area and use it to put her clean supplies in reach. She does not believe that she would place dirty gloves on the bedside table, as she would have her trash can close by for that purpose. She states that the thought of someone putting soiled gloves, dressing supplies on a bedside table is very offensive to her. She also adds that there was another nurse in the room, holding the resident on his side so LPN #3 could perform the dressing change. A second nursewho was also has supplied a written statement saying that at no time did she see LPN #3 dispose of any items improperly. She adds that she was facing LPN #3 during the whole dressing change due to her holding resident #35 on his side for the dressing change. (Exhibit K Nurse's Hand written statement)	

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	ulcer. LPN #3 handwashed and donned gloves before applying saline wound wash to gauze and cleaned the pressure area. The nurse continued to measure the area and place a new dressing over the coccyx without handwashing or changing the gloves she had been wearing while cleaning the wound. The soiled gauze and measuring instruments were then placed into the gloves and the nurse turned the gloves inside out upon removal to contain the items. The gloves were placed on the bedside table. After the nurse removed the items from the bedside table she handwashed and left the room without sanitizing the bedside table. The policy and procedure titled "Skin Conditions, Prevention of Pressure Ulcers" indicated the purpose of the policy and procedure was to prevent skin breakdown. The policy indicated resident's who are most at risk for skin breakdown include the following: Bedfastness/chairfastness, immobility, bowel/ bladder incontinence, poor nutrition and lowered mental awareness. The policy states, "It is the responsibility of the Licensed Nurse to recognize that assessment and documentation		As stated regarding this same nurse on a separate tag (F441) associated with this same incident: This is an excellent nurse, that gets nervous when being observed. Although she did admit to the fact that she did not wash her hands as stated on the separate tag, she is adamant that she did not take her dirty gloves off and put them on the table without cleaning the table afterwards. Corrective actions taken. Nursing staff will be in-serviced regarding Infection Control measures during dressing changes. (Exhibit B Inservice sign in.) Measures and systemic changes. Four Seasons policy on Infection Control will be reviewed for any changes that need to be updated. Monitoring of corrective actions. Dressing changes will be observed randomly once a week and infection control techniques will be observed. Findings will be discussed at our quarterly QAA meetings x 2 (six months). Any nurses still using poor Infection Control techniques will be re-educated and will receive a counseling write up. These systemic changes will be completed by January 19, 2014.	

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	is an ongoing process. Accurate documentation provides for timely, preventative and therapeutic interventions. These interventions may minimize the development and severity of pressure ulcers, and assist in the healing of all wounds." 3.1-40(a)(2)			
F000371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on record review, observation and interview, the facility failed to ensure male dietary employees with facial hair wore protective coverings to prevent food contamination during 3 of 3 kitchen and/or dining room observations. This deficient practice affected 61 of 62 residents currently residing in the Health Center. Finding includes:	F000371	F371 Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiencies cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement, that	01/19/2014

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	1. During the initial tour, on 12/16/13 between 10:15 a.m. and 10:40 a.m., the Dietary Manager was observed in/out of walk-in and reach-in refrigerators and freezers, looking over foods being cooked on stove and on steam table, and in dry storage room. His facial moustache was not covered throughout the tour. 2. During a kitchen observation of meal service between 11:15 a.m. and 12:00 p.m.- the Dietary Manager, Executive Chef and Chef were observed walking around kitchen, looking over at the food on steam table and on stove and 2 servers were serving food plates to residents in the dining room and room trays walking from inside the kitchen to the dining room. All of the 5 male employees had facial hair that was not covered. At 11:25 a.m., food temperatures were taken by the Cook with the Dietary Manager standing directly next to her looking over food at the thermometer. His facial moustache was not covered. 3. During an kitchen observation of the lunch meal service on 12/18/13		the allegations made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Four Seasons requests that compliance with Federal and State rules be determined through paper review. With several years of surveys involving the same surveyors and the same staff with the same styles of facial hair, we are perplexed as to how this deficiency came to be cited as part of this year's survey. In 2012, this facility was cited for loose hair not covered by nets, but not for facial hair which was present. Nevertheless, we have taken corrective actions and measures as outlined here. Corrective actions. Facility policies have been rewritten to include the following: that all facial hair must be covered. (Exhibit L Food Service Workers) This	

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	between 11:20 a.m. and 12:10 p.m., while accompanied by the Dietary Manager, the following was observed: - Server #2 was observed leaning over 2 resident room trays, taking orders and serving food from kitchen to dining room residents, placing food items on trays for Assisted Dining Room residents. His facial hair was not covered. - The Dietary Manager was gathering up utensils for serving from the clean dish room and placing them in front of uncovered food pans on the steam table. - The Executive Chef arrived at 11:30 a.m., to assist with food preparation for short orders and dipped up food for dining room and room trays from the steam table. His facial hair was not covered. - Server #1/short order cook was prepping short order requests and making salads. His facial hair was not covered. At 12:26 p.m., on 12/18/13, the Dietary Manager presented a copy of the facility's current policy titled " Uniform Dress Code". Review of this policy at that time included, but		includes all production staff and anyone entering production areas. Also includes staff that are preparing trays or assisting in production. This affects all Residents, Visitor and employees that order food from Dinning Services. Measures and systemic changes. An in-service for all staff has been documented, with copy of policy handed out to all employees and managers. In-service was held January 2nd - January 6th. (Exhibit M Food Service Sign In) Any new male employee hired in the future will receive a copy of our updated policy. Disciplinary action for non compliance will be enforced. Monitor corrective actions. All Supervisors will assist in maintaining compliance with these corrective actions. Sanitation inspections which now include facial hair checks are performed monthly, and reported to QAA quarterly.	

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	was not limited to: "...Procedures:..Wait staff do not need hair restraints unless assisting in production of food items. Long facial hair must be covered with a surgical mask and/or hood. Mustaches and/or sideburns must be neatly trimmed. Mustache should not extend below the corners of the mouth; sideburns should not grow beyond the earlobe...." At 1:55 p.m. on 12/18/13, an interview with the Dietary Manager indicated: "I thought we could have a beard, moustache or goatee as long as it was short and neatly groomed. Will have to change the policy." 3.1-21(i)(3)		These corrective actions and systemic changes will be implemented and completed by January 19, 2014.	

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F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview,	F000441		01/19/2014

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	and record review, the facility failed to ensure handwashing was done during a dressing change that affected 1 of 1 residents. (Resident #35) Findings include: Review of the clinical record of Resident #35 on 12/18/2013 at 9:41 a.m., indicated the resident had the diagnosis of, but not limited to, traumatic brain injury, diabetes mellitus and hypertension. The record indicated on 10/31/2013 an order was written for Optifoam (an absorbent dressing) to area on coccyx, change every 3 days and as needed for soilage. Reassess and measure area every week. A wound/skin healing record dated 12/15/2013 indicated the resident had a stage 2 pressure ulcer located on his coccyx. On 12/18/2013 at 12:20 p.m., LPN #3 was observed performing a dressing change to Resident #35's coccyx area for a stage 2 pressure ulcer. LPN #3 handwashed and donned gloves before applying saline wound wash to gauze and cleaned the pressure area. The nurse continued to measure the area and place a new dressing over		Plan of Correction for F441 Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiencies cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement, that the allegations made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Four Seasons requests that	

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	the coccyx without handwashing or changing the gloves she had been wearing while cleaning the wound. The soiled gauze and measuring instruments were then placed into the gloves and the nurse turned the gloves inside out upon removal to contain the items. The gloves were placed on the bedside table. After the nurse removed the items from the bedside table she handwashed and left the room without sanitizing the bedside table. A Policy for "Infection Control Statement" was provided by the DoN on 12/20/13 at 11:05 a.m. The policy indicated, but was not limited to, "The following infection control measures should be exercised whenever using any of the policies or procedures in this manual, as they apply: 1. Observe Universal Precautions. 2. Wash your hands before and after all procedures. Wear gloves when appropriate...9. Thoroughly clean all equipment used and return to appropriate storage area...." 3.1-18(l)		compliance with Federal and State rules be determined through paper review. The nurse involved in this incident, LPN #3, is a trusted caregiver at Four Seasons, fully trained in infection control skills. The nurse was nervous to be observed by the Surveyors, and acknowledges that she did not wash her hands nor change her gloves when she should have. Corrective actions taken. LPN #3, will be educated one-on-one regarding dressing changes. She will sign a document upon completion of this re-education. (Exhibit N acknowledgement of one-one reeducation) In addition, LPN #3 will be assigned education regarding hand washing, wearing gloves, and dressing changes in our employee in-service education program, Silverchair.	

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			Corrective actions for other residents. All nursing staff will be reeducated on correct hand washing, wearing of gloves, and dressing changes. (Exhibit B In-service sign in) Measures and systemic changes. Dressing changes will be observed randomly once a week by a nurse supervisor, and infection control techniques will be observed. Monitor Corrective actions. Findings from these observations will be discussed at quarterly QAA meetings x 2. (six months). Any nurses using poor Infection Control techniques will be re-educated one on one, and will received a counseling write up. Counseling process per our discipline policy will be followed for any further episodes. Goal will be that all nurses (100%) are using the proper infection control techniques at all times within two weeks following re-education.	

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R000000	These state findings are cited in accordance with 410 IAC 16.2.	R000000	These systemic changes will be implemented and completed by January 19, 2014. Plan of Correction of F-0000Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiencies cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement, that the allegations	

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			made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Four Seasons requests that compliance with Federal and State rules be determined through paper review.	
R000273	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 record review, observation and interview, the facility failed to ensure male dietary employees and a maintenance employee with facial hair wore protective coverings to prevent food contamination during 1 of 1 kitchen and/or dining room observations. This deficient practice affected 36 of 36 Residential Residents and 12 visitors served lunch on 12/17/13.	R000273	Plan of Correction for R273 Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiencies cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement, that	01/19/2014

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	Finding includes: During a kitchen/meal service observation on 12/17/13, between 11:20 a.m. and 12:10 p.m., while accompanied by the Dietary Manager, the following was observed: - Maintenance Worker #1 was observed standing in the middle of the kitchen. Upon interview with Cook #1 at 11:25 a.m., he indicated the Maintenance Worker was waiting on his lunch plate. Maintenance Worker #1 was observed to have no hair net on to cover his hair while in the kitchen. - The Dietary Manager was observed walking around the kitchen and standing by steam table while food temperatures were being taken. His mustache was not covered. - Cook #1 was observed preparing mashed potatoes and serving food items from the steam table. His facial hair was not covered. - The Chef was observed cutting up a tray of hams, dipping up plates from the steam table for the dining room, checking temperatures of various food items and occasionally		the allegations made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Four Seasons requests that compliance with Federal and State rules be determined through paper review. With several years of surveys involving the same surveyors and the same staff with the same styles of facial hair, we are perplexed as to how this deficiency came to be cited as part of this year's survey. In 2012, this facility was cited for loose hair not covered by nets, but not for facial hair which was present. Nevertheless, we have taken corrective actions and measures as outlined here. Corrective actions. Facility policies have been rewritten to include the following: that all facial hair must be covered. (Exhibit L Food Service Workers) This	

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	walking around the kitchen while staff were plating foods and preparing items for the next meal/day. His facial hair was not covered. At 12:26 p.m. on 12/18/13, the Dietary Manager presented a copy of the facility's current policy titled "Uniform Dress Code". Review of this policy at this time included, but was not limited to: "...Procedures:..Wait staff do not need hair restraints unless assisting in production of food items. Long facial hair must be covered with a surgical mask and/or hood. Mustaches and/or sideburns must be neatly trimmed. Mustache should not extend below the corners of the mouth; sideburns should not grow beyond the earlobe...." At 1:55 p.m. on 12/18/13, an interview with the Dietary Manager indicated: "I thought we could have a beard, moustache or goatee as long as it was short and neatly groomed. Will have to change the policy."		includes all production staff and anyone entering production areas. Also includes staff that are preparing trays or assisting in production. This affects all Residents, Visitor and employees that order food from Dinning Services. Measures and systemic changes. An in-service for all staff has been documented, with copy of policy handed out to all employees and managers. In-service was held January 2nd - January 6th. (Exhibit M Food Service Sign In) Any new male employee hired in the future will receive a copy of our updated policy. Disciplinary action for non compliance will be enforced. Monitor corrective actions. All Supervisors will assist in maintaining compliance with these corrective actions. Sanitation inspections which now include facial hair checks are performed monthly, and reported to QAA quarterly.	

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			These corrective actions and systemic changes have been implemented and completed by January 19, 2014.	