

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF	STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131
---	--

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

F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00169894.</p> <p>Complaint IN00169894 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: April 13, 14, 15, 16, 17, 20, 21, 22, and 23, 2015.</p> <p>Facility number: 001127 Provider number: 155771 AIM number: 200247220</p> <p>Census bed type: SNF: 29 NF: 120 SNF/NF: 17 Residential: 132 Total: 298</p> <p>Census payor type: Medicare: 21 Medicaid: 89 Other: 56 Total: 166</p> <p>Residential sample: 9</p> <p>These deficiencies reflect state findings</p>	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations the facility has taken and will take actions set forth in the Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that the deficiencies cited have been corrected by the date certain.	
-----------------------	---	-------	---	--

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: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF	STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131
---	--

(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
F 364 SS=E Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</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 provide residents with food meeting their taste requirements for palatability.</p> <p>Findings Include:</p> <p>On 04/15/15 at 10:44 a.m., an interview with Resident #28 (Rehab unit) indicated; "It's [the food] too cold." Breakfast is ok, but then the other meals are not.</p> <p>On 04/15/15 at 11:00 a.m., interview with Resident #21 (Rehab unit) indicated, sometimes the food does and sometimes the food doesn't taste good.</p> <p>On 04/20/15 at 11:40 a.m., the dietary staff prepared trays for the Rehabilitation unit. The food cart left the service line at at 12:10 p.m. Arrived on the unit at</p>	F 364	<p>F364--- failed to provide residents with food meeting their taste requirements for palatability</p> <p><u>Corrective action taken for residents affected:</u></p> <p>· Dining Services staff will be in-serviced on May 18, 2015. Topics will include steps to assure all equipment is operating properly to maintain acceptable food temperatures throughout meal service; sampling meal prior to service to determine if meal is acceptable to send out to residents; test trays to monitor temperature and</p>	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF			STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131		
(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>12:20 p.m. One person was assigned to pass lunch trays. At 12:40 p.m., all trays had been delivered and a test tray was pull from the cart. The food temperatures on the test tray were taken by the Dietary Manager and were as follows: Chicken 124 Degrees Fahrenheit, Vegetables: 120 Degrees Fahrenheit, Pasta: 111 Degrees Fahrenheit. The Chicken had a greasy coating that was starting to harden and tasted cold. The Pasta was cold, sticking together, and had a greasy film starting to jell. The Vegetables were cold and greasy.</p> <p>Interview, at this time, with the Dietary Manager she indicated she knew over thirty minutes had passed from time the cart left the serving area until the test tray was served. She and the Dietitian had discussed making some changes in this area. The Dietary Manager indicated, "The temperatures of the food was to low."</p> <p>3.1-21(a)(2)</p>		<p>time at meal service time in Dining Room/room.</p> <p><u>Identification of residents with potential to be affected:</u> All residents have the potential to be affected by the issues cited in the statement of deficiencies.</p> <p><u>Measures taken to prevent recurrence:</u></p> <ul style="list-style-type: none"> · Dining Service Managers will conduct daily audits at meal service times to ensure: <ul style="list-style-type: none"> o Steam table, plate warmers, transport carts are operating at acceptable temperatures to maintain food temp; o Meals are taste tested prior to service to ensure palatability, temperature, and appearance are acceptable; o Test trays are conducted to ensure palatability, temperature, and appearance are maintained to the point that the resident receives the meal. o Tools include: <ul style="list-style-type: none"> § Taste Temp form 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF			STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131		
(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	
F 371 SS=E Bldg. 00	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 observation and interview, the facility failed to ensure 166 of 166 residents, who received food prepared in	F 371	§ Meal Accuracy form § Meal Evaluation form § Dining Observation form <u>Monitoring Corrective Action and Responsibility:</u> · Dining Service Managers will audit logs daily x's 30 days for each meal for the first 30 days; then weekly x's 30 days and continue on a weekly basis for Taste Temp log, Meal Accuracy log, and Meal Evaluation log. Dining Observation Log will be audited quarterly after the first 60 days. · Logs will be presented to the facility QA Committee quarterly beginning July 1, 2015. F371--- failed to ensure residents who received food prepared in kitchen, received food prepared, distributed and	05/23/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015	
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF				STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(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>kitchen, received food prepared, distributed and served under sanitary conditions.</p> <p>Findings Include:</p> <p>During the service of noon meal on 04/20/15 at 11:20 A.M., the following were observed:</p> <p>1) Dietary Second Team Lead #1 was observe to handle the bread and baked potato halves with gloved hands. The dietary staff was observe performing multiple tasks of touching plates, handles of serving utensils, handle of heated cart, serving pans, spice shaker, and then go back to handling bread and potatoes with out changing gloves.</p> <p>2) Dietary Aide #1 was observed to set up meal trays and serve the noon meal with her hair net covering only the back half of her, exposing the front half of her hair.</p> <p>3) Dietary Aide #2 was observed to set up meal trays and serve the noon meal with her hair net covering only the back half of her hair, exposing the front half of her hair. Long strands of hair on the sides were hanging free of the hair net.</p> <p>4) The Dietary Manger and Dietitian was</p>		<p>served under sanitary conditions. <u>Corrective action taken for residents affected:</u> Dining Services Staff will be in-serviced on May 18, 2015. o Topics to be included in in-service: § Hair restraints-proper use § Hand washing-appropriate times and frequency § Glove usage § Bare hand contact with ready to eat foods § Use of proper serving utensils <u>Identification of Residents with potential to be affected:</u> · All residents have the potential to be affected by the issues cited in the statement of deficiencies. <u>Measures taken to prevent recurrence:</u> · Dining Services Managers will conduct audits daily to ensure that proper sanitation standards are followed: o Hair restraints are donned correctly o Hand washing is taking place appropriately o Glove changes are occurring appropriately o Proper serving utensil is in place for each food item served o Tools include: § Taste Temp form § Meal Accuracy form § Meal Evaluation form § Dining Observation form <u>Monitoring Corrective Action and Responsibility:</u> Dining Service Managers will audit logs daily x's 30 days for each meal for the first 30 days; then weekly x's 30 days and continue on a weekly basis for Taste Temp log, Meal Accuracy log, and Meal Evaluation log. Dining Observation Log will be</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF	STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>observed in the Serving Kitchen with hair laying loose on their forehead, out of the hair net.</p> <p>On 04/23/15 at 10:30 a.m., the Dietary Manager provided a policy: titled #E004, dated 3/11, and indicated it was the current policy use by the facility. Review of the policy indicated, "Personal cleanliness and a neat appearance are essential for food service workers." Under procedure #5, "Wear the approved hair restraint when on duty. The only exception is to remove hair restraint when delivering trays to patients/residents for food service work residents."</p> <p>On 04/23/15 at 11:00 a.m., the Dietary Manager provided a policy titled F006, dated 01/2014, indicated it was the current policy use by the facility. Review of the policy indicated, "To prevent the contamination of food with infectious microorganisms, Food and Nutrition Services associates are expected to observe the following infection Control Practices." Under procedure #9, "Use a spatula or tongs, or wear disposable gloves when handling food, do not touch food with bare hand. Do not perform multiple activities while wearing gloves which will be used in food handling."</p>		<p>audited Quarterly after the first 60 days. Logs will be presented to the facility QA Committee quarterly beginning July 1, 2015.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF	STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131
---	--

(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
F 431 SS=E Bldg. 00	<p>During an interview with the Dietary Manager on 04/20/15 at 1: 30 p.m., she indicated the staff receive training on hair coverage and facility policies are gone over during orientation. She indicated she expects all the staff's hair to be contained in the head cover and worn while in the food preparation areas. Hair is covered to prevent contamination food, equipment and utensils.</p> <p>3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF	STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to store nutritional supplements according to manufacture recommendations after the supplement was opened on Health Center 2, Health Center 3, and Advanced Special Care Unit.</p> <p>Findings include:</p> <p>During the initial tour of the facility on 4/13/15 at 10:45 a.m., cartons of Med Pass, a physician ordered nutritional supplement administered to residents by the nursing staff, were observed sitting on the medication carts on Health Center 2, Health Center 3, and Advanced Special Care Unit. The cartons had been opened and were warm to touch.</p> <p>During an interview with Registered</p>	F 431	<p>Tag F431 Drug Records Label/Store Drugs & Biologicals The licensed nursing staff and all interdisciplinary team members understand the importance of following the manufacture's recommendations regarding the storage of nutritional supplements once opened. During the annual survey the survey team identified that the facility was out of compliance with the regulation of F431. Three of the nursing units had "Med Pass" nutritional supplement opened and stored on top of the nursing medication carts at room temperature. A. All of the nursing medication carts throughout the facility now have containers on them in which to place the Med Pass in ice while it is on the medication carts throughout the medication pass. B. All nursing units have the potential for the storage of the</p>	05/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF			STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131		
(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	
F 456 SS=D Bldg. 00	<p>Nurse #3 on 4/15/15 at 10:21 a.m., RN #3 indicated the supplement was removed from the refrigerator at the beginning of the shift, used throughout the shift, and then returned to the refrigerator at the end of the shift. RN #3 indicated the cartons were stored on the cart at room temperature during the shift. RN #3 indicated the shift started at 7:00 a.m., and ended at 3:00 p.m.</p> <p>The label on the Med Pass carton indicated, "Directions: Refrigerate prior to serving. When ready to serve, shake well, open cap, pull tab, and pour. Reseal and refrigerate unused portion." The section marked storage and handling indicated, "Store in a cool dry place. Do not expose to moisture and heat. Do not freeze. Refrigerate after opening."</p> <p>During an interview with the Director of Nursing (DON) on 4/15/15 at 3:30 p.m., the DON indicated the Med Pass should have been refrigerated or stored on ice after opening.</p> <p>3.1-25(m)</p> <p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p>		<p>nutritional supplements to be opened and left at room temperature which is not the manufactures recommendations. All of the medication carts throughout the facility will have a container on the top in which ice can be placed. After the Med Pass is opened it will be placed in the container with ice to maintain refrigeration. C. Each medication cart will have a check list for daily monitoring to ensure the Med Pass is on ice after opening and out on the medication carts. Each licensed nurse each shift (days/evenings/nights) will be responsible to document that the nutritional supplement is stored per recommendations. D. Unit manager or designee will conduct an audit review of all medication carts at the beginning of each week. This auditing will continue for four weeks, then monthly times three months, and then quarterly thereafter. E. Collected data from the audit process will be reviewed at weekly "standards of care meeting" and reported to the Quality Improvement Committee for further recommendations. The Director of Nursing or designee is responsible for assuring data presentation. Substantial compliance date: May 11, 2015</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF	STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview, the facility failed to maintain community wheelchairs and a mechanical lift in safe operating condition for random observations of 3 wheelchairs and 1 mechanical lift.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During a Stage 1 observation of Resident #64 on 4/15/10:29 a.m., the wheelchair arm rests of the wheelchair were torn and frayed with the white foam exposed on both arm rests. The back rest was also torn and frayed in 3 places with the white foam exposed. 2. During an initial tour of the facility on 4/13/15 at 10:45 a.m., the following items were found: <ul style="list-style-type: none"> 2. A stand up mechanical lift, located in the West Hall of Health Center 2, had a large area of foam exposed on the kneepad. The cover surrounding the foam was torn and frayed. 3. A wheelchair in the Health Center 2 West Shower Room had torn and frayed arm rests. The white foam was visible on both arm rests. 	F 456	<p>Tag F456 Essential Equipment. Safe Operating Condition The licensed nursing staff and all interdisciplinary team members understand the importance of having resident equipment in safe operation condition. During the annual survey the survey team identified that the facility was out of compliance with the regulation of F456. Three wheelchairs were noted to have torn and frayed arm rests (one belonging to Resident #64 and two others stored on units) and one mechanical lift was noted to have foam exposed. A. In this case, Resident #64's arm rests on the wheel chair have been replaced. The other two wheel chairs that were in storage have also both been repaired. The mechanical lift with the foam exposed has been repaired. B. All residents have the potential to be affected by equipment that becomes worn and torn or frayed. All wheelchairs and mechanical lifts will be inspected weekly to ensure they remain in safe operating condition. This will be done weekly according to the cleaning schedule on each unit. A checklist form will be completed by each staff member indicating the lifts and wheelchairs on their assignments have been inspected. C. Unit manager or designee will conduct an audit review of all audit sheets each</p>	05/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF			STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131		
(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	
F 514 SS=D Bldg. 00	<p>4. A wheelchair in the East Hall of Health Center 2 had torn and frayed arm rests and the foam was exposed on both arm rests.</p> <p>During an interview with Unit Manager (UM) #1 on 4/21/15 at 11:30 a.m., UM #1 indicated parts had been ordered to repair the torn and frayed pieces on the equipment.</p> <p>3.1-19(bb)</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>1. Based on observation, record review, and interview, the facility failed to ensure a Stage 4 pressure ulcer location was accurately documented in the resident's</p>	F 514	<p>week. Any indication of equipment that is unsafe and not in operating condition will result in a work request being submitted to the maintenance department. All wheelchairs found to be in unsafe operating conditions will be removed from circulation until repaired. D. Collected data from the audit process will be reviewed at weekly "standards of care meeting" and reported to the Quality Improvement Committee for further recommendations. The Director of Nursing or designee is responsible for assuring data presentation.E. Substantial compliance date: May 11, 2015.</p> <p>Tag F514 Res Records-Complete/Accurate/Ac cessible The licensed nursing staff and all interdisciplinary team members understand the</p>	05/11/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015	
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF				STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(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>record, for 1 of 3 residents who met the criteria for review of pressure ulcers (Resident #100) and care of a resident using a seat belt restraint was documented for 1 of 3 residents who met the criteria for restraint review (Resident #231).</p> <p>Findings include:</p> <p>1. The clinical record of Resident #100 was reviewed on 7/17/15 at 9:43 a.m. Diagnoses for the resident included, but were not limited to, Stage 4 pressure ulcers (full thickness tissue loss with exposed bone, tendon or muscle) and osteomyelitis (an infection of the bone). The resident was admitted to the facility on 3/9/15 with these pressure ulcers.</p> <p>An observation on 4/17/15 at 9:15 a.m. with the Unit Manager, indicated wound dressings were intact on the resident's left buttock, over her Stage 4 pressure ulcer. No dressings or wounds were observed on the resident's right buttock. The Unit Manager indicated, at that time, the resident did not have any wounds on the right buttock.</p> <p>An initial Ulceration Record, for 3/9/15, indicated Resident #100 had a Stage 4 pressure wound on the right posterior buttock. This location was marked as an</p>		<p>importance of accurate and complete documentation for all residents in the facility. During the annual survey the surveyors identified one of three residents (Resident #231) who utilized a seat belt restraint was lacking restraint monitoring documentation from February 1-February 18, 2015; and one of three residents with pressure sores (Resident #100) had documented the wrong location of the pressure sore throughout March 9-April 16, 2015. A. In the case of Resident #100, all documentation was appropriately corrected to reflect the accurate location of the resident's pressure ulcer. Resident #231 received a physician order for the utilization of the seat belt restraint. At the time of the order on January 28, 2015, a Restraint Record form was initiated. The resident activities of daily living and restraint record books for the month of February had already been placed out for the month of February by the Unit Secretary the day before the order was obtained. It wasn't until February 18, 2015 that a staff member noticed the form was not available for documentation of Resident #231. The lack of an activity sheet for Resident # 231 who was utilizing a restraint was rectified immediately on February 18, 2015 as soon as it was reported. B. All residents have</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF			STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131		
(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>error on 4/17/15, and replaced with, "L [left] gluteal fold."</p> <p>A weekly Ulceration Record for 3/24/15, 3/31/15, and 4/7/15, indicated the resident had a stage 4 pressure ulcer on the left gluteal fold. R (right) posterior buttock had been marked as an error.</p> <p>A weekly Ulceration Record for 3/24/15, indicated the resident had a stage 4 pressure ulcer on the right posterior buttock. This was marked as an error on 4/17/15, and the location was written as left gluteal fold.</p> <p>During an interview on 4/17/15 at 3:00 p.m., the Unit Manager indicated she had corrected the above Ulceration Records to indicate the resident's Stage 4 pressure ulcer was on the left buttock/left gluteal fold.</p> <p>Other references to Resident #100 having a Stage 4 pressure ulcer on the right buttock included nurses' notes on:</p> <p>3/11/15 at 2:18 a.m., 3/11/15 at 11:26 p.m., 3/12/15 at 10:01 p.m., 3/13/15 at 9:38 p.m., 3/14/15 at 3:17 p.m., 3/16/15 at 11:52 p.m., 3/17 at 1:49 p.m.,</p>		<p>the potential to have inaccurate or incomplete medical records. Audits are routinely completed from the medical records department monthly. In regards to pressure areas and restraints the facility has now added additional audits to ensure completeness and accuracy. The facility has created a position and now hired a "Nurse Educator/Wound Nurse". This staff member will be responsible to evaluate all new residents for any skin issues upon admission. They will also be responsible for weekly rounds and documentation of any newly acquired pressure areas or skin issues, ensuring accurate documentation in regards to the pressure areas or other skin issues will be completed weekly by this staff member. This position will also be responsible to ensure that any new restraint is documented on accurately and completely. C. The Nurse Educator/Wound Nurse will monitor the accuracy and completeness of all residents with either pressure areas or restraints weekly. She will submit an audit weekly times four and then monthly thereafter to the Director of Nursing or designee to ensure compliance. D. Collected data from the audit process will be reviewed weekly and reported to the Quality Improvement Committee for further recommendations. The Director</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF	STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131
---	--

(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>3/20/15 at 3:15 p.m., 3/20/15 at 9:46 p.m., 3/25/15 at 10:56 p.m., 3/28/15 at 12:35 a.m., 4/3/15 at 7:26 p.m., 4/7/15 at 5:06 p.m., 4/8/15 at 1:20 p.m., 4/9/15 at 2:46 a.m., 4/10/15 at 2:39 a.m., 4/11/15 at 6:40 p.m., 4/12/15 at 1:58 a.m., 4/12/15 at 11:02 a.m., 4/12/15 at 3:42 p.m., 4/13/15 at 1:07 a.m., 4/14/15 at 12:58 a.m., 4/14/15 at 12:59 a.m., 4/15/15 at 3:25 a.m., 4/16/15 at 1:08 a.m., 4/16/15 at 4:02 a.m.,</p> <p>In an interview on 4/17/15 at 3:00 p.m., the Unit Manager indicated all references to Resident #100 having a pressure ulcer on the right buttock were in error.</p> <p>2. The clinical record of Resident #231 was reviewed on 4/16/15 at 11:44 a.m. Diagnoses for the resident included, but were not limited to, dementia with behaviors and delirium disorder.</p> <p>A physician's order, dated 1/28/15, indicated Resident #231 was, "to be up in</p>		of Nursing or designee is responsible for assuring data presentation. E. Substantial compliance date: May 11, 2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF	STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131
---	--

(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>wheelchair with safety release belt."</p> <p>A significant change Minimum Data Set assessment, dated 12/31/14, indicated the resident was severely impaired in the ability to make decisions.</p> <p>A care plan for Resident #231, dated 1/28/15, indicated a problem of, "Requires use of self release belt in [wheelchair] due to decreased safety awareness." Interventions included, "Release restraint and reposition resident per facility policy."</p> <p>On 4/16/15 at 11:15 a.m., the assistant Unit Manager provided a policy, dated 5/21/98, titled Physical Restraint Policy, and indicated it was the policy currently used by the facility. The policy indicated, "...18. Residents who are restrained will be visited by nursing personnel at intervals of at least every hour to observe restraint application and to assure safety and response. 19. Residents physically restrained will be temporarily released from the restraint at least every two (2) hours...21. Monthly restraint-use record will be maintained by Nursing and include:...b. Times in and out of restraint..."</p> <p>A restraint record for Resident #231, for February, 2015, indicated spaces to be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF	STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131
---	--

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

R 000 Bldg. 00	<p>marked hourly for when the resident was in restraint, out of the restraint, checked, ambulated, exercised, bathed, toileted, released/repositioned, asleep and at meals. No information was in any of the spaces until 2/18/15.</p> <p>On 4/16/15 at 3:20 p.m., the Unit Manager indicated a restraint record had not been initiated for Resident #231 until 2/18/15.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>	R 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations the	
	The following residential finding was cited in accordance with 410 IAC 16.2-5.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF	STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131
---	--

(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
R 273 Bldg. 00	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to assure 132 of 132 residents, who ate food prepare in kitchen, received food prepared, distribute and serve under sanitary conditions.</p> <p>Findings Include:</p> <p>During the service of noon meal on 04/20/15 at 11:20 A.M., the following were observed:</p> <p>1) Dietary Second Team Lead #1 was observe to handle the bread and baked potato halves with gloved hands. The dietary staff was observe performing multiple tasks of touching plates, handles of serving utensils, handle of heated cart,</p>	R 273	<p>facility has taken and will take actions set forth in the Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that the deficiencies cited have been corrected by the date certain.</p> <p>R273--- failed to ensure residents who received food prepared in kitchen, received food prepared, distributed and served under sanitary conditions. <u>Corrective action taken for residents affected:</u> Dining Services Staff will be in-serviced on May 18, 2015. Topics to be included in in-service: § Hair restraints-proper use § Hand washing-appropriate times and frequency § Glove usage § Bare hand contact with ready to eat foods § Use of proper serving utensils <u>Identification of Residents with potential to be affected:</u> All residents have the potential to be affected by the issues cited in the statement of</p>	05/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015	
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF				STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(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>serving pans, spice shaker, and then go back to handling bread and potatoes with out changing gloves.</p> <p>2) Dietary Aide #1 was observed to set up meal trays and serve the noon meal with her hair net covering only the back half of her, exposing the front half of her hair.</p> <p>3) Dietary Aide #2 was observed to set up meal trays and serve the noon meal with her hair net covering only the back half of her hair, exposing the front half of her hair. Long strands of hair on the sides were hanging free of the hair net.</p> <p>4) The Dietary Manger and Dietitian was observed in the Serving Kitchen with hair laying loose on their forehead, out of the hair net.</p> <p>On 04/23/15 at 10:30 a.m., the Dietary Manager provided a policy: titled #E004, dated 3/11, and indicated it was the current policy use by the facility. Review of the policy indicated, "Personal cleanliness and a neat appearance are essential for food service workers." Under procedure #5, "Wear the approved hair restraint when on duty. The only exception is to remove hair restraint when delivering trays to patients/residents for food service work</p>		<p>deficiencies. <u>Measures taken to prevent recurrence:</u> Dining Services Managers will conduct audits daily to ensure proper sanitation standards are followed:</p> <ul style="list-style-type: none"> o Hair restraints are donned correctly o Hand washing is taking place appropriately o Glove changes are occurring appropriately o Proper serving utensil is in place for each food item served o Tools include: <ul style="list-style-type: none"> § Taste Temp form § Meal Accuracy form § Meal Evaluation form § Dining Observation form <p><u>Monitoring Corrective Action and Responsibility:</u> Dining Service Managers will audit logs daily x's 30 days for each meal for the first 30 days; then weekly x's 30 days and continue on a weekly basis for Taste Temp log, Meal Accuracy log, and Meal Evaluation log. Dining Observation Log will be audited quarterly after the first 60 days. Logs will be presented to the facility QA Committee quarterly beginning July 1, 2015.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY RES & COM CAF	STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131
---	--

(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>residents."</p> <p>On 04/23/15 at 11:00 a.m., the Dietary Manager provided a policy titled F006, dated 01/2014, indicated it was the current policy use by the facility. Review of the policy indicated, "To prevent the contamination of food with infectious microorganisms, Food and Nutrition Services associates are expected to observe the following infection Control Practices." Under procedure #9, "Use a spatula or tongs, or wear disposable gloves when handling food, do not touch food with bare hand. Do not perform multiple activities while wearing gloves which will be used in food handling."</p> <p>During an interview with the Dietary Manager on 04/20/15 at 1: 30 p.m., she indicated the staff receive training on hair coverage and facility policies are gone over during orientation. She indicated she expects all the staff's hair to be contained in the head cover and worn while in the food preparation areas. Hair is covered to prevent contamination food, equipment and utensils.</p>			