STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155473	A. BUILDING 00 B. WING	10/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALET VILLAGE HEALTH AND REHABILITATION CENTER	1065 PARKWAY ST BERNE, IN 46711

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 3, 4, 5, 6, and 10, 2017 Facility number: 000546 Provider number: 155473 AIM number: 100267370 Census bed type: SNF/NF: 31 Total: 31 Census payor type: Medicare: 4 Medicaid: 25 Other: 2 Total: 31 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 12, 2017.	F 0000	Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute admission or an agreement by the provider of the truth of facts alleged or corrections 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

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F 0157 SS=D Bldg. 00	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent			

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	information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). Based on interview, and record review the facility failed to ensure the physician was notified of a need for clarification for 1 resident on a medication for mood stabilization. This affected 1 of 5 residents reviewed with medications. (Resident 4) Findings included: A review of Resident 4's clinical record on 10/4/2017 at 4:16 p.m., indicated a BIMS (Brief Interview of Mental Status) score of 12 out of 15, meaning moderate cognitive impairment. Diagnoses included, but were not limited to: arthritis, kidney disease, diabetes, chronic pain, high blood pressure, chronic urinary tract infection, dementia, asthma, and	F 0157	1.Resident #4's Physician was notified and a proper diagnosis obtained for the use of Depakote for mood disturbance. The Depakote has been decreased as a trial GDR attempt. A Valporic acid level was drawn and was in the low normal range which is expected with the use of Depakote for mood stabilization. 2.A chart audit was conducted for all other residents who utilize Depakote for mood disorders, to assure proper diagnosis, GDR attempts and labs completed, if indicated. 3.The Nursing staff have been re-educated on the use of Depakote for mood disorders with a special focus on proper diagnosis, GDR, and monitoring labs, if necessary. An audit sheet has been initiated. The DON	11/06/2017

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	heart disease. A review of Resident 4's discharge paperwork from a hospital stay dated 9/21/2016 indicated the resident was discharged on depakote (a medication used to treat seizures and often used as a mood stabilizer to treat a mood disorder) 125 mg (milligrams) give one tablet by mouth three times a day. The diagnoses list, on the discharge summary, dated 9/21/2016, had not included mood disorder or siezures. A review of Resident 4's Physician's Orders indicated an order was given, dated 12/19/2016, for depakote 250 mg give one tablet, by mouth, two times a day. Another order dated 3/10/2017, for depakote 125 mg give one tablet with the 250 mg depakote tablet to equal 375 mg, by mouth, two times a day. there was no diagnosis to support this medication noted in either order. A review of the Mood and Behavior Monthly Monitoring Summary's from 9/2016 to 9/2017 indicated no GDR attempt was trialed for the depakote use. The"Mood and Behavior Monthly Monitoring Summary" dated 9/6/2017 indicated "...Depakote due for GDR - contraindicated..."		and/or designee will monitor all residents using Depakote for mood disorders to assure proper diagnosis, GDR attempts and labs, if indicated. Audits will be conducted daily 5 days per week x 2 weeks, weekly for 2 weeks, then monthly thereafter. Should concerns be noted, immediate corrective action shall be taken. 4.Results of these audits and any corrective actions will be reviewed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the plan will be adjusted, if indicated on the basis of audit findings. 5.11-6-17	

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	A review of Resident 4's Physician Progress Notes indicated no documentated reson for depakote GDR being contraindicated. A review of Physician Order's indicated no orders for laboratory tests had been given while Resident 4 was on the depakote medication regimen. A "Care Plan Worksheet" dated 8/24/2017, indicated "...The resident requires the use of Depakote to treat: mood stabilizer and is at risk for adverse side effects..." and in interventions section "...*Monitor labs as indicated..." During an interview on 10/5/2017 at 11:54 a.m., the DON (Director of Nursing) indicated she did not know why there was no diagnosis of mood disorder for the use of the depakote. She indicated Resident 4 had "fired" the Psychiatric NP (Nurse Practitioner) who used to provide them services. The DON indicated she was sure they had not ordered depakote levels to be drawn since the initial start of the medication, but should have notified the physician for clarification of the diagnosis for use, to clarify if labs should have been drawn to monitor depakote levels, and for the reason the GDR was contraindicated.			

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	During an interview on 10/6/2017 at 2:30 p.m., the Regional Nurse had indicated they had no policy regarding lab draws for depakote levels. 3.1-5(a)(3)			
F 0246 SS=D Bldg. 00	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to provide care and services in a manner to accomodate individual resident needs. This deficiency affected 1 of 8 residents who ate meals in the dining room. (Resident 21)	F 0246	1.Resident #21 had no negative effects from the improper table height in the dining room. The table height has been adjusted and the staff were re-educated on the proper way to lower and/or raise the adjustable table as well as proper seating for residents. 2.Residents eating in the dining room for meals were reviewed to	11/06/2017

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	Findings include: The record review for Resident 21 began on 10-5-2017 at 10:44 a.m. Diagnoses included, but were not limited to, dementia, chronic pain, hypothyroidism, osteoporosis, dysphagia (difficulty swallowing), osteoarthritis, anemia, diabetes, chronic obstructive pulmonary disease, and peripheral vascular disease. Resident 21's diet order on the September 2017 physician's recapitulation was for a pureed diet and "...resident to sit at assist table...small portions...." The last quarterly MDS (Minimum Data Set) assessment, dated 7-28-2017, indicated a BIMS (Brief Interview of Mental Status) score of 5/15 for Resident 21, which indicated severe cognitive impairment. The resident required an extensive assist of 1 for transfers and locomotion on and off the unit, and supervision of one person for eating. The resident's height was 48 inches and her weight was 110 pounds. A care plan for staff assistance for meal consumption was dated 8-17-2017. The care plan indicated Resident 21 required set up and supervision for meals with the assistance of 1 person. The interventions		confirm proper positioning and proper table height during meals for all other residents. 3.All residents have the potential to be affected. Staff have been re-educated on the proper way to lower and/or raise the adjustable table as well as proper seating for residents. A monitoring tool has been initiated to assure residents are positioned properly in the dining room and are seated with table at proper height. The administrator and/or designee will monitor the dining room for proper seating 5 days per week at staggered meals x 2 weeks, weekly x 2 weeks, then monthly thereafter to assure proper seating for meals. Should concern be observed, immediate corrective action shall be taken. 4.Results of the monitoring and any corrective actions will be reviewed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the plan will be adjusted if indicated, on the basis of observation findings. 5.11-6-17	

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	were to ensure the resident was seated in an environment which would provide assistance and encourage meal consumption.. An observation of Resident 21 in the main dining room on 10-3-2017 at 11:53 a.m., indicated the resident was seated in her wheelchair with her chin just barely reaching the top of the table. The resident's mouth was observed to be at the level of the the top of the blue sectioned plate which was placed in front of her. The top of the cup of hot chocolate was observed at the level of the resident's forehead. There were 2 tables observed to be pushed together where Resident 21 was sitting. One table was adjustable and the other table where Resident 21 was seated, was not adjustable. There were 2 residents who were seated at the adjustable table who were positioned with the table at mid chest. At the non-adjustable table where Resident 21 was seated, there were 2 other residents seated with the table at mid chest height. An observation in the main dining room on 10-3-2017 at 12:03 p.m., indicated CNA 1 (Certified Nurse's Aide) removed the clothing protector from Resident 21 and the resident was able to self propel her wheelchair out of the dining room			

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	and down the hall. The resident was not observed to eat any of the food on her sectioned plate, or in her bowl or her supplement. Resident 21's hot chocolate was left full in the cup. An observation in the main dining room on 10-4-2017 at 8:12 a.m., indicated Resident 21 was in her wheelchair with her head bent down and her eyes closed. The resident was positioned at a table with her forehead at the height of the table. An interview at this time with CNA 7, who was seated next to the resident, indicated she had been trying to get the resident to eat. CNA 7 indicated she only got the resident to take some milk and a couple bites of the food on her sectioned plate. An observation in the main dining room on 10-4-2017 at 11:46 a.m., indicated Resident 21 was observed in her wheelchair with her head down and her forehead even with the top of the table. The resident was observed to raise her head and her chin was even with the top of the table. An observation in the main dining room on 10-4-2017 at 11:51 a.m., indicated CNA 2 moved Resident 21 to another table that was an inch lower than the table where the resident was first seated.			

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	CNA 2 and the Dietitian were observed to discuss how to lower the adjustable table and CNA 2 was observed to try to lower the adjustable table, but the table was not lowered. The table top where the resident was seated, was 34 1/2 inches from the floor. Resident 21's chin was at the level of the blue sectioned plate which was placed on the table. An interview with the Dietitian and CNA 2 on 10-4-2017 at 4:13 p.m., indicated someone kept raising the table and they did not know how to lower the table. An observation in the main dining room on 10-4-2017 at 4:18 p.m., indicated the assist dining room table had not been lowered. An interview with Housekeeper 6 on 10-4-2017 at 4:20 p.m., indicated she lowered the table in the dining room. CNA 2 indicated Housekeeper 6 showed her how to lower the table. An observation of the main dining room on 10-10-2017 at 11:40 a.m., indicated the table where Resident 21 was seated, measured 30 inches from the floor. The table came to the resident's mid chest. The resident was able to reach her food, rest her wrist area on the edge of the table and was observed to be eating.			

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	An interview with the Administrator on 10-10-2017 at 11:13 a.m., indicated the table should have been lowered for Resident 21 and if the staff didn't know how to lower the table, she should have been notified. A copy of the most current Resident Rights updated on 11-28-2016 was provided by the Administrator on 10-10-2017 at 11:18 a.m., and indicated "...the resident has a right to be treated with reasonable access to a table of proper hieght...." 3.1-3(p)(1)			
F 0329 SS=D Bldg. 00	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or			

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	(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; Based on interview, and record review the facility failed to ensure medicaiton had adequate indication s and monirtoing for use for 1 resident on a medication for mood stabilization. This affected 1 of 5 residents reviewed with medications. (Resident 4) Findings included: A review of Resident 4's clinical record on 10/4/2017 at 4:16 p.m., indicated a BIMS (Brief Interview of Mental Status)	F 0329	1.Resident #4's Physician was notified and a proper diagnosis for the use of Depakote for mood disturbance obtained. The Depakote has been decreased as a trial GDR attempt. A Valporic acid level was drawn and was in the low normal range which is expected with the use of Depakote for mood stabilization. 2.A chart audit was conducted for all other residents who utilize Depakote for mood disorders, to assure proper diagnosis, GDR attempts and labs completed, if indicated. 3.The Nursing staff have been	11/06/2017

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	score of 12 out of 15, meaning moderate cognitive impairment. Diagnoses included, but were not limited to: arthritis, kidney disease, diabetes, chronic pain, high blood pressure, chronic urinary tract infection, dementia, asthma, and heart disease. A review of Resident 4's discharge paperwork from a hospital stay dated 9/21/2016 indicated the resident was discharged on depakote (a medication used to treat seizures and often used as a mood stabilizer to treat a mood disorder) 125 mg (milligrams) give one tablet by mouth three times a day. The diagnoses list, on the discharge summary, dated 9/21/2016, had not included mood disorder or siezures. A review of Resident 4's Physician's Orders indicated an order was given, dated 12/19/2016, for depakote 250 mg give one tablet, by mouth, two times a day. Another order dated 3/10/2017, for depakote 125 mg give one tablet with the 250 mg depakote tablet to equal 375 mg, by mouth, two times a day. there was no diagnosis to support this medication noted in either order. A review of the Mood and Behavior Monthly Monitoring Summary's from 9/2016 to 9/2017 indicated no GDR		re-educated on the use of Depakote for mood disorders with a special focus on proper diagnosis, GDR, and monitoring labs, if necessary. An audit sheet has been initiated. The DON and/or designee will monitor all residents using Depakote for mood disorders to assure proper diagnosis, GDR attempts and labs, if indicated. Audits will be conducted daily 5 days per week x 2 weeks, weekly for 2 weeks, then monthly thereafter. Should concern be noted, immediate corrective action shall be taken. 4.Results of these audits and any corrective actions will be reviewed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the plan will be adjusted if indicated on the basis of audit findings. 5.11-6-17	

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	attempt was trialed for the depakote use. The"Mood and Behavior Monthly Monitoring Summary" dated 9/6/2017 indicated "...Depakote due for GDR - contraindicated..." A review of Resident 4's Physician Progress Notes indicated no documentated reson for depakote GDR being contraindicated. A review of Physician Order's indicated no orders for laboratory tests had been given while Resident 4 was on the depakote medication regimen. A "Care Plan Worksheet" dated 8/24/2017, indicated "...The resident requires the use of Depakote to treat: mood stabilizer and is at risk for adverse side effects..." and in interventions section "...*Monitor labs as indicated..." During an interview on 10/5/2017 at 11:54 a.m., the DON (Director of Nursing) indicated she did not know why there was no diagnosis of mood disorder for the use of the depakote. She indicated Resident 4 had "fired" the Psychiatric NP (Nurse Practitioner) who used to provide them services. The DON indicated she was sure they had not ordered depakote levels to be drawn since the initial start of the medication, but			

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	should have notified the physician for clarification of the diagnosis for use, to clarify if labs should have been drawn to monitor depakote levels, and for the reason the GDR was contraindicated. During an interview on 10/6/2017 at 2:30 p.m., the Regional Nurse had indicated they had no policy regarding lab draws for depakote levels. 3.1-48(a)(3)			
F 0371 SS=E Bldg. 00	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional			

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	standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Based on observation, interview and record review, the facility failed to ensure staff performed hand hygiene adequately, handled food to prevent the potential for contamination, and failed to ensure the kitchen staff changed gloves adequately. These deficient practices had the potential to affect 30 of 31 residents who ate food prepared and served by the facility. Findings include: 1. During a lunch meal service in the dining room on 10/5/17 the following was observed: At 11: 57 a.m., the residents were seated in the dining room awaiting the lunch meal to be served. Five residents in wheelchairs or broda chairs (a positoning chair with wheels) were around two square tables pushed together and 1 staff was seated at the table with the residents. At 11:58 a.m., Staff 8 washed their hands with soap and water at the dining room sink, lathered their hands for 28 seconds covering all surfaces of their hands,	F 0371	1.As 30 of 31 residents have the potential to be affected, the following corrective actions have been taken. Staff #8 was re-educated as to the appropriate use/handling of chairs, clothing protectors, straws, drinking glasses and plates. Dietary staff #4 was re-educated on correct hand washing procedures and food handling in order to ensure proper sanitation and food safety. 2.The Glove Use and Meal Service policy was reviewed and no changes were made. The Hand Washing policy was reviewed and no changes were made. The Dietary and nursing staff were re-educated on correct hand washing procedures and food handling to ensure proper sanitation and food safety. 3.Staff have been re-educated on proper hand washing and use/handling of chairs, clothing protectors, straws, drinking glasses and plates. A monitoring tool has been put into place to monitor the dining room for proper hand washing during meal service. The Administrator and/or designee will monitor 5 days per	11/06/2017

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	rinsed with water and dried their hands with a clean, dry paper towel and turned the water off with a clean, dry paper towel, then discarded the paper towel into the trash. At 11:59 a.m., Staff 8 was observed to use both hands to pick up an armed chair and moved the chair beside a resident to assist the resident with their lunch meal. Staff 8 sat down in the chair, adjusted the resident's clothing protector, moved the resident's water glass, and then moved the plate in front of the resident with their right hand. Staff 8 was not observed to perform hand hygiene after touching the arms of the chair nor before touching the residents clothing protector, water glass or the plate. At 12:01 p.m., Staff 8 stood up from the chair and retrieved a drinking straw. Staff 8 removed the paper warpper from the straw as they returned to the table. Staff 8 was observed to put the drinking straw into the resident's beverage. Staff 8 sat down in the armed chair by the resident and then moved the resident's bowl. Staff 8 was not observed to perform hand hygiene before removing the paper from the drinking straw, before putting the drinking straw into the beverage, nor moving the resident's bowl in front of them.		week at staggered meals x 2 weeks, weekly x 2 weeks, then monthly thereafter to assure proper hand washing during meals. Should concerns be observed, immediate corrective action shall be taken. The dietary manager and/or designee will be responsible for completing monitoring observations at least five times weekly until compliance is maintained. A monitoring sheet has been implemented. Each meal (Breakfast, Lunch, and Supper) will be observed at least one time per week. The assigned consultant dietician will be responsible for bi weekly visits to confirm compliance with food handling and hand washing. Should concerns be observed, immediate corrective action shall be taken. 4.Results of these audits and any corrective actions will be reviewed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the plan will be adjusted if indicated, on the basis of monitoring/observations. 5.11-6-17	

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	2. During the observation in the facility kitchen staff preparing and plating the lunch meal on 10/6/17 the following was observed: At 11:05 a.m., the Dietary Manager (DM), indicated the lunch meal was ready to be plated. The DM indicated the 100/400 Hall meal carts were prepared first and then the 200/300 Hall meal cart before the lunch meal would be served in the dining room. At 11:06 a.m., Dietary Staff 4 had disposable gloves on their hands, the serving utensils were in place on the steam table, the meal tickets on metal stands, napkin wrapped silverware, the bowls of coleslaw, and a large package of square cheese slices were placed at the beginning, on the right end of the food line. Insulated plate bases and domed plate covers were stored on a rack and were on Dietary Staff 4's left side, the heated metal plate warmers were on the stove top behind Dietary Staff 4, and the plates were in the plate lowerator on Dietary Staff 4's right side. From 11:07 a.m. to 11:21 a.m., Dietary Staff 4 was observed to put a meal tray on the rolling food line, picked up the meal ticket and put it on the meal tray along with the napkin wrapped			

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	silverware, and the bowl of coleslaw. Dietary Staff 4 then retrieved the insulated plate base, stacked the plate warmer and plate, and placed the assembly in front of the steam table. Dietary Staff 4 used tongs with their gloved right hand to remove a bun from the package and put the bun on the plate. Dietary Staff 4 then used their left gloved hand to lift the top of the bun, while using tongs to put the fish on the bottom bun. Dietary Staff 4 continued to hold the top of the bun in their left gloved hand while retrieving a slice of cheese with their right gloved hand and put the cheese slice on top of the fish and returned the top of the bun on the sandwich. Dietary Staff 4 used tongs to plate corn nuggets on the plate, covered the plate with a domed plate cover, and placed the lunch meal plate onto the meal tray. Dietary Staff 4 continued to prepare the lunch meals for the 100/400 Hall. Dietary Staff 4 prepared 11 fish sandwiches and 1 sloppy joe sandwich using their gloved hands to remove the top of the bun and handle the cheese slices. At 11:22 a.m. the 100/400 Hall meal cart was taken from the kitchen to the unit for delivery to the residents. At 11:24 a.m. Dietary Staff 4 stepped			

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	away from the food line, with the same gloves on, retrieved the 200/300 Hall meal tickets on metal stands from the countertop next to the sink, put the meal tickets on the tray and arranged them in order of preparation. Dietary Staff 4 was not observed to change their disposable gloves before they returned to the food line. From 11:26 a.m. to 11:30 a.m., Dietary Staff 4 was observed to put a meal tray on the rolling food line, pick up the meal ticket, put it on the meal tray along with the napkin wrapped silverware, and the bowl of coleslaw. Dietary Staff 4 retrieved the insulated plate base, stacked the plate warmer and plate, and placed the assembly in front of the steam table. Dietary Staff 4 used tongs with their gloved right hand to remove a bun from the package and put the bun on the plate. Dietary Staff 4 then used their left gloved hand to lift the top of the bun, while using tongs to put a fish on the bottom bun. Dietary Staff 4 continued to hold the top of the bun in their left gloved hand while retrieving a slice of cheese with their right gloved hand, put the cheese slice on top of the fish, and returned the top of the bun on the sandwich. Dietary Staff 4 used tongs to plate corn nuggets on the plate, covered the plate with a domed plate cover, and			

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	placed the lunch meal plate onto the meal tray. Dietary Staff 4 continued to prepare the lunch meals for the 200/300 Hall. Dietary Staff 4 prepared 6 fish sandwiches using their gloved hands to remove the top of the bun and handle the cheese slices. At 11:32 a.m., the 200/300 Hall meal cart was taken from the kitchen to the unit for delivery to the residents. At 11:33 a.m., Dietary Staff 4 stepped away from the food line with the same gloves on, retrieved the dining room meal tickets on metal stands from the countertop next to the sink, put the meal tickets on the tray, and arranged them in order of preparation. Dietary Staff 4 retrieved the [Brand] protein and calorie supplements with a plastic scoop and put them on the counter by the left end of the steam table. Dietary Staff 4 was not observed to change their disposable gloves before they returned to the food line. At 11:36 a.m., Dietary Staff 5 returned to the kitchen and was observed to wash their hands with soap and water, lathered their hands for 30 seconds, rinsed with water and dried their hands with clean, dry paper towel, then turned the running water off with the used, wet paper towel,			

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	and discarded the paper towel into the trash. Dietary Staff 5 then went to the walk-in refrigerator, retrieved the prepared beverages which were coved with plastic wrap and labeled. Dietary Staff 5 placed the cart of beverages at the end of the food line. At 11:40 a.m., a staff knocked on the kitchen door and indicated they were ready for the lunch meal to be served. Dietary Staff 5 opened and propped the door open then placed a rolling 2 tiered cart into the doorway, to put the meal trays as it was ready to be served to the residents. Dietary Staff 5 washed their hands with soap and water, lathered their hands for 25 seconds, rinsed with water and dried their hands with clean, dry paper towel, turned off the running water with the same used wet paper towel and discarded into the trash. Dietary Staff 5 returned to the end of the food line to complete the meal tray with putting 1/2 of a banana and the beverages on the tray, then delivered the lunch meal tray to the cart in the doorway to the dining room. From 11:31 a.m. to 11:5 a.m., Dietary Staff 4 began to plate the food for the residents who eat in the main dining room. Dietary Staff 4 was not observed to change the disposable gloves from the beginning of food service. Dietary Staff			

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	4 observed to put a meal tray on the rolling food line, picked up the meal ticket and put it on the meal tray along with the napkin wrapped silverware, and the bowl of coleslaw. Dietary Staff 4 retrieved the insulated plate base and stacked the plate warmer and plate and placed in front of the steam table. Dietary Staff 4 used tongs with their gloved right hand to remove a bun from the package and put the bun on the plate. Dietary Staff 4 then used their left gloved hand to lift the top of the bun, while using tongs to put a fish on the bottom bun. Dietary Staff 4 continued to hold the top of the bun in their left gloved hand while retrieving a slice of cheese with their right gloved hand and put the cheese on top of the fish and returned the top of the bun on the sandwich. Dietary Staff 4 used tongs to plate corn nuggets on the plate, covered the plate with a domed plate cover and placed the lunch meal plate onto the meal tray. Dietary Staff 4 continued to prepare the lunch meals for the main dining room. Dietary Staff 4 prepared 6 fish sandwiches, 2 of the sandwiches were fish chopped into small pieces with a cheese slice on the bun for the mechanical soft diets. Dietary Staff 4 continued to use their gloved hands to remove the top of the bun and handle the cheese slices. Dietary Staff 4 also plated 4 puree meals into			

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	divided plates or bowls. At 11:46 a.m., The DM entered the kitchen area and washed her hands with soap and water, lathered her hands for 30 seconds, covering all areas of her hands and wrist, rinsed with running water and dried her hands with clean, dry paper towels, then turned the running water off with the same used, wet paper towel. At 11:47 a.m., The DM retrieved a small plate and requested Dietary Staff 4 put a bun on the plate. Dietary Staff 4 used tongs to remove the bun from the package and put the bun on the plate. The DM requested Dietary Staff 4 to removed the top of the bun. Dietary Staff 4 used their gloved hand and removed the top of the bun and the DM proceeded to put some meat on the bottom bun and Dietary Staff 4 put the top of the bun back on the sandwich. The DM wrapped the sandwich and left the kitchen with the sandwich. At 11:49 a.m., the DM returned to the kitchen, she washed her hands with soap and water, lathered her hands for 25 seconds, covering all surfaces of her hands and wrist, then rinsed her hands with running water, dried her hand with a clean, dry paper towels, then turned the running water off with the same used,			

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	wet paper towel and discarded the paper towels in the trash. An interview with the DM on 10/6/17 at 11:50 a.m., indicated staffs hands should be lathered for at least 20 seconds and the entire process should take 40-60 seconds. The DM indicated hands should be dried with clean paper towels. She indicated the water could be turned off with the paper towels used to dry their hands. She also indicated food should not be handled with bare hands and indicated ready made foods could be touched with gloved hands. The DM also indicated foods with skin to peel could be handled with bare hands, like bananas. She further indicated the tongs should have been used to handle the top of the bun and tongs should have been used to retrieved and put the cheese slice on the sandwich. The DM indicated the laminated meal tickets and holders were sanitized after each meal service. The DM indicated she was not aware of the need to use a clean, dry paper towel to turn off the water. She indicated there was teachable moments on the use of gloves, use of tongs and turning off the water with a clean paper towel. A current, undated facility policy, titled, "Hand Washing" was provided by the DM on 10/6/17 at 12:30 p.m. The policy			

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	indicated, "...It is the policy of the Dietary Department to prevent the spread of infection through proper handwashing. Hand sanitizer may not be used...1. Hands are washed: a. When entering and before starting work in the Dietary Department...b. After handling soiled dishes and utensils...d. Before and after handling foods...h. prior to putting on gloves...2. Handwashing Procedure:...e. Hands must be washed for a minimum of 20 seconds...f. Rinse thoroughly...g. Wipe dry with disposable paper towels...h. Turn off water faucet with paper towels...." A current , undated facility policy, titled, "Glove Use & Meal Service" provided by the Dietary Manager on 10/6/17 at 12:30 p.m., indicated, "...In an effort to protect food products from contamination, all products should be served using utensils...Procedure:...3. Hands must be washed often per the Handwashing policy...4. Employees may not touch ready-to-eat foods with a bare hands, gloves must be worn...5. Hands should be washed thoroughly between tasks...6. Utensils should be clean, sanitized and in good repair (i.e.. free fro rust)...9. Hands must be washed and completely dried prior to putting on a pair of gloves...10. If an employee handles raw food, leaves and enters the kitchen, touches equipment			

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	handles (i.e.. refrigerators, trash can lids) or touches any area of their body - they MUST immediate wash their hands...11. Gloves may be worn during food preparation but only for single task items (handling raw chicken)...." An interview with the Corporate HFA (Health Facility Administrator) on 10/6/17 at 12:35 p.m., indicated the facility policy indicated to turn the water faucet off with a paper towel and did not indicated it needed to be a different paper towel. A current poster from the World Health Organization, dated , May 2009, titled, "How to Handwash?", provided by the Corporate HFA and DM on 10/6/17 at 12:42 p.m., indicated, "...8. Rinse hands with water;...9. Dry hands thoroughly with a single use towel;...10. Use towel to turn off faucet;...11. Your hands are now safe...." 3.1-21(i)(2)			