DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	02/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAKEVIEW MANOR	45 BEACHWAY DR INDIANAPOLIS, IN 46224

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00248281, IN00251675, and IN00249036. This visit was in conjunction with the Investigation of Complaint IN00252443. Complaint IN00248281 - Substantiated. Federal/State deficiencies related to the allegations are cited at F0602. Complaint IN00251675 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00249036 - Unsubstantiated due to lack of sufficient evidence. Complaint IN00252443 - Substantiated. No deficiences related to the allegations are cited. Survey dates: January 30, 31, and February 1, 2, 5, and 6, 2018. Facility number: 000032 Provider number: 155077 AIM number: 100273330 Census Bed Type: SNF/NF: 96 SNF: 0 NF: 0 Total: 96 Census Payor Type: Medicare: 5 Medicaid: 87	F 0000	Lakeview Manor (Provider) submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The Provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employee, agents, officers, or directors. The Provider reserves the right to challenge the cited findings if at any time the Provider determines that the disputed findings are relied upon in a manner adverse to the interests of the Provider either by the governmental agencies or third party. Any changes to the Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Other: 4 Total: 96 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 13, 2018.		proceeding on that basis. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests paper compliance review in lieu of a Post Survey Review on or after March 8, 2018.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.			

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	§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, interview and record review, the facility failed to ensure resident's rights to privacy that maintained or enhanced their dignity, for 1 of 3 residents reviewed for dignity. (Resident 37) Findings include: In an initial interview with Resident 37 on 2/1/18, at 10:15 a.m., he indicated several staff members were "quick" with him so that he often felt "brushed off", not taken seriously, and disrespected. He did not provide any staff names and indicated he did not want to get anyone in trouble. During a random, continuous observation on 2/2/18 from 2:54 to 3:15 p.m. the following was observed: At 2:54 p.m., Resident 37 was observed entering the C-Wing shower room with Certified Nurse Aide (CNA) 16 who closed the door behind them.	F 0550	F550 RESIDENT RIGHTS/EXERCISE OF RIGHTS CFR(s): 483.10(a)(1)(2)(b)(1)(2) The facility will make every reasonable effort to ensure resident's rights to privacy that maintained or enhanced their dignity. CORRECTIVE ACTION: 1.Certified Nurse Aide (CNA) 16 received 1:1 inservice and counseling regarding Resident Rights with emphasis on providing a shower and maintaining resident's privacy and dignity on 02/07/18 by Director of Nurses (DON). 2.On 02/16/18, Resident 37 received a Mental Anguish	03/08/2018

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	At 3:01 p.m., CNA 16 was observed opening the shower room door. He was observed turned away from the resident as he stepped into the door frame and left the door standing ajar. Resident 37 was observed naked, under the shower faucet, facing away from the hall, his backside was exposed and visible. The shower curtain was observed pulled half way closed. CNA 16 kept the door open as he called across the hall to Qualified Medications Aid (QMA) 17 at the nurses' station and asked who was coming in at 3:00 p.m. to take over. At 3:05 p.m., CNA 16 was observed opening the shower room door a second time, turned away from the resident and called across the hall into the nurses' station asking for a razor. He waited with the door left open and ajar. The shower curtain was observed pulled closed. At 3:09 p.m., CNA 16 was observed opening the shower room door a third time. He was observed to step fully into the hallway leaving Resident 37 unattended, and allowed the shower room door to close against his back, leaving his left hand in the door frame door to keep it from shutting. CNA 16 called across the hall into the nurses station and asked where QMA 17 was. Without an answer he re-reentered the shower room and closed the door. At 3:13 p.m., CNA 16 opened the shower room door a fourth time. He was observed to turn his back to the resident, stepped into the hall and motioned with a wave for QMA 20. He waited in the open door until QMA 20 came to the door. At 3:15 p.m., CNA 16 indicated to QMA 20 he was waiting on QMA 17 and had told her three times to come in and take over for him so he would not		Assessment and discussed with Administrator concerns disclosed in this survey. Resident 37 plan of care was updated. IDENTIFICATIONOF OTHER RESIDENTS AT RISK: All Residents have the potential to be affected by this deficient practice, none were found to be affected. The remainder of the employees was noted to be in compliance with shower procedure 02/07/18. MEASURES/SYSTEMATIC CHANGES: All staff was inservice on Resident Rights and Shower procedure on 02/19/18 by Administrator/Designee. Administrator/Designee will monitor the facility treatment of each resident with respect and dignity and care by interviewing residents weekly during Guardian Angel Rounds. MONITOR: To ensure compliance, the Administrator/Designee is	

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	have to stay until 3:30 p.m. QMA 20 indicated to CNA 16 to return to the resident and she would find QMA 17. On 2/2/18 at 3:17 p.m., in an interview with QMA 20, she indicated that CNA 17 should not have left the shower room door open while a resident was in the shower so that the resident could be seen from the hall and staff should never turn their back on a resident while in the shower. In a follow up interview with the Resident 37, on 2/2/18 at 3:50 p.m., after his shower, he indicated his frustration about his shower. Resident 37 indicated the aid was rushing him and kept opening the door, the resident was afraid someone might have seen him since the curtain was only pulled half shut. Resident 37 indicated he was told by CNA 16, his shower was late because he had been busy helping with other CNA's patients. Resident 37 indicated it bothered him like crazy and it made him feel like he was a burden to the CNA, since he was in a hurry to leave for the day. On 2/5/18 at 12:18 p.m., in an interview with CNA 19, she indicated during private and sensitive care tasks, staff should always try to keep the door closed for the whole task and not to open it unless you need something urgent. On 2/5/18 at 12:23 p.m., in an interview with CNA 18 , she indicated while residents were in the shower staff should not to open the door unless of an emergency and to always stay with the resident and reassure them through the care process and be a good listener. On 2/2/18 at 3:45 p.m. the Administrator provided a policy titled, "Resident Rights" dated 9/2017,		responsible for the audit of Guardian Angel monitoring tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 months and then quarterly until continued compliance is maintained for two consecutive quarters. The QAA committee overseen by the Administrator will review the results of these audits. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	and indicated the policy was the one currently being used by the facility. The policy indicated, "...this facility shall treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life...." On 2/2/18 at 3:45 p.m. the Administrator provided a second policy titled, "Showering A Resident," dated 10/2014, and indicated the policy was the one currently being used by the facility. The policy indicated, "... A shower will clean, refresh, and soothe the residents...never turn your back or leave resident unattended while in the shower...." 3.1-3(t)			
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.			
	Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from misappropriation of property for 3 of 3 residents reviewed for allegations of drug diversion (Residents D, E, and F). Findings include: On 1/30/18 at 12:15 p.m., during an interview, the Administrator indicated the facility had had an incident of drug diversion. On 12/7/17 during the	F 0602	F602 FREE FROM MISSAPPROPRIATION/EXPLOIT ATION CFR(s): 483.12 The facility will make every reasonable effort to protect the residents' right to be free from misappropriation of property.	03/08/2018

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	night shift, the nurse realized hydrocodone/acetaminophen (narcotic pain medication) tablets were missing, from the medication cart, along with the residents' documentation sheets. The facility had conducted an investigation and all employees with access to the medication cart were removed from the schedule, and sent for drug testing. Employee 23, a Licensed Practical Nurse (LPN) had been terminated due to the laboratory reports, when she failed to provide prescriptions for any positive results, of drugs found in her urine test. Residents D, E, and F (combined) had approximately 81 tablets of the narcotic pain medication missing. On 1/30/18 at 12:31 p.m., the Administrator provided the investigation report. The urine test results from the contracted laboratory indicated, LPN 23's urine tested positive for narcotic drugs, bendodiazepines (narcotic medication used to treat anxiety) and oxycodone (narcotic pain medication). The report identified the amounts that were present in the urine as, oxepam (pain medication) confirmed 624 ng/ ml (nanograms per milliliter), lorazepam (anxiety medication) confirmed 834 ng/ml, and oxymorphone (pain medication) confirmed 1935 ng/ml. The employee provided no scripts (prescriptions) for the above medications. On 2/6/18 at 11:03 a.m., during an observation of narcotic storage, and interview, on the C Hall, QMA (Qualified Medication Aid) 24 indicated the narcotic count was done at the beginning and the end of each shift, between the out going and on coming nurses. A three ring binder contained a medication sheet for each narcotic, filed in order by resident name. A second sheet in the front of the binder had signatures for nurses coming on		CORRECTIVE ACTION: 1.Facility terminated Licensed Practical Nurse (LPN) 23 on 12/13/17 and reported to regulatory authorities post the completion of the facility investigation. 2.Residents D, E, and F narcotic pain medication was replaced by the facility on 12/07/17. IDENTIFICATIONOF OTHER RESIDENTS AT RISK: All Residents who have orders for Schedule II narcotics have the potential to be affected by this deficient practice, none were found to be affected. The remainder of the Schedule II narcotic cards and count sheet was noted to be in compliance on 12/09/17. MEASURES/SYSTEMATIC CHANGES: Licensed Nurses (LN) and Qualified Medication Aides (QMA) were inservice on Drug Diversion policy and procedure on 02/26/18 by DON/Designee. LN and QMA will complete the Daily Narcotic Card & Sheet Reconciliation that requires two signatures when	

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	and leaving each shift. The sheet was identified as the February Narcotic Count. A third sheet in the front pocket of the binder had signatures for each shift, and indicated how many individual sheets, and cards of narcotic medication, should have been present in the cart, at each count. QMA 24 indicated, if any of the sheets were missing she did not know how she would know. On 2/6/18 at 11:12 a.m., during an observation of the narcotic storage, and interview, on the D Hall, QMA 25 indicated, the narcotic count was done at the beginning and end of each shift. She indicated if any of the residents' narcotics were missing she would know because she signs for them, when the arrive from pharmacy, but she probably couldn't remember all the narcotic medications, for all the residents. They had a count sheet to sign for the amount of medication cards and sheets, by resident, that were on each cart. A three ring binder contained a medication sheet for each narcotic, filed in order by resident name. A second sheet in the front of the binder had signatures for nurses coming on and leaving each shift. The sheet was identified as the February Narcotic Count. A third sheet in the front pocket of the binder had signatures for each shift, and indicated how many individual sheets, and cards of narcotic medication were in the cart. On 1/31/18 at 10:30 a.m., A policy titled, "Drug Diversion", was provided by the Administrator. This policy indicated, "... should the facility note missing medications indicative of possible drug diversion, the following steps shall be taken and notifications made to applicable regulatory agencies in an effort to prevent recurrence of drug diversion....' A second policy titled, "Narcotic		changes to the cards and sheets counts are made. MONITOR: To ensure compliance, the DON/Designee is responsible for the audit of Narcotics Audit monitoring tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 months and then quarterly until continued compliance is maintained for two consecutive quarters. The QAA committee overseen by the Administrator will review the results of these audits. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. DATE OF COMPLIANCE: 03/08/18	

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	Count/Disposal", was also provided, at that time. This policy indicated, ".. purpose to deter potential drug diversion through ongoing accountability of narcotic use/disposal... The facility will reconcile Schedule II narcotics each shift. At the end of each shift, the oncoming nurse and the off going nurse will count the medications and reconcile them with the count sheets. If the count is incorrect, investigation will be started immediately...." This Federal tag relates to Complaint IN00248281. 3.1-28 (a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure resident was wearing a left hand splint per medical doctor's order (Resident 36). Findings include: During an observation on 1/30/18 at 12:10 p.m., Resident 36 was not wearing a splint on her left hand. During an observation on 1/31/18 at 10:23 a.m.,	F 0684	F684 QUALITY OF CARE CFR(s): 483.25 The facility will make every reasonable effort to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	03/08/2018

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	Resident 36 was not wearing a splint on her left hand. During an observation on 2/6/17 at 10:51 a.m., Resident 36 was not wearing a splint on her left hand. During an observation and interview on 2/6/18 at 12:42 p.m., Resident 36 was observed with splint on left hand. Husband indicated the staff came in this morning and gave her a new splint. She used to wear a splint but had not worn one for about two years. During a record review on 1/31/18 at 11:18 a.m., Resident 36 had diagnoses, including, but not limited to, paraplegia and physician's orders for left hand splint on for 2-4 hours daily during 7:00 a.m. to 3:00 p.m. shift. During a record review on 2/6/18 at 2:31 p.m., the Minimum Data Set (MDS) indicated: Resident 36 had no splint or brace assistance and had impairment in upper and lower extremity on one side. During a record review on 2/6/18 at 2:39 p.m., Resident 36's care plan, dated 11/21/17, was as follows: "Splint/Brace...The resident requires the use of a splint/brace to ensure proper positioning of limb: left hand splint 2-4 hours daily. Goal: The resident will remain free from complications associated with splint/brace use through next review. Interventions: 1. Apply the splint/brace as order. 2. Cleanse, dry and inspect the skin under the appliance prior to application. 3. Observe for complications such as: redness, numbness, swelling, color changes, increased skin temperature at application site, skin breakdown. 4. Notify the nurse of problems for further		CORRECTIVE ACTION: On 02/06/18, Resident 36 was assessed by nursing and referred to occupational therapy for splint wear schedule. Assessment was provided to NP and new order was obtained. IDENTIFICATIONOF OTHER RESIDENTS AT RISK: All Residents who have contractures have the potential to be affected by this deficient practice, none were found to be affected. MEASURES/SYSTEMATIC CHANGES: Nursing staff was inservice on Splint Application policy and procedure on 02/26/18 by DON/Designee. DON/Designee will reassess all residents who have contractures and update their plan of care, Nurses and CNA assignment sheets. MONITOR: To ensure compliance, the	

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	evaluation and possible physician, resident representative, and/or therapy department notification." During an interview on 2/6/18 at 10:53 a.m., Certified Nursing Assistant (CNA) 35 indicated Resident 36 did not wear a hand brace although her left hand was contracted. During an interview on 2/6/18 at 10:54 a.m., Licensed Practical Nurse (LPN) 36 indicated Resident 36's left hand splint should have been on 2-4 hours per day, and the nursing staff was to place it and remove it. During an interview on 2/6/18 at 3:19 p.m., Qualified Medical Assistant (QMA) 37 indicated per the Medical Administration Record (MAR), Resident 36 wore the left hand splint 2-4 hours on day shift. They put it on at 11:00 a.m., and initial the MAR. A policy was provided, titled, "Care Plan Development and Review," the last revised date was 9/17. It indicated, "Purpose: To ensure an interdisciplinary approach to plan for and meet each resident's needs ..." and, " ...The comprehensive care plan shall then be developed and shall describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ..." and " ...The services provided or arranged by the facility, as outlined by the comprehensive care plan, shall meet professional standards of quality." A policy, titled, "Resident Rights," no date, was provided by the Administrator, on 2/2/18 at 3:45 p.m. It indicated, "The facility shall treat each resident with respect and dignity and care for		DON/Designee is responsible for the audit of Special Equipment Audit monitoring tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 months and then quarterly until continued compliance is maintained for two consecutive quarters. The QAA committee overseen by the Administrator will review the results of these audits. If threshold of 100% is not achieved an action plan will be developed to ensure compliance.	

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	each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life," and, " ...this facility shall provide equal access to quality of care .... 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure an environment was free from potential hazards for 1 of 7 resident reviewed for accidents (Resident 43). Findings include: On 2/2/18 at 10:21 a.m., an empty pill cup and one oblong white pill was observed on top of Resident 43's bed covers. The room was empty. At 2/2/18 at 10:24 a.m. Resident 43 entered her room and sat on the side of her bed. The resident indicated she had been given her medicine that morning and identified the pill left on her bed as a Trazadone for her anxiety. The resident indicated she must have forgotten to take that one and started to pick the pill up. She was instructed to please wait for the nurse and did not pick up the pill. The resident indicated, sometimes the nurses	F 0689	F689 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2) The facility will make every reasonable effort to ensure resident's environment is free from potential hazards. CORRECTIVE ACTION: On 02/02/18, LPN 22 received 1:1 inservice and counseling on Medication Administration by the DON. Resident 43 was assessed with no adverse affect and new physician order was obtained.	03/08/2018

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	155077	A. BUILDING 00 B. WING	02/06/2018

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LAKEVIEW MANOR	45 BEACHWAY DR INDIANAPOLIS, IN 46224

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	left her pills for her in a pill cup at her bedside table when she was in the bathroom and she would take them by herself when she was finished. The resident indicated, "I don't track them down to say, 'hey I'm going to take this now' I just take them if I see them left for me." On 2/2/18 at 10:31 a.m., Unit Manager 21 entered the room and picked up the pill from the resident's bed. She identified the pill as a Buspar (an anti-anxiety medication) 5 milligrams (mg). The unit manager indicated that the nurse should have ensured that the pill was not left unattended and the Resident 43 did not have an order or assessment to self-administer medications. In an interview with Unit Manager 21 and Licensed Practical Nurse (LPN) 22 on 2/2/18 at 10:33 a.m., Unit Manager 21 confirmed the identification of the pill as Buspar 5 mg from Resident 43's physician orders. LPN 22 identified the tablet as the Resident's 2:00 p.m. dose. Unit Manager 21 indicated the 8:00 a.m. and 2:00 p.m. doses for that day had been signed off as given, and LPN 22 had given Resident 43 her 8:00 a.m. dose and her 2:00 p.m. dose both at 8:00 a.m. that morning when she should not have. A medical record review for Resident 43 was completed on 2/2/18 at 11:00 a.m. A most recent comprehensive assessment, a quarterly Minimum Data Set (MDS) dated 1/19/18, was provided by Administrator on 2/5/18 at 10:00 a.m. The MDS indicated Resident 43 was cognitively intact with a BIMS (Brief Interview for Mental Status) score of 14 out of 15. Resident 43 scored a 24 out of 27 on the PHQ-9 (a Patient Health Questionnaire screening for depressive symptoms) and had severe depression. Resident 43 was receiving regularly scheduled anti-anxiety and		IDENTIFICATIONOF OTHER RESIDENTS AT RISK: All Residents have the potential to be affected by this deficient practice, none were found to be affected. MEASURES/SYSTEMATIC CHANGES: Licensed Nurses and QMA staff was inservice on Medication Administration policy and procedure on 02/26/18 by DON/Designee. DON/Designee will do 3 Medication Pass Observation per week for 4 weeks. MONITOR: To ensure compliance, the DON/Designee is responsible for the audit of Medication Pass monitoring tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 months and then quarterly until continued compliance is maintained for two consecutive quarters. The QAA committee overseen by the Administrator will review the results of these audits. If threshold of 95% is not achieved an action	

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	ant-depressant medication 7 days a week. A care plan for Resident 43, last revised on 1/31/18, was provided by the Administrator on 2/5/18 at 10:00 a.m. The care plan indicated she was taking Buspar as an anit-anxiety medication and to administer medications as ordered. A current copy of physician orders for Resident 43 was provided by Unit Manager 21 on 2/2/18 at 11:00 a.m. The physician orders included but were not limited to: -Buspar 5 milligram tablet, give 1 tablet 1 time a day at 2:00 p.m. -Buspar 10 milligram tablet, give 1 tablet 2 times a day at 8:00 a.m., and 2:00 p.m. A copy of Resident 43's Medication Administration Record (MAR) was provided by Unit Manager 21 on 2/2/18 at 11:00 a.m. the MAR indicated LPN 22's initial for administering both the Buspar 10 mg 8:00 a.m. dose and the Buspar 5 mg 2:00 p.m. dose. On 2/2/18 at 3:45 p.m. the Administrator provided a policy titled, "Medication Administration" dated 4/2017, and indicated the policy was the one currently being used by the facility. The policy indicated, "... to safely administer medications as her physician's orders... always observe the resident taking their medication(s). Never permit medication to remain in the resident's room...." 3.1-45(a)(1)		plan will be developed to ensure compliance.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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	§483.60(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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation, interview, and record review, the facility failed to ensure dietary employees wore proper hair and beard restraints, and wore appropriate clothing in the kitchen per facility policy. This had the potential to affect 96 of 96 residents who consume food from the kitchen. Findings include: 1. During an observation on 1/30/18 at 10:32 a.m., the Dietary Manager (DM) had a hair net on top of her head with her long pony tail out of the hair net. During the tour of the kitchen and storage area, she did not put her pony tail inside her hair net. During a serving line observation on 1/30/18 at 12:52 p.m., the DM was behind the serving line	F 0812	F812 FOOD PROCURE, STORE/PREPARE/SERVE-SANI TARY CFR(s): 483.60(i)(1)(2) The facility will make every reasonable effort to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and to store, prepare, distribute and serve food in accordance with professional standards for food service safety. CORRECTIVE ACTION: 1.(a) Dietary Manager (DM), Dietary Aide 30, Respiratory	03/08/2018

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	with her long pony tail out of her hair net, and she was pouring juices. Dietary Aide 30 was observed in the kitchen with no beard cover on. Respiratory Therapist (RT) 34 was leaning in the kitchen serving window with her hair on the counter as she talked to the kitchen staff, then trays were placed onto the counter and served. Cook 32 had hair out of hair net while prepping pattied meat, grilling sandwiches, and scooping up mashed potatoes. Dietary Aide 31 adjusted her glasses, then continued setting up food trays for residents without washing or sanitizing her hands.. During an observation on 2/1/18 at 10:08 a.m., Dietary Aide 30 was in the kitchen with no beard cover on. During an interview on 2/5/18 at 3:17 p.m., the DM indicated hair nets and beard covers should have been worn at all times, and RT 34 should not have been leaning on the serving window counter or had her hair on the counter. A policy titled, "Hair Restraints," dated 11/2014, was provided by the Business Office Manager on 2/1/18 at 2:37 p.m. It indicated, "Hair restraints shall be worn by all dietary employees while working in the kitchen area. Procedure: 1. All employees will be provided with a hair restraint. It will be worn by all employees while on duty. 2. Men with beards or other facial hair may be required to wear beard protectors. 3. Failure to wear appropriate hair restraints shall result in disciplinary action. 4. Ball caps are not acceptable hair restraints." The Indiana State Department of Health, "Retail Food Establishment Sanitation Requirements-Title 410 IAC 7-24," dated November 13, 2004, indicated under "410 IAC 7-24-138: Effectiveness of hair		Therapist 34 and Cook 32 was provided 1:1 inservice on the proper utilization of hair restraints on 02/01/2018 by Administrator/Designee. (b) Dietary Aide 31 was provided inservice on proper food handling and hand washing on 02/01/2018 by Administrator. 2.DM and Dietary Aide 30 was provided inservice on acceptable personal appearance in the dietary department on 02/23/2018 by Administrator. IDENTIFICATIONOF OTHER RESIDENTS AT RISK: All Residents have the potential to be affected by this deficient practice, none were found to be affected. The remainder of the employees was noted to be in compliance with procedure for dining services in wearing hairnets and acceptable personal appearance on 02/07/18. MEASURES/SYSTEMATIC CHANGES: All staff was inservice on proper utilization of hair restraints in the kitchen and during dining services on 02/19/18 by Administrator/Designee. All	

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	restraint., Sec. 138.... (b) food employees shall wear hair restraints, such as...beard restraints,...that are designed and worn to effectively keep hair from contacting: (1) exposed food; (2) clean equipment, utensils...." 2. During an observation on 1/30/18 at 12:46 p.m., Dietary Aide 30 was in the kitchen wearing a stained hooded sweatshirt over his uniform. During an observation on 1/30/18 at 12:52 p.m., the DM was behind the serving line, she was wearing a hooded sweatshirt, and Cook 33 was wearing a hooded sweatshirt in the kitchen. During an observation on 2/1/18 at 2:35 p.m., Dietary Aide 30 was in the kitchen wearing a soiled hooded sweatshirt over his uniform. During an observation on 2/5/18 at 3:17 p.m., the DM was observed wearing a hooded sweatshirt in the kitchen, she indicated it was cold in the kitchen. A policy titled, "U. Personal Appearance," with no date, was provided by the Business Office Manager on 1/30/18 at 1:27 p.m. It indicated, "...1. Purpose ...The personal appearance of employees is important to the public image of our Company. Employees are expected to present a well-groomed and appropriate professional appearance... 2. Policy ...it is essential to avoid wearing anything to the facility that is excessively worn, frayed, faded, or wrinkled. Avoid clothing that is too revealing, tight fitting, torn, stained, sloppy, mismatched, thin, or see-through.... For our residents and visitors to easily identify department affiliation please refer to the following dress code: ...Dietary: black bottoms and tops... Visible body piercings, other than of the ear, are		dietary staff was inservice on proper food handling, hand washing and acceptable personal appearance on 02/26/18F by Registered Dietician. DM/Designee will monitor the utilization of hair restraints, proper handling of food and acceptable personal appearance in the kitchen and during dining services weekly for at least 3 meals. MONITOR: To ensure compliance, the DM/Designee is responsible for the audit of Dining Service monitoring tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 months and then quarterly until continued compliance is maintained for two consecutive quarters. The QAA committee overseen by the Administrator will review the results of these audits. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	prohibited. Employees are expected to remove any visible pierced body jewelry ...visible tattoos are prohibited... Hair must be a naturally-occurring hair color .... Personal Appearance Chart. Men's clothing: Non-acceptable: sweatshirts... caps/hats worn outdoors, jeans/denims .... Women's clothing: Non-acceptable: radical hair color, sweatshirts, t-shirts, midriffs/low necklines...." The Indiana State Department of Health, "Retail Food Establishment Sanitation Requirements-Title 410 IAC 7-24," dated November 13, 2004, indicated under "410 IAC 7-24-135: Clean condition of outer clothing., Sec. 135. (a) Food employees shall wear clean outer clothing to prevent contamination of the following: (1) Food. (2) Equipment. (3) Utensils. (4) Linens. (5) Single-service and single-use articles." 3.1-21(i)(2) 3.1-21(i)(3)			