STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: November 21 and 22, 2016 Facility number: 001150 Provider number: 001150 AIM number: N/A Census bed type: Residential: 17 Total: 17 Census payor type: Private: 17 Total: 17 Sample: 7 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5. Quality Review completed by 29081 on November 23, 2016	R 0000	In consideration of the past survey history and the low scope and severity of these citations; we request consideration for a paper compliance review.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure the night shift licensed QMA (Qualified Medication Aide) who was the only licensed staff on duty, was certified in First Aid. This practice had the potential to effect 17 of 17 Residents who resided in the facility. (QMA #5) Findings include: An interview with LPN #6 on 11/21/16 at 4:20 p.m., indicated the 3rd shift was staffed with a QMA #5 during the week	R 0117	1. Immediate Corrective Action- Night Shift QMA scheduled for first aid training. In consideration of the past survey history and the low scope and severity of this citation; we request consideration for a paper compliance review. 2. Corrective action taken for those residents having the potential to be affected by the same deficient practice- All nursing staff will be trained in	01/01/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	as the only licensed staff on duty and indicated she would call the nurse supervisor at Saint Anne Home for authorization of a PRN (as needed) medication request from a Resident. On 11/22/16 at 9:00 a.m., a review of the facility's staffing schedules for a 7 day period, from 11/16/16 through 11/22/16 indicated QMA #5 was the only licensed staff who worked on 11/16/16, 11/17/16, 11/18/16, 11/21/16 and 11/22/16 the third shift. A review of the scheduled staff's CPR (Cardiopulmonary Resuscitation) and First Aid certifications provided by the Administrator on 11/22/16 at 9:50 a.m., indicated QMA#5 had successfully completed the American Heart Association's BLS (Basic Life Support) for Healthcare Providers on 10/16/15 with recommended Renewal date on 10/2017. A review of the American Heart Association (AHA) website, www.heart.org, on 11/22/16 at 10:00 a.m., indicated, "...Course: BLS Provider...Content: After successfully completing the BLS Course students should be able to: Describe the importance of high-quality CPR and its impact on survival...Describe all of the		first aid. 3. Measures/systemic changes put into place to ensure the deficient practice does not recur- Education and first aid training will be provided to nursing personnel. Facility will receive copies of all first aid license cards for records. 4. Correction actions to be monitored to ensure the deficient practice will not recur- Checks will be done once a month for twelve months to ensure all nursing staff has correct first aid training. QAPI committee will monitor staff education and first aid checks to ensure compliance. 5. Date of Compliance-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	steps of the Chain of Survival and apply the BLS concepts...Recognize the signs of someone needing CPR...Perform high-quality CPR for an adult, child and infant...Describe the importance of early use and demonstrate the appropriate use of an automated external defibrillator (AED)...Provide effective ventilation using a barrier device...Describe the importance of teams in multirescure CPR...Describe the technique for relief of foreign-body airway obstruction for an adult, child or infant....Audience:...In-facility: Providers who work in hospital, clinic, or other healthcare facility (i.e. dentist office, skilled nursing and assisted living facilities)...." On 11/22/16 at 10:30 a.m., the AHA office was phoned. During the interview the AHA Representative indicated the BLS course did not include first aid and indicated the Heart Saver First Aid Course would need to be taken for First Aid Certification. An interview with the Administrator on 11/22/16 at 10:35 a.m., indicated the BLS Course included CPR and First Aid certifications. At 10:37 a.m., the Administrator indicated QMA #5, had her certification for First Aid but the facility did not have a copy of her First		1/1/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	Aid Card on file and would have to call her and wake her up because she worked the 3rd shift. He indicated he would ask her to bring in her First Aid Certification Card.			
R 0152 Bldg. 00	410 IAC 16.2-5-1.5(i) Sanitation and Safety Standards - Deficiency (i) The facility shall handle, store, process, and transport clean and soiled linen in a safe and sanitary manner that will prevent the spread of infection. Based on observation, interview and record review, the facility failed to protect clean laundry and linens while transporting through the hallways to resident rooms. This deficiency had the potential to affect the 17 residents who resided in the facility. Findings include: An observation of clean laundry being transported in the hallway by Housekeeper #4 on 11-21-2016 at 1:50 p.m., indicated the clean laundry was stacked in a wire basket with wheels. A piece of plastic partially covered the top portion of the clean laundry, leaving the bottom, sides and part of the top of the	R 0152	1. Immediate Corrective Action- Laundry being transported was immediately covered completely by a plastic bag to prevent contamination. In consideration of the past survey history and the low scope and severity of this citation; we request consideration for a paper compliance review 2. Corrective action taken for those residents having the potential to be affected by the same deficient practice- All laundry being transported was checked to ensure it was being covered correctly.	01/01/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	laundry exposed to contamination. An observation of clean laundry being transported in the hallway by Housekeeper #4 on 11-21-2016 at 11:05 a.m., indicated the clean laundry was stacked inside a plastic bin with holes on all sides which was placed in a wire basket with wheels. The clean laundry was not protected from contamination as the clean laundry was uncovered on top and on all sides. An interview with Housekeeper #4 at this time, indicated the clean laundry was being transported to a resident room. An interview with the Administrator #1 on 11-22-2016 at 12:25 p.m., indicated clean laundry should be covered when being transported in the hallway. A current, undated policy "Transporting Linens Procedure" was provided by House Supervisor #8 on 11-22-2016 at 1:05 p.m.,and indicated "...all linens and clothing items, either clean or dirty will be transported in plastic bags or soiled linen container throughout the facility...."		3. Measures/systemic changes put into place to ensure the deficient practice does not recur- In-service on policy and procedures will be given to staff regarding correctly covering laundry. 4. Correction actions to be monitored to ensure the deficient practice will not recur- Observation checks for correct laundry transportation will be done once a month for twelve months. QAPI Committee will monitor staff education and observation checks to ensure compliance. 5. Date of Compliance- 1/1/17	
R 0273 Bldg. 00	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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. A. Based on observation and interview, the facility failed to ensure the safe food storage in the facility's Wellness Center's Medication Room. The practice had the potential to affect 17 of 17 residents who resided at the facility. B. Based on observation, interview and record review, the facility failed to ensure opened packages of food products were labeled with opened dates and were re-sealed to prevent contamination, failed to defrost meat in the reach in refrigerator on the bottom shelf, failed to ensure hair coverings were worn by staff while in the kitchen and failed to ensure the floor was maintained in good repair. These deficiencies had the potential to affect the 17 residents who were served their meals from the kitchen. Findings include: A1. On 11/21/16 at 4:30 p.m., the two refrigerators in the medication room were observed with Nurse #6 and indicated the following: The white full size refrigerator was locked with a keyed pad lock and Nurse #6 unlocked the refrigerator to check the	R 0273	1. Immediate Corrective Action- All food and beverages in the medication refrigerator were removed. Food and beverages not labeled or dated correctly in the kitchen were removed and disposed of. Meat that was defrosting was correctly placed on the bottom shelf of the kitchen refrigerator. All staff in kitchen put on hair nets. Floor crack was identified for repair by maintenance. In consideration of the past survey history and the low scope and severity of this citation; we request consideration for a paper compliance review. 2. Corrective action taken for those residents having the potential to be affected by the same deficient practice- All food in kitchen and refrigerators were checked for correct labeling and dating. Any improperly labeled or dated food and beverages were thrown out. Refrigerators were checked to ensure all	01/01/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	medications stored inside. Inside the refrigerator with the medications were food and beverage items, including, but not limited to: one 32 ounce carton of Med Pass 2.0 (nutritional supplement), one 32 ounce bottle of Apricot Nectar and one box of 12 Snack Pack Pudding cups. None of the food items in the refrigerator were labeled with a date or a name. The small, black, countertop, laboratory specimen refrigerator was opened and stored inside were 3 cans of soda, two 12 ounce cans of Diet [Brand] clear soda and one 8 ounce can of [Brand] Twist, lemon-lime soda. One of the 12 ounce cans of soda was opened and none of the cans were labeled with a name or date. An interview with the facility's Dietitian, by telephone, on 11/22/16 at 1:40 p.m., indicated the food and beverage items should not be stored in the refrigerator with medications. B. An initial observation of the kitchen with Dietary Manager #3 on 11-21-2016 from 9:50 a.m. to 10:08 a.m., indicated the following: An observation in the walk in refrigerator indicated an opened and partially used bag of tossed salad without an opened		meats were defrosting appropriately. All staff was told to put on a hair net if they went into the kitchen. Kitchen floor was examined to identify any more cracks in the floor. 3. Measures/systemic changes put into place to ensure the deficient practice does not recur- Staff will be educated on not putting food or beverage in the medication refrigerator. Staff will be educated to correctly label and date all food that is stored in kitchen or refrigerators. Dietary staff will be educated on correct procedures for defrosting meat in the refrigerator. Staff will be educated on wearing hair nets any time they go into the kitchen. Maintenance identified	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	date written on the package. An observation in the walk in freezer indicated two opened and partially used containers of ice cream without open dates on the containers. An observation in the dry storage area indicated a 16 ounce box of shell pasta was opened and the cardboard tab was slipped into the slot to keep it closed. The box was not labeled with an opened date or sealed securely to prevent contamination. A plastic package of yellow cake mix was opened and partially used. The package was secured but not dated with an opened date. An observation of the reach in refrigerator indicated 3 bowls of prunes were covered without a date on the covering. Further observation of the reach in refrigerator, indicated 2 packages of ham were defrosting in a tin foil tray on the top shelf of the refrigerator with prepared food items stored on the shelves underneath the defrosting ham. An observation on one of the prep tables indicated a gallon bag of pasta was not labeled with an opened date. During the initial tour of the kitchen, an interview with the Dietary Manager #4		cracks in the kitchen floor and is scheduled to fix all areas identified. 4. Correction actions to be monitored to ensure the deficient practice will not recur- Observation checks on staff following correct Dining/Nursing policies mentioned above will be done once a month for twelve months. QAPI Committee will monitor staff education and observation checks to ensure compliance. 5. Date of Compliance-1/1/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	indicated she did not date opened food items if she was going to use them in the next few days. The floor area between the stove and convection oven and the food prep table had two 10 inch long cracks. The edges of the floor covering in one of the 10 inch cracks were separated 3/16 of an inch. The edges were black and the floor underneath was exposed. The other 10 inch crack in the floor covering was along the same line and was observed to be separated less than 3/16 of an inch. During an observation in the kitchen on 11-21-2016 at 11:47 a.m., Administrator #1 was observed standing in the kitchen by the food prep table without a hair net to cover his hair. On the prep table, was a large pan of bread pudding and next to the prep table were 15 uncovered bowls of bread pudding on the top shelf of a metal cart. The bread pudding was observed to be served for the lunch meal on this date. During an observation in the kitchen on 11-21-2016 at 12:01 p.m., Volunteer #2 was observed to remove her hair net by the stove and walk around the food prep area to the bathroom which was located in the office area connected to the kitchen. Volunteer #2 was observed to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	leave the bathroom and walk past the food prep area, past the food serving area where the hot food was placed to be served and out the door to the dining room. An observation on the second shelf of the serving table in the kitchen on 11-21-2016 at 12:14 p.m., indicated there were 6 undated plastic containers filled and labeled with 6 different kinds of cereal. An observation of the dry storage room on 11-22-2016 at 8:45 a.m., indicated a box with 5 opened packages of cereal without opened dates written on the packages. On the 2nd shelf of the prep table outside the walk in freezer, an opened package of gravy did not have an opened date written on the package. During an interview with Dietary Manager #3 on 11-22-2016 at 8:55 a.m., the Dietary Manager #3 indicated Volunteer #2 should not have removed her hair net in the kitchen and walk through the kitchen when leaving from her shift. An interview with the Administrator #1 on 11-22-2016 at 9:00 a.m., indicated he just walked in and then out of the kitchen yesterday and did not don a hair net.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	Administrator #1 indicated he would have to walk to the chemical storage closet by the (out) door to get a hair net but since he was just in there quickly he didn't don a hair net. The Administrator #1 indicated he was not aware of the large pan or dishes of the bread pudding, which were observed uncovered, in the kitchen near where he was standing. An interview with Administrator #1 on 11-22-2016 at 12:25 p.m., indicated the food packages should have had opened dates on them and that the cracked areas of the kitchen floor between the stove and the prep table were unable to be sanitized. A policy for the kitchen floor maintenance and cleaning was requested, but not provided. An interview with House Supervisor #8 on 11-22-2016 at 12:30 p.m., indicated she performed the maintenance checks per the maintenance checklist on a monthly basis, which included the floor in the kitchen. The Maintenance Checklist dated 11-9-2016 had a checkmark in the "yes" box. House Supervisor #8 indicated the "yes" indicated no problems or changes in the kitchen. Further interview with House Supervisor #8, indicated she looked for any cracks in the kitchen floor and was aware of the two cracks between the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	stove and the prep table. She indicated no one told her what to watch for with the cracks or told her how wide the cracks had to be for it to be a concern. She indicated she was to note only if there were any changes to the cracks. A telephone interview with the Dietitian on 11-22-2016 at 1:40 p.m., indicated she was aware of the cracks in the flooring between the stove and the prep table. She indicated the flooring should probably be repaired. Further interview with the dietitian, indicated she was not aware the opened food items were not labeled with the opened dates. A current, undated policy "Personal Hygiene Procedures" was provided by Administrator #1 on 11-21-2016 at 3:25 p.m., and indicated "...a hair net or head covering that completely covers all hair must be work <sic> during meal preparation and service...." A current, undated policy "Proper Food Handling Procedure" was provided by the Administrator # 1 on 11-21-2016 at 3:25 p.m., and indicated "...store raw meat on the bottom shelf of the refrigerator in a separate container while thawing...." A current, undated policy "Proper Food Handling Procedure" was provided by the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	Administrator #1 on 11-21-2016 at 3:25 p.m., and indicated store prepared leftover foods in the refrigerator or freezer...label and date...." A current, undated policy "Food and Cleaning Supply Storage" was provided by the Administrator #1 on 11-21-2016 at 3:25 p.m., and indicated "...store leftover food and liquids and opened, unused portions of food and liquids according to he procedures for leftover food...." A current, undated policy "Dry Goods Storage Procedure" was provided by House Supervisor #8 on 11-22-2016 at 1:25 p.m., and indicated "...plastic containers with tight-fitting lids or re-sealable plastic bags should be used to store dry items previously opened, such as pastas, rice and dry cereals...all products that have been opened previously should be labeled and dated...."			
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, interview and record review, the facility failed to ensure the open dates were recorded on multi-use medications in 1 of 1 medication carts. This practice had the potential to affect 16 of 17 Residents who's medication were administered by the facility nurse. Findings include: An observation in the facility's medication cart on 11/21/16 at 4:10 p.m., with LPN #6 indicated the following: Three ProAir HFA AER Inhalers (a respiratory medication) for Resident #5 were opened and were not labeled with an open date. One-Symbocort 160-4.5 mCg (microgram) Inhaler (a respiratory mediation) for Resident #5 was opened and was not labeled with an open date. One-Fluticasone 50 mCg Nasal Spray (allergy and decongestant medication) for Resident #11 was opened and was not labeled with an open date.	R 0300	1. Immediate Corrective Action- Any medications identified as not being labeled correctly were examined and corrected according to state regulations. EDK medications that were expired were properly disposed of and new medications were brought in. In consideration of the past survey history and the low scope and severity of this citation; we request consideration for a paper compliance review. 2. Corrective action taken for those residents having the potential to be affected by the same deficient practice- All medications in the cart were reviewed to ensure correct labeling. All medications in the EDK were examined to ensure there were no more expired medications in it. 3. Measures/systemic changes put into place	01/01/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	One-Fluticasone 50 mCg Nasal Spray for Resident #16 was opened and was not labeled with an open date One-Flonase/OTC (Over the Counter) Nasal Spray (allergy and decongestant medication) for Resident #16 was opened and was not labeled with an open date. One-Nasonex 50 mCg/AC Nasal Spray (allergy and decongestant medication) for Resident #8 was opened and was not labeled with an open date. One bottle of Lumigan Soln (solution) 0.01% (eye drop for glaucoma) for Resident #8 was opened and was not labeled with an open date. One-Fluticasone 50 mCg Nasal Spray for Resident #15 was opened and was not labeled with an open date. An interview with LPN #6 on 11/21/16 at 4:15 p.m., indicated the inhalers, nasal sprays and eye drops should have been labeled with open dates. An interview with LPN #7 on 11/21/16 at 4:20 p.m., indicated the weekend nurse was to clean the medication cart and check for labels on the medications and expiration dates.		to ensure the deficient practice does not recur- Education will be given to nursing staff on correct policy and procedures for labeling and dating medications. EDK kit will be monitored by nursing staff and pharmacy and will be properly changed out when necessary. 4. Correction actions to be monitored to ensure the deficient practice will not recur- Observation checks on medications being correctly labeled and dated will be done once a month for twelve months. QAPI committee will monitor observations checks and education to ensure compliance. Pharmacy consultant will review findings at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An observation of the medication refrigerator in the locked medication room with LPN #6 on 11/21/16 at 4:30 p.m., indicated the following: The medication refrigerator was locked with a keyed pad lock, LPN #6 unlocked the refrigerator. The refrigerated EDK (Emergency Drug Kit) was on the top shelf in the refrigerator and was zip tied shut with numbered blue zip ties. The box was labeled with the content of the EDK and the Rx filled date was 4/25/16. The box was observed to contain but, was not limited to the following: Four vials of Lorazepam 2 mg (milligrams)/ml (milliliter) in 1 ml vials had an expiration date of 10/16. Four suppositories of Promethazine (an antihistamine with multiple uses for treatment of but, not limited to nausea and vomiting, allergies and motion sickness) had an expiration date of 10/16. An interview with LPN #7 on 11/22/16 at 1:10 p.m., indicated she had checked with the Pharmacy who provided the facility's EDK and they indicated they replace the EDK whenever a medication had been removed. The Pharmacy also indicated they kept records of the medications' expiration dates and would replace the expired medication. LPN #7		QAPI meetings. 5. Date of Compliance-1/1/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	indicated the Pharmacy was bringing new EDK's to the facility. On 11/22/16 at 9:00 a.m., the Administrator provided a page from the current non-titled facility policy, "Medication Storage" and following paragraph was highlighted in blue, inducted, "...As of August 1, 2005, no medications will be stored in a refrigerator in a common area unless it is in a locked container with resident name and room number visibly seen on it. This is a State Board of Health requirement and must be adhered to at all times...Please direct any questions regarding this requirement to the Nursing Department...."			
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation, interview and record review, the facility failed to ensure over-the-counter (OTC) medications	R 0302	1. Immediate Corrective Action-Medications identified as not labeled correctly were examined and labeled correctly according to	01/01/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	were labeled with a residents' name and or a physician's name in 1 of 1 medication carts. This practice had the potential to affect 16 of 17 Residents whose medication were administered by the facility nurse. Findings include: An observation in the facility's medication cart on 11/21/16 at 4:10 p.m., with LPN #6 indicated the following: One OTC bottle Vitamin B12 (supplement) 2500 mCg (microgram) was not labeled with a resident's name or a Physician's name. An interview with LPN #6 on 11/21/16 at 4:15 p.m., indicated the Vitamin B12 belonged to Resident #13 and indicated the Vitamin B12 bottle should have been labeled with the Resident's name and the Physician's name on the bottle. One OTC bottle of Allergy Relief with 2 initials on the cap was not labeled with a resident"s name or a physicians name on the bottle. An interview with LPN #6 on 11/21/16 at 4:16 p.m., indicated the Allergy Relief medication belonged to Resident #13 and indicated the bottle of Allergy Relief		state regulations. In consideration of the past survey history and the low scope and severity of this citation; we request consideration for a paper compliance review. 2. Corrective action taken for those residents having the potential to be affected by the same deficient practice- Residents medications were reviewed to ensure correct labeling. Corrections were made to any findings according to state regulations. 3. Measures/systemic changes put into place to ensure the deficient practice does not recur- Nursing staff will be educated on policy and procedures for correct labeling. Pharmacy will institute a monthly medication cart audit to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	should have been labeled with the Resident's name and the Physician's name on the bottle One OTC 12 fluid ounce bottle of [Brand] Cough + Chest + Congestion DM (DM = dextromethophan, a cough suppressant) was labeled with a Resident's name but was not labeled with a Physician's name on the bottle. One OTC bottle, 225 count (number of tablets in the container), Extra Strength [Brand] acetaminophen (pain and fever medication) 500 mg (milligrams) was labeled with a first name only and was not labeled with the Physician's name on the bottle. An interview with LPN #6 on 11/21/16 at 4:18 p.m., indicated the Extra Strength [Brand] acetaminophen belonged to Resident #4. One OTC 4 fluid ounce bottle of [Brand] DM Nighttime (for cough and congestion) was labeled with Resident #4's full name but was not labeled with the Physician's name on the bottle. One OTC, 200 count, bottle of [Brand] naproxen (for pain and fever) was labeled with Resident's first name and last initial on the bottle. The Physician's name was		4. Correction actions to be monitored to ensure the deficient practice will not recur- Observation checks on correct labeling of medications will be done once a month for twelve months. Observation checks and education will be monitored by QAPI committee to ensure compliance. Cart audit will be monitored by pharmacy and QAPI Committee. 5. Date of Compliance- 1/1/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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
	not labeled on the bottle. An interview with LPN #7 on 11/21/16 at 4:20 p.m., indicated the weekend nurse was to clean the medication cart and check for labels on the medications and expiration dates. On 11/22/16 at 9:00 a.m., the Administrator provided a page from the current non-titled facility policy, "Medication Storage" and following paragraph was highlighted in blue, inducted, "...As of August 1, 2005, no medications will be stored in a refrigerator in a common area unless it is in a locked container with resident name and room number visibly seen on it. This is a State Board of Health requirement and must be adhered to at all times...Please direct any questions regarding this requirement to the Nursing Department...." No additional medication storage policies were provided.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE COMMUNITIES AT BISHOP LUERS	5610 NOLL AVE FORT WAYNE, IN 46806

(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