

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/20/2014
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NAME OF PROVIDER OR SUPPLIER LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: November 12, 13, 14, 17, 18, 19, and 20, 2014</p> <p>Facility number: 000347 Provider number: 155715 AIM: 100275440</p> <p>Survey team: Julie Dover, RN - TC Rita Bittner, RN Tammy Forthofer, RN</p> <p>Census bed type: SNF/NF: 105 Residential: 33 Total: 138</p> <p>Census payor type: Medicare: 15 Medicaid: 51 Other: 39 Total: 105</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000279 SS=D	<p>Quality review completed on December 2, 2014, by Janelyn Kulik, RN.</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>Based on record review and interview the facility failed to complete a comprehensive care plan for 1 of 20 residents whose care plans were reviewed. (Resident #32)</p> <p>Finding included:</p> <p>During an interview with LPN (Licensed Practical Nurse) #11 on 11/18/2014 at 2:13 PM, she indicated Resident #32 had episodes of urinary incontinence</p>	F000279	F 279 Develop Comprehensive Care Plans: It is the policy of this facility to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. Corrective Action For The Resident Affected: The record for Resident #32 was reviewed for incontinence, an updated bowel and bladder assessment was completed, and the care plan was revised to include incontinence. Other Residents Having The Potential To Be Affected: All	12/18/2014
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F000280 SS=D	<p>occasionally some days and other days she doesn't have any problems. It depends how she was feeling.</p> <p>On 11/18/2014 at 10:35 AM the clinical record for Resident #32 was reviewed. Her diagnoses included, but was not limited to atrial fibrillation, hypertension, chronic obstructive pulmonary disease, restless leg syndrome, and osteoarthritis.</p> <p>The quarterly Minimum Data Set assessment (MDS) dated 10/08/2014 indicated Resident #32 had less than seven episodes of urinary incontinence in the look back time frame of seven days. The Certified Nursing Assistant (CNA) worksheet for Resident #32 indicated she was incontinent and toilets herself.</p> <p>Review of the care plan section of the resident's record indicated there was no care plan for urinary incontinence.</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to</p>		<p>incontinent residents have the potential to be affected. All care plans of incontinent residents were audited to assure the presence of an incontinence care plan. Systemic Changes and Steps to Assure Deficient Practice Does Not Recur: The DON or designee will audit bowel and bladder assessments quarterly and assure the care plan reflects the resident's bowel and bladder status as indicated in the bowel and bladder assessment. (Attachment titled Bowel and Bladder Audit). Monitoring of Corrective Action: Audit results will be reviewed by the Quality Assurance Performance Improvement Committee monthly for six months. If the care plan reflects the resident's bowel and bladder status as indicated in the bowel and bladder assessment 100% of the time, monthly monitoring will be stopped and random audits will occur. A sample size of 25% will be completed monthly. If opportunities for improvement are identified through the random audit, a full audit will resume. If after six months of random audits 100% compliance continues, auditing will stop.</p>				

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	<p>participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview the facility failed to update the care plans for 3 of 20 residents whose care plans were reviewed. (Residents # 73, #129 and #4)</p> <p>Findings included:</p> <p>1. During an interview on 11/19/2014 12:01 PM, RN #10 indicated Resident #73 was not currently receiving a nutritional supplement.</p> <p>On 11/19/2014 at 10:54 AM the clinical record for Resident #73 was reviewed. Diagnoses included, but were not limited to, bipolar disorder, syncope, falls, stage III chronic kidney disease, hypertension, and depressive disorder.</p> <p>The meal consumption record indicated Resident #73 had consumed 75-100% of</p>	F000280	F 280 Right To Participate Planning Care/Revising Care Plan It is the policy of this facility that the resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. Care plans are periodically reviewed and revised as indicated. Corrective Action for Residents Affected: Resident # 73 (2567 says Resident #79 but there is not a Resident #79 on the sample list) and #129 are discharged from the facility. The Fall care plan for Resident #4 was reviewed and revised as necessary to reflect current fall interventions. The Fall Intervention Sheet information for Resident #4 was reviewed and revised as necessary. Other Residents Having The Potential	12/18/2014

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	<p>each meal from 10/01/2014 through 11/19/2014.</p> <p>Resident #73 had a care plan dated 9/8/2014 for impaired nutritional status related to diabetes, weight change, diuretic use, depression, and anxiety. The goal for the care plan was for the resident to maintain a stable weight through the next review of 12/31/2014. The interventions included consuming at least 75% of meals, monitoring weight, and reporting any chewing or swallowing problems.</p> <p>The admission Minimum Data Set assessment (MDS) dated 9/12/14 indicated resident's height was 63 inches and weight was 151 pounds. The resident's weight on 11/18/2014 was recorded as 136 pounds. No further updates to the care plan regarding interventions for weight loss were noted.</p> <p>2. During an observation on 11/17/2014 at 2:53 PM, Resident #4 was observed in the lounge/dining area. Certified Nursing Assistant (CNA) #9 provided assistance for mobility and balance from the dining area to the lounge chair.</p> <p>The record for Resident #4 was reviewed on 11/17/2014 at 2:43 PM. Current diagnoses included, but were not limited to, anemia, heart failure, hypertension,</p>		<p>To Be Affected: All residents having accidents and all residents at nutritional risk have the potential to be affected. The Fall care plans were reviewed for all residents in the facility to assure interventions were indicated on the Fall Intervention Sheets. A review of falls for the previous 30 days was completed to identify interventions consisting of therapy referrals without another intervention indicated. Additional interventions were added as necessary. The Nutrition care plans were reviewed and updated as necessary for all residents in the facility. An initial nutrition audit (Attachment titled Initial Nutrition Audit) was completed for all residents indicated for weight loss or weight gain in the Optimus EMR Alerts report. (Optimus is the facility's electronic medical record). Referrals to the Dietitian were made based on the results of the audit. Systemic Changes and Steps to Assure Deficient Practice Does Not Recur: The DON or designee will review fall interventions when closing each Accident/Injury Report to assure an additional intervention is provided when a therapy referral is the chosen intervention. This will assure an alternate intervention is in place in the event therapy will not be initiated for that resident. The ADON or designee will audit for compliance when completing the Fall Review Note (Attachment titled Fall</p>				

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	<p>dementia and depression.</p> <p>An Incident Details form, dated 10/27/2014 at 8:33 PM, indicated Resident #4 lost her balance while being transferred in the shower room. Under the Corrective Measures column the facility indicated "Physical Therapy to assess gait and balance." This was signed by LPN #8.</p> <p>An Incident Details form, dated 10/30/2014 at 11:30 AM, indicated Resident #4, "CNA was toileting resident in the whirlpool room and when resident got up from toilet and started to walk with her walker, resident when [sic] to turn walker and started falling back and to the side." "CNA reports resident frequently has problems with turns when up using walker". Corrective Measures taken by the facility, dated 10/30/2014 by LPN #11, indicated, "Therapy referral form filled out and delivered to therapy staff."</p> <p>An Interdisciplinary Rehabilitation Screening Form, signed by Physical Therapist #14, dated 11/6/2014, was received from OT #7. The form indicated Resident #4 had shown a decline in functional mobility for the past few months. The family was contacted by the therapy department. Resident's family</p>		<p>Review Note). The DON or designee will complete the Nutrition Audit (Attachment titled Nutrition Audit) twice a month and make referrals to the dietitian if indicated. Nursing staff education will be completed to review the need for an additional intervention when a therapy referral is the chosen intervention in the event therapy will not be initiated. Monitoring of Corrective Action: Audit results will be reviewed by the Quality Assurance Performance Improvement Committee monthly for six months. If appropriate referrals, interventions, and care plans are documented 100% of the time, monthly monitoring will be stopped and random audits will occur. A sample size of 25% will be completed monthly. If opportunities for improvement are identified through the random audit, a full audit will resume. If after six months of random audits, 100% compliance continues, auditing will stop.</p>				

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	<p>had refused therapy.</p> <p>The CNA Worksheet was received from CNA #9 on 11/17/2014 at 2:50 PM and was identified as current. The worksheet indicated Resident #4 needed one person to assist her with transferring. A notation at the bottom of the worksheet indicated to "See Fall Intervention Sheets for resident specific Fall Interventions."</p> <p>The Fall intervention Sheet, was received from LPN #8 on 11/17/14 at 2:55 PM and it was identified as current. The current Care Plan was "10-30-14 Therapy referral due to difficulty with turning when up with rolling walker." No further update to the Fall Prevention Care Plan was noted after the families refusal of therapy.</p> <p>An interview on 11/17/2014 at 2:40 PM with Occupational Therapist (OT) #7 indicated Resident #4 had a decline in functional mobility for the past few months and family had refused therapy. She indicated the nursing staff were advised of no physical therapy being performed.</p> <p>An interview on 11/17/2014 at 2:54 PM with License Practical Nurse (LPN) #8 indicated the fall interventions for Resident #4 had been changed from a one</p>			

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	<p>person assist to a two person assist. LPN #8 indicated this was the plan and intervention due to Resident #4's recent falls and increasing weakness.</p> <p>During an interview, on 11/17/2014 at 2:56 PM, with CNA #9, she indicated the CNA Worksheet listed Resident #4 as requiring the assistance of one person when showering. CNA #9 indicated, "the resident's balance is not good and balancing with one person is very difficult".</p> <p>3. The record for Resident #129 was reviewed on 11/18/2014 at 10:37 AM. Current diagnoses included, but were not limited to Cerebral Artery Occlusion with infarction, peripheral vascular disease, kidney disease stage 2, hypertension, esophageal reflux, hypothyroidism, iron deficiency anemia, osteoporosis, and rheumatoid arthritis.</p> <p>Resident's recorded weights were as follows:</p> <p>06/06/2014: 119 pounds 06/23/2014: 115 pounds 07/01/2014: 113 pounds</p> <p>A Dietary progress note, dated 6/9/2014 at 10:13 AM by Registered Dietician #13, indicated resident's current weight was</p>				

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	<p>119 pounds. Estimated nutrition needs were listed as "1350-1620 kilocalorie, 54-65 grams of protein, and 1350-1620 cubic centimeters." No nutrition diagnosis at this time was noted on the progress note. Dietary Preferences Comments indicated the resident's average meal intake was 56% and her fluid intake was 480 milliliters.</p> <p>A Dietary progress note, dated 6/23/2014 at 8:21 AM by Registered Dietician #13, indicated resident's current weight was 115 pounds, "no weight change noted". General Dietary Comments included "30 day noted. No new meds. No new recommendations at this time". Dietary Preferences comments indicated the resident's average meal intake was 64%, with fluid intake of 840 milliliters.</p> <p>The Resident Admission Assessment form, dated 06/05/2014, indicated Resident #129's weight was 119 pounds, and height was 64 inches. On the admission assessment the resident's appetite was noted as "good".</p> <p>Resident #129's Nutritional Status Care Plan, dated 06/09/2014, indicated the resident was at risk for impaired nutritional status related to anxiety, weight change and diuretic use. The goal for the resident was to maintain a stable</p>			

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F000323 SS=D	<p>weight through the next review. The Care Plan approach was for the resident to be encouraged to consume at least 75% of all meals, provide diet as ordered, monitor weight and observe for and report any problems with chewing, swallowing, etc, to MD.</p> <p>During an interview, on 11/18/2014 at 11:23 AM, the DON indicated Resident #129 was not receiving a nutritional supplement during her stay at the facility from 06/05/2014 to 07/08/2014. The DON indicated, after reviewing the Dietary Progress Note, dated 06/24/2014, there were no new medication orders or recommendations pertaining to the resident's average intake of 64%. The DON indicated Resident #129's Nutritional Status Care Plan, dated 06/09/2014, indicated the goal for the resident was to maintain a stable weight through the next review. The DON indicated the Care Plan did not address the weight loss or meal consumption less than 75%.</p> <p>3.1-35(d)(2)(B)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident</p>				

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	<p>receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure the resident's fall interventions were in place for 1 of 3 that met the criteria for falls. (Resident #4)</p> <p>Findings included:</p> <p>During an observation on 11/17/2014 at 2:53 PM, Resident #4 was observed in the lounge/dining area. Certified Nursing Assistant (CNA) #9 provided assistance for mobility and balance from the dining area to the lounge chair.</p> <p>The record for Resident #4 was reviewed on 11/17/2014 at 2:43 PM. Current diagnoses included, but were not limited to, anemia, heart failure, hypertension, Dementia and depression.</p> <p>An Incident Details form, dated 10/27/2014 at 8:33 PM, indicated Resident #4 lost her balance while being transferred in the shower room. Under the Corrective Measures column the facility indicated "Physical Therapy to assess gait and balance." This was signed by LPN #8.</p> <p>An Incident Details form, dated 10/30/2014 at 11:30 AM, indicated</p>	F000323	<p>F 323 Free of Accident Hazards It is the policy of this facility that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Corrective Action for Residents Affected: The Fall care plan for Resident #4 was reviewed and revised as necessary to reflect current fall interventions. The Fall Intervention Sheet information for Resident #4 was reviewed and revised as necessary. Other Residents Having The Potential To Be Affected: All residents having accidents have the potential to be affected. The Fall care plans were reviewed for all residents in the facility to assure interventions were indicated on the Fall Intervention Sheets. A review of falls for the previous 30 days was completed to identify interventions consisting of therapy referrals without another intervention indicated. Additional interventions were added as necessary. Systemic Changes and Steps to Assure Deficient Practice Does Not Recur: The DON or designee will review fall interventions when closing each Accident/Injury Report to assure an additional intervention is provided when a therapy referral is the chosen intervention. This will assure an alternate</p>	12/18/2014

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	<p>Resident #4, "CNA was toileting resident in the whirlpool room and when resident got up from toilet and started to walk with her walker, resident when [sic] to turn walker and started falling back and to the side." "CNA reports resident frequently has problems with turns when up using walker". Corrective Measures taken by the facility, dated 10/30/2014 by LPN #11, indicated, "Therapy referral form filled out and delivered to therapy staff."</p> <p>An Interdisciplinary Rehabilitation Screening Form, signed by Physical Therapist #14, dated 11/6/2014, was received from OT #7. The form indicated resident #4 had shown a decline in functional mobility for the past few months. The family was contacted by the therapy department. Resident's family had refused therapy in the past.</p> <p>The CNA Worksheet was received from CNA #9 on 11/17/2014 at 2:50 PM and was identified as current. The worksheet indicated Resident #4 needed one person to assist her with transferring. A notation at the bottom of the worksheet indicated to "See Fall Intervention Sheets for resident specific Fall Interventions."</p> <p>The Fall intervention Sheet, was received from LPN #8 on 11/17/14 at 2:55 PM</p>		<p>intervention is in place in the event therapy will not be initiated for that resident. The ADON or designee will audit for compliance when completing the Fall Review Note (Attachment titled Fall Review Note). Nursing staff education will be completed to review the need of an additional intervention when a therapy referral is the chosen intervention in the event therapy will not be initiated. Monitoring of Corrective Action: Audit results will be reviewed by the Quality Assurance Performance Improvement Committee monthly for six months. If appropriate intervention and documentation occurs 100% of the time, monthly monitoring will be stopped and random audits will occur. A sample size of 25% will be completed monthly. If opportunities for improvement are identified through the random audit, a full audit will resume. If after six months of random audits 100% compliance continues, auditing will stop.</p>				

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	<p>and it was identified as current. The current Care Plan was "10-30-14 Therapy referral due to difficulty with turning when up with rolling walker." No further update to the Fall Prevention Care Plan was noted after the families refusal of therapy.</p> <p>An interview on 11/17/2014 at 2:40 PM with Occupational Therapist (OT) #7 indicated Resident #4 had a decline in functional mobility for the past few months and family had refused therapy. She indicated the nursing staff were advised of no physical therapy being performed.</p> <p>An interview on 11/17/2014 at 2:54 PM with License Practical Nurse (LPN) #8 indicated the fall interventions for Resident #4 had been changed from a one person assist to a two person assist. LPN #8 indicated this was the plan and intervention due to Resident #4's recent falls and increasing weakness.</p> <p>During an interview, on 11/17/2014 at 2:56 PM, with CNA #9, she indicated the CNA Worksheet listed Resident #4 as requiring the assistance of one person when showering. CNA #9 indicated, "the resident's balance is not good and balancing with one person is very difficult".</p>			

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F000325 SS=D	<p>3.1-45(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to prevent weight loss for a resident identified at risk for impaired nutritional status for 1 of 3 residents reviewed for weight loss. (Resident #129)</p> <p>The record for Resident #129 was reviewed on 11/18/2014 at 10:37 AM. Current diagnoses included, but were not limited to Cerebral Artery Occlusion with infarction, peripheral vascular disease, kidney disease stage 2, hypertension, esophageal reflux, hypothyroidism, iron deficiency anemia, osteoporosis, and rheumatoid arthritis.</p> <p>Resident's recorded weights were as follows:</p>	F000325	F 325 Maintain Nutrition Status Unless Unavoidable It is the policy of this facility to ensure that residents maintain acceptable parameters of nutritional status and receive a therapeutic diet when there is a nutritional problem. Corrective Action For Resident Affected: Resident #129 is discharged from the facility. Other Residents Having The Potential To Be Affected: All residents at nutritional risk have the potential to be affected. The Nutrition care plans were reviewed and updated as necessary for all residents in the facility. An initial nutrition audit (Attachment titled Initial Nutrition Audit) was completed for all residents indicated for weight loss or weight gain in the Optimus EMR Alerts report. Referrals to the dietitian were made based on the results of this audit. Systemic	12/18/2014			

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	<p>06/06/2014: 119 pounds 06/23/2014: 115 pounds 07/01/2014: 113 pounds</p> <p>A Dietary progress note, dated 6/9/2014 at 10:13 AM by Registered Dietician #13, indicated resident's current weight was 119 pounds. Estimated nutrition needs were listed as "1350-1620 kilocalories, 54-65 grams of protein, and 1350-1620 cubic centimeters." No nutrition diagnosis at this time was noted on the progress note. Dietary Preferences Comments indicated the resident's average meal intake was 56% and her fluid intake was 480 milliliters.</p> <p>A Dietary progress note, dated 6/23/2014 at 8:21 AM by Registered Dietician #13, indicated resident's current weight was 115 pounds, "no weight change noted". General Dietary Comments included "30 day noted. No new meds. No new recommendations at this time". Dietary Preferences comments indicated the resident's average meal intake was 64%, with fluid intake of 840 milliliters.</p> <p>The Resident Admission Assessment form, dated 06/05/2014, indicated Resident #129's weight was 119 pounds, and height was 64 inches. On the admission assessment the resident's appetite was noted as "good".</p>		<p>Changes to Ensure Deficient Practice Does Not Recur: The DON or designee will complete Nutrition Audit (Attachment titled Nutrition Audit) twice a month and make referrals to the dietitian if indicated. Monitoring of Corrective Action: Audit results will be reviewed by the Quality Assurance Performance Improvement Committee monthly for six months. If appropriate care plans, referrals, and documentation occur 100% of the time, monthly monitoring will be stopped and random audits will occur. A sample size of 25% will be completed monthly. If opportunities for improvement are identified through the random audits, a full audit will resume. If after six months of random audits 100% compliance continues, auditing will stop.</p>				

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	<p>Resident #129's Nutritional Status Care Plan, dated 06/09/2014, indicated the resident was at risk for impaired nutritional status related to anxiety, weight change and diuretic use. The goal for the resident was to maintain a stable weight through the next review. The Care Plan approach was for the resident to be encouraged to consume at least 75% of all meals, provide diet as ordered, monitor weight and observe for and report any problems with chewing, swallowing, etc, to MD.</p> <p>During an interview, on 11/18/2014 at 11:23 AM, the DON indicated Resident #129 was not receiving a nutritional supplement during her stay at the facility from 06/05/2014 to 07/08/2014. The DON indicated, after reviewing the Dietary Progress Note, dated 06/24/2014, there were no new medication orders or recommendations pertaining to the resident's average intake of 64%. The DON indicated Resident #129's Nutritional Status Care Plan, dated 06/09/2014, indicated the goal for the resident was to maintain a stable weight through the next review. The DON indicated the Care Plan did not address the weight loss or meal consumption less than 75%.</p>			

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F000364 SS=D	<p>3.1-46(a)(1)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation and interview, the facility failed to serve food at a acceptable temperature. This affected all of the residents who received a pureed diet.</p> <p>Findings included:</p> <p>On 11/18/2014 at 12:28 PM a test tray was provided. The Dietary Manager was present and checked the temperatures on the plate of food provided. The turkey manhattan's temperature was 114 degrees. The green beans' temperature was 118 degrees. The mashed potatoes were cool. During the taste test of the meal the Dietary Manager indicated the food was not, "hot, hot". When asked if it was a temperature she would want to receive her food at, she indicated, "No".</p> <p>The "Food Preparation and Storage Areas" Policy, provided by RN #40 on 11/18/2014 at 2:42 PM, listed under item</p>	F000364	<p>F 364 Nutritive Value/Appearance/Palatable Temperature It is the policy of this facility to provide food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Corrective Action For Residents Affected: The test tray was not served to a resident. Upon discovery of the temperature issues that were identified, the dietary manager began tray auditing the meal trays that were going to be delivered to the resident rooms. Other Residents Having The Potential To Be Affected: All residents receiving pureed trays have the potential to be affected. On 12/12/2014 a new food service management company will take ownership of the dining services department. On 12/11/2014 an In-service was conducted to the dining service staff to address: thermometer calibration, proper food holding temperature regulations, and proper food</p>	12/18/2014

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	#14. "Hot foods or potentially hazardous food will leave the kitchen or steam table at 140 degrees F or above." 3.1-21(a)(2)		holding temperature logs. (Attachments titled Thermometer Calibration and Thermometer Calibration Log). Systemic Changes and Steps To Assure Deficient Practice Does Not Recur: Dietary staff will continue to check food temperatures before food leaves the kitchen. A chef manager position was added to the dining service team. The chef manager and dining services director will routinely review the Food temperature logs, Thermometer Calibration logs and general safe food handling. The department will also perform quality assurance test trays three times a week at rotating meals and diets. Tray Assessments will be completed. (Attachments titled Test Tray and Tray Assessment). Monitoring of Corrective Action: A review of both above referenced logs will be addressed at the daily staff meeting and the dining managers will monitor and initial the logs for accuracy and 100% completion daily to ensure food is cooked and held at proper temperature. The results of the audits will be reviewed in the monthly Quality Assurance Performance Improvement monthly for three months. This is an ongoing audit that will continue in the Dining Services Department. Reason For IDR Request: This tag references that hot food will leave the kitchen or steam table at 140		

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F000371 SS=F	<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, record review, and interview, the facility failed to transport and prepare food under sanitary conditions. This had the potential to effect 105 residents who received meals prepared in the kitchen.</p> <p>Findings included:</p>	F000371	<p>degrees or above. The tray did leave the kitchen at the appropriate temperature but fell below this temperature during a ten minute period when the dietary manager was searching for a working thermometer as the surveyors did not have one to test the temperature. The Dietary Manager reported to the unit as requested, had to return to the kitchen for a thermometer and return to the nursing unit. That thermometer was not operational so she had to return to the kitchen again for another thermometer and back to the nursing unit. The tray sat on a counter during this time. It was not in the hot cart as it normally would be to hold the temperature before being served to a resident.</p> <p>F 371 It is the policy of this facility to store, prepare, distribute, and serve food under sanitary conditions. Corrective Action for Resident Affected: Finding 1: No residents were affected. The referenced particle board was removed from the kitchen during the survey on 11/19/2014 after the surveyor</p>	12/18/2014

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	<p>1. During the initial kitchen tour, on 11/12/2014 at 11:35 AM, with the Dietary Manager, the following was observed: In the food preparation area there was a message board made of wood and cork fibers attached to the end of the serving table where trays were filled. The message board had a large hole measuring 8 inches by 2 inches. There were fibers of particle board and cork lying on the end of the serving table and the pipe below the end of the table.</p> <p>An interview, on 11/12/2014 at 11:45 AM, Dietary Manager indicated she had replaced the message board due to the same condition last year. The Dietary Manager indicated, "the board needs to be replaced". The dietary Manager indicated the only way to prevent particles from possibly going into food was to remove the board.</p> <p>A policy on Food Preparation and Storage Areas was received from Office staff #2 on 11/18/2014 at 2:42 PM. This form was identified as current. The policy indicated under item #3. "All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, and cracks, and chipped areas that may affect their proper use or</p>		<p>interviewed the Dietary Manager. Findings 2 and 3: No immediate action could be taken as we were not made aware of this concern during the survey or during the exit conference. The concern was only brought to our attention upon receipt of the 2567. Other Residents Having The Potential To Be a Affected: All residents have the potential to be affected. Systemic Changes and Steps to Assure Deficient Practice Does Not Recur: Finding 1: An in-service was conducted on 12/11/2014 to educate the staff on how to properly identify possible cross contamination items in the kitchen. As of 12/12/2014 a new food service company will assume ownership of the dining services department and a weekly sanitation audit will be conducted to monitor and ensure compliance. (Attachments titled Weekly Safety and Sanitation Audit and Weekly Sanitation Checklist). The dining services director will conduct a weekly sanitation audit to ensure compliance. Copies of the audit will be kept to document progress and be accessible to the community administrator. The manager on duty will hold a daily meeting with the staff to address any areas of concern for immediate correction. An updated cleaning list has been implemented for the staff to use for daily cleaning assignments. (Attachment</p>	

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	<p>cleaning. Seals, hinges, and fasteners will be kept in good repair. Damaged or broken equipment what cannot be repaired will be discarded."</p> <p>2. During an observation, in the main dining room, on 11/12/2014 at 12:15 PM, Dietary Aide #1 was holding seven cups of covered bread pudding against her apron top with her bare arms and hands. Dietary Aide #1 served a cup of bread pudding to residents #5, #30, and #102.</p> <p>A policy for Maintaining a Sanitary Tray Line was received from the DON (Director of Nursing) on 11/20/2014 at 12:30 PM, and was identified as current. The policy indicated under item #3 "(1) All foods and beverages should be covered before leaving the kitchen unless the tray is being served in the dining room adjacent to the kitchen."</p> <p>3. On 11/18/2014 at 12:20 PM Dietary Aide #15 was observed in C Hall carrying a stainless steal bowl filled with individual cartons of Mighty Shakes. She had the bowl pressed against her chest, touching her scrub top. Three of the Mighty Shake cartons were sticking above the top of the bowl and touching her scrub top. The bowl had no lid or cover. The shakes were being delivered to the Forest Path hall.</p>		<p>Cleaning List). Findings 2 and 3: On 12/11/2014 an in-service on sanitation was provided to the dining services team. The education covered proper transportation of food outside of the kitchen, proper hand washing and the use of gloves, and proper sanitation of the uniform. On 12/12/2014 a new food services management company will begin managing the dining services department. The dining services director will conduct a weekly sanitation audit to ensure compliance. Copies of the audit will be kept to document progress and be accessible to the community administrator. The manager on duty will hold a daily meeting with the staff to address any areas of concern for immediate correction. (Attachments titled Weekly Safety and Sanitation audit, Hand Washing, and Weekly Sanitation Checklist). Monitoring of Corrective Action: The dining managers will monitor proper hand washing and glove usage. The dining services manager will make sure the manager on duty is conducting routine staff meetings to address any concerns. Audit results will be reviewed by the Quality Assurance Performance Improvement Committee monthly for three months. If compliance is maintained 100% of the time this review will stop although the audits will continue ongoing.</p>	

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R000000	<p>A policy on Personnel Adherence to Sanitary Procedures was received from Office staff #2 on 11/18/2014 at 2:55 PM. This form was identified as current. The policy indicated under item #2 "Food Service and Dietary personnel will wear clean uniforms per facility policy. Aprons will be clean and changed as soiled." Under item #4 "The Food Services Manager or Dietitian will enforce appropriate and necessary sanitation requirements in addition to the standards listed above." 3.1-21(i)(3)</p> <p>Lutheran Community Home was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R000000	<p>Reason For IDR Request: The bulletin board was removed when the surveyor mentioned it to the Dietary Manager. This was not done the first day of the survey as referenced in the report. It was mentioned on the day before the end of the survey and it was removed immediately. The particles from the board did not actually get into the food on any trays. We are requesting that the scope of this tag be reviewed. The other two observations in this tag only affected 3 residents each. The 2567 also references that all food leaving the kitchen be covered. The referenced dessert was covered.</p> <p>Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p>		