

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155596	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/27/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LAKELAND SKILLED NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703
---	--

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

F000000	<p>This visit was for the Investigation of Complaint IN00145434.</p> <p>Complaint IN00145434-Substantiated. Deficiency related to the allegations is cited at F 371.</p> <p>Survey dates: March 26, and 27, 2014</p> <p>Facility number : 000474 Provider number: 155596 AIM number: 100290510</p> <p>Survey team: Christine Fodrea, RN, TC</p> <p>Census bed type: SNF: 4 SNF/NF: 67 Total: 71</p> <p>Census payor type: Medicare: 17 Medicaid: 37 Other: 17 Total: 71</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p><b>This Plan of Correction is the center's credible allegation of compliance.</b></p> <p><b>Preparation and /or execution of this plan of correction does not constitutes admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</b></p> <p><b>We respectfully request that this Plan of Corretion be given a desk review.</b></p>	
---------	--	---------	---	--

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:  155596	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/27/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LAKELAND SKILLED NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703
---	--

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

	Quality review completed on March 28, 2014 by Randy Fry RN.			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155596		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND SKILLED NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703			
(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			
F000371 SS=E	<p>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</p> <p>Based on observation, interview and record review, the facility failed to maintain safe food storage in the main dry storage area. The facility further failed to maintain clean equipment in the back dining area. This had the potential to affect 69 of 71 residents in the facility.</p> <p>Findings include:</p> <p>1. On 3-26-2014 at 5:02 PM, in the dry storage area of the kitchen, the following was observed.: a box marked corrosive liquid was on top of a document shredding bin touching the shelf and boxes of coffee, coffee filters, and styrofoam cups; small pieces of paper were observed on the floor around the document shredding bin; a 30 gal trash can with a lid on had no liner, and contained hairnets, pieces of paper, and a plastic fork; and a box of cornflakes was on the seat of an office chair, and the seat of the chair was stained brown and</p>	F000371	<p>It is the policy of this facility to store, prepare, distribute and serve food under sanitary conditions. 1. The box marked corrosive liquid was removed to its designated area by the Dietary Manager on 3-26-14 by 5:38 PM. The dry storage area was swept, the trash can emptied and new liner place, the box of cornflakes reshelfed, and the shred bin and chair removed from the dry storage area by 5:38 PM on 3-26-14. Dietary staff were re-educated on appropriate storage in the dry storage area on 4-10-14. The dry storage area floor will be swept/mopped daily and initialed on the cleaning schedule. A weekly audit of the storage area will be conducted by the Dietary Manager or her designee for four weeks. If no further issues are found the audits will be completed on a monthly basis for 6 month. The Dietary manager will present the results of the audits to the Business Leadership Team on a weekly/monthly basis The Business Leadership Team will present the results to the Quality Assurance Committee. The</p>	04/26/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155596	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2014
NAME OF PROVIDER OR SUPPLIER  LAKELAND SKILLED NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703		
(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>gray.</p> <p>In an interview on 3-26-2014 at 5:12 PM, Dietary Employee #1, indicated the chemicals should have been in the chemical area and not in the dry food storage area. She indicated she was not sure about the other items.</p> <p>On 3-26-2014, at 5:38 PM, the Dietary Manager indicated the paper bin and trash can had been moved to appropriate locations and the corn flakes had been placed on the shelf. Additionally, the chair should not have been on the dry storage area and had been taken out.</p> <p>In an interview on 3-26-2014 at 5:41 PM, LPN #2 indicated there were only 2 residents of the 71 in the facility who did not eat food prepared in the kitchen.</p> <p>2. On 3-26-2014 at 5:41 PM, in the Dining Room on the 400 hall way, the following was observed: white scale was noted on the ice machine that could be flaked off; the microwave had yellowish dried substance on the tray, and brownish splattered matter on the sides and top of the interior, the door to the microwave also had whitish scaly drip marks from the ice machine above it, and the hand sink</p>		<p>Quality Assurance Committee responsible to the Administrator will monitor the results for continued compliance. 2. The ice machine and microwave were both taken out of use on 3-26-14 so that additional cleaning could be completed. The hand sink spigot was cleaned on 3-26-14. All cleaning of the mentioned items was completed by 3-27-14. Dietary staff were re-educated on the cleaning schedules for the microwave, ice machine and hand sink on 4-10-14. The ice machine, microwave and hand sink will be cleaned after each meal service and initialed on the cleaning schedule. A daily audit will be conducted by the Dietary Manager or her designee for two weeks. If there are no further issues the audit will be conducted weekly for an additional four weeks. If there are no further issues after the six week period, the audit will be conducted monthly for six months. The Dietary Manager will present the results of the audits to the Business Leadership Team on a weekly/monthly basis. The Business Leadership Team will present the results to the Quality Assurance Committee. The Quality Assurance Committee, responsible to the Administrator will monitor the results for continued compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155596		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2014	
NAME OF PROVIDER OR SUPPLIER  LAKELAND SKILLED NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703			
(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>next to the microwave and ice machine had white scale on the end of the spigot that could be flaked off.</p> <p>In an interview on 3-26-2014 at 5:47 PM, LPN #2 indicated the sink next to the ice machine and microwave was used to wash hands.</p> <p>In an interview on 3-26-2014 at 5:48 PM, LPN #3 indicated the microwave was to be cleaned after each use if spills or splatters occurred, and no one had cleaned the microwave that she knew of that day.</p> <p>In an interview with the Administrator on 3-26-2013 at 6:02 PM, the Administrator indicated the microwave on the 400 hall had been cleaned, and the ice machine had been taken out of order until cleaning could be completed.</p> <p>A review of the ice machine cleaning schedule dated 2014 provided by the Administrator on 3-27-2014 at 9:31 AM, indicated in March the Ice machine was cleaned and sanitized in the main Dining Room and in the 400 Hall Dining room. Additionally, the form indicated the ice machine lines were flushed per manufacturer's recommendation in March. The form did not indicate when in March the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155596	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2014
NAME OF PROVIDER OR SUPPLIER  LAKELAND SKILLED NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703		
(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>maintenance had been completed.</p> <p>A review of the 400 hall Dining Room Cleaning schedule dated week of March 24, 2014, provided by the Dietary Manager on 3-27-2014 at 9:28 AM indicated the microwave was to be cleaned each shift and there were 2 check marks indicating the cleaning had been completed on 3-26-2014.</p> <p>This Federal tag relates to Complaint IN00145434.</p> <p>3.1-21(i)(1)(2)</p>				