This visit was for the Investigation of Complaints IN00209696, IN00210710, and IN00212992.

Complaint IN00209696 - Substantiated. Federal/State deficiencies related to the allegations are cited at F241 and F312.

Complaint IN00210710 - Substantiated. Federal/State deficiencies related to the allegations are cited at F241 and F312.

Complaint IN00212992 - Unsubstantiated due to lack of evidence.

Unrelated deficiency cited.

Survey dates: October 23, 24, & 25, 2016

Facility number: 000108
Provider number: 155653
AIM number: 100267410

Census bed type:
SNF/NF: 62
Total: 62

Census payor type:
Medicare: 6
Medicaid: 55

Kim Rhoades, Director of Long Term Care Indiana State Department of Public Health 2 North Meridian St. Sec 4-B Indianapolis, In 46204-3006

Dear Ms. Rhoades:

Please reference the enclosed 2567L as “Plan of Correction” for the October 25, 2016 Complaint (IN00209696) and...
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
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<tr>
<th>Identification Number:</th>
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<th>X2) MULTIPLE CONSTRUCTION</th>
<th>X3) DATE SURVEY COMPLETED</th>
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<tr>
<th>NAME OF PROVIDER OR SUPPLIER</th>
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<tbody>
<tr>
<td>LAKE COUNTY NURSING AND REHABILITATION CENTER</td>
<td>5025 MCCOOK AVE EAST CHICAGO, IN 46312</td>
</tr>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>Other: 1</td>
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<td>Total: 62</td>
<td></td>
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<td>(IN00210710) survey that was conducted at Lake County Nursing and Rehabilitation Center. I will submit signature sheets of the in-servicing, content of in-service and audit tools November 7, 2016. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community.</td>
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<tr>
<td>Sample: 11</td>
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<td></td>
<td>The Plan of Correction submitted on November 7, 2016 serves as our allegation of compliance. The provider</td>
</tr>
</tbody>
</table>

These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.

Quality review completed by 32883 on 10/26/16.
<table>
<thead>
<tr>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
<th>PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653</th>
<th>X2) MULTIPLE CONSTRUCTION</th>
<th>A. BUILDING  B. WING</th>
<th>X3) DATE SURVEY COMPLETED 10/25/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME OF PROVIDER OR SUPPLIER</td>
<td>LAKE COUNTY NURSING AND REHABILITATION CENTER</td>
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<td>5025 MCCOOK AVE EAST CHICAGO, IN 46312</td>
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<td>ID</td>
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<td>F 0241</td>
<td>483.15(a)</td>
<td>483.15(a)</td>
<td>DIGNITY AND RESPECT OF INDIVIDUALITY</td>
<td>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's</td>
</tr>
<tr>
<td>SS=D Bldg. 00</td>
<td>RESPECTFUL ADDRESS</td>
<td>RESPECTFUL</td>
<td>RESPECTFUL</td>
<td>RESPECTFUL</td>
</tr>
</tbody>
</table>

Respectfully request a Desk review on or after November 7, 2016. Should you have any question or concerns regarding the Plan of Corrections, please contact me.

Respectfully,

Neyssa Stewart, HFA

Event ID: JWZE11 Facility ID: 000108 If continuation sheet Page 3 of 17
dignity and respect in full recognition of his or her individuality.

Based on observation, record review, and interview, the facility failed to provide care to enhance each resident's dignity related to residents not dressed in their own clothing during day time hours, staff standing while feeding residents, failure to respond to a request to be repositioned, and a resident not served her meal tray while her roommate was eating for 2 of 3 residents reviewed for Activities of Daily Living in a sample of 11. (Residents #G and #L)

Findings include:

1. During Orientation Tour on 10/23/16 at 4:15 p.m., Resident #G was observed in bed. The resident was awake and dressed in a hospital gown. There were no staff members or visitors in the room.

On 10/23/16 at 5:40 p.m., the resident remained in bed. The resident was awake and dressed in a hospital gown. There were no staff members or visitors in the room. The resident did not have a meal tray. The resident's roommate was in bed and eating her dinner.

On 10/23/16 at 6:00 p.m., 6:10 p.m., and 6:15 p.m., the resident remained in bed. The resident was awake and dressed in a
### Statement of Deficiencies and Plan of Correction

**Identification Number:**
- **X1:** PROVIDER/SUPPLIER/CLIA
  - **A. Building:** 155653
  - **B. Wing:**

**Multiple Construction A. Building 00**

**Date Survey Completed:** 10/25/2016

**Name of Provider or Supplier:**
- **Lake County Nursing and Rehabilitation Center**
  - **Street Address, City, State, Zip Code:**
    - 5025 McCook Ave
    - East Chicago, IN 46312

**Event ID:** JWZE11

#### Summary Statement of Deficiencies

1. The corrective action for those residents having the potential to be affected by the same deficient practice:

   1. The corrective action for those residents having the potential to be affected by the same deficient practice:

   - All residents that need assist with feeding, repositioning and dressing themselves are at risk for this alleged deficient practice. No other residents were found to be affected by this alleged deficient practice.

2. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:

   1. **C.N.A. #1 was given 1:1 education/disciplinary action.**

   2. On 10/23/16 & 10/24/16 the DON educated all nursing staff on providing care with dignity such as sitting while feeding, offering alternatives, addressing resident's needs timely and respectfully, assisting with repositioning and appropriate day time clothing.

   3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:

   - C.N.A. #1 was given 1:1 education/disciplinary action.

   - On 10/23/16 & 10/24/16 the DON educated all nursing staff on providing care with dignity such as sitting while feeding, offering alternatives, addressing resident's needs timely and respectfully, assisting with repositioning and appropriate day time clothing.

   - The CNA then took the meal tray into Resident #G's room. The resident was in bed and remained dressed in a hospital gown. There were no staff members or visitors in the room. The head of the residents bed was elevated. The resident was slouched down in bed and her head was leaning on the right halo rail on the bed. The resident's head was approximately 12 inches down from the top of the mattress.

   - On 10/23/16 at 6:14 p.m. the resident remained in the room as above. The resident stated she wanted to sit up and had asked someone to get her up but they did not come back. The resident did not have a meal tray. The resident's roommate was in bed with her meal tray remaining on the table over her bed.

   - On 10/23/16 at 6:15 p.m., a meal cart was observed down the hall from the resident's room. CNA #1 exited another resident's room and opened the cart. Resident #G's meal tray was the only tray in the cart. CNA #1 indicated Resident #G was a "feeder" and had to wait as he was feeding another resident at this time.

   - The CNA then took the meal tray into Resident #G's room. The resident was in bed and remained dressed in a hospital gown. The CNA placed the tray on the resident's over bed tray and removed the lid from the meal plate. The CNA cut the resident's sandwich and started to
assist the resident with the sandwich while standing bedside the bed. The resident remained in the same position as above and CNA #1 did not offer or attempt to reposition the resident. The resident said to the CNA "I need you to sit me up please." CNA #1 stated "you are as high as you go." The CNA did not attempt to reposition the resident. The resident asked three more times to be raised up and the CNA repeated the above response and still did not attempt to repositioned the resident.

CNA #1 picked up a piece of the sandwich and placed the sandwich near the resident's mouth. The resident stated "I don't like grilled cheese." The CNA did not respond to the resident. The CNA again picked up a piece of the sandwich and the resident stated "I don't like it" twice and raised her voice repeating this.

The record for Resident #G was reviewed on 10/24/16 at 3:25 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, anemia, hemiplegia (weakness of an extremity), and a history of falling.

The 9/21/16 Minimum Data Set annual assessment indicated the resident's BIMS (Brief Interview for Mental Status) score...
was (15) and the resident's cognitive patterns were intact. The resident did not exhibit any behaviors during the reference period. The resident required extensive assistance of one staff member for eating and personal hygiene, and extensive assistance of two staff members for dressing. The resident had impairment in range of motion of both her upper and lower extremities on one side.

When interviewed on 10/23/16 at 6:35 p.m., the Director of Nursing indicated the CNA should not have referred to the resident as a feeder and the resident should not have had to wait for assistance with her meal while her roommate was already eating her dinner in the room.

2. During Orientation Tour on 10/23/16 at 4:10 p.m., Resident #L was observed in bed. The resident was awake and laying flat in bed with his eyes open. The resident was dressed in a hospital gown. There were no staff members or visitors in the resident's room.

On 10/23/16 at 5:30 p.m. and 5:45 p.m., the resident was awake and laying flat in bed with his eyes open. The resident was dressed in a hospital gown. There were no staff members or visitors in the resident's room.
On 10/23/16 at 6:05 p.m., the resident was observed in bed. LPN #1 was feeding the resident. The resident was dressed in a hospital gown. There were no staff members or visitors in the resident's room.

On 10/23/16 at 6:50 p.m., the resident was awake and remained in bed. The resident was dressed in a hospital gown. There were no staff members or visitors in the resident's room.

The record for Resident #L was reviewed on 10/24/16 at 12:46 p.m. The resident's diagnoses included, but were not limited to, cerebral palsy, major depressive disorder, insomnia, and schizophrenia.

The 8/29/16 Minimum Data Set quarterly assessment indicated the resident's cognitive status was modified independence. The resident did not reject care during the reference period. The resident required extensive assistance of two staff members for transfers and extensive assistance of one staff member for dressing.

A Care Plan last reviewed on 6/24/16 indicated the resident was cognitively impaired and at risk to be dressed in an undignified manner. Care plan
interventions included, but were not limited to, staff to dress the resident in appropriate attire at all times.

This Federal tag relates to Complaints IN00209696 and IN00210710.

3.1-3(t)

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<td>F 0312</td>
<td>F 312</td>
<td>11/07/2016</td>
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ADL CARE PROVIDED FOR DEPENDENT RESIDENTS
A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

Based on observation, record review, and interview, the facility failed to ensure residents who required assistance with ADLs (Activities of Daily Living) received the necessary treatment and services to transfer out of bed for 2 of 3 residents reviewed for ADLs in a sample of 11. (Residents #G and #L)

Findings include:

Please accept the following as the facility’s plan of correction.
1. During Orientation Tour on 10/23/16 at 4:10 p.m., Resident #L was observed in bed. The resident was awake and laying flat in bed with his eyes open. The resident was dressed in a hospital gown. There were no staff members or visitors in the resident's room.

On 10/23/16 at 5:30 p.m. and 5:45 p.m., the resident was awake and laying flat in bed with his eyes open. The resident was dressed in a hospital gown. There were no staff members or visitors in the resident's room.

On 10/23/16 at 6:05 p.m., the resident was observed in bed. LPN #1 was feeding the resident.

On 10/23/16 at 6:50 p.m., the resident was awake and remained in bed. There were no staff members or visitors in the resident's room.

The record for Resident #L was reviewed on 10/24/16 at 12:46 p.m. The resident's diagnoses included, but were not limited to, cerebral palsy, major depressive disorder, insomnia, and schizophrenia.

The 8/29/16 Minimum Data Set quarterly assessment indicated cognitive status was modified independence. The resident did not get up and dress on 10/24/16.

On 10/23/16 R# G was lifted up in the bed by staff.

C.N.A #1 received education/disciplinary action.

This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.

1. The corrective action taken for the resident found to have been affected by the deficient practice:

R# L did get up and dressed on 10/24/16.

On 10/23/16 R# G was lifted up in the bed by staff.

C.N.A #1 received education/disciplinary action.

2. The corrective action for those residents having the potential to be affected by the same deficient practice:

All residents that are dependent...
not reject care during the reference period. The resident required extensive assistance of two staff members for transfers and extensive assistance of one staff member for dressing.

When interviewed on 10/24/16 at 10:00 a.m., the Director of Nursing indicated staff do assist the resident out of bed and could have gotten the resident out of bed for dinner.

2. During Orientation Tour on 10/23/16 at 4:15 p.m., Resident #G was observed in bed. The resident was awake. There were no staff members or visitors in the room.

On 10/23/16 at 5:40 p.m., the resident remained in bed. The resident was awake. There were no staff members or visitors in the room.

On 10/23/16 at 6:00 p.m., 6:10 p.m., and 6:15 p.m., the resident remained in bed. The resident was awake. There were no staff members or visitors in the room. The head of the resident's bed was elevated. The resident was slouched down in bed and her head was leaning on the right halo rail on the bed. The resident's head was approximately 12 inches down from the top of the mattress.

3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:

Nursing staff was re-educated accommodating residents request and ADL needs related to transferring out of bed and repositioning by the DON on 10/23/16 & 10/24/16.

4. To ensure the deficient practice does not reoccur, the monitoring system established is to:

DON / Designee will monitor 10 residents weekly for 4 weeks on alternating shifts. Then 7 residents weekly for 3 months to ensure residents requiring assistance with ADLs receive the necessary treatment and services to transfer out of bed on alternating shifts.
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>00</td>
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<td></td>
<td>On 10/23/16 at 6:14 p.m. the resident remained in the room as above. The resident stated she wanted to sit up and had asked someone to get her up but they did not come back.</td>
<td>Any issues will be addressed immediately.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>On 10/23/16 at 6:15 p.m., CNA #1 took Resident #G's meal tray into her room. The resident was in bed and remained dressed in a hospital gown. The CNA placed the tray on the resident's over bed tray and removed the lid from the meal plate. The CNA cut the resident's sandwich and started to assist the resident with the sandwich. The resident remained in the same position as above and CNA #1 did not offer to or attempt to reposition the resident. The resident said to the CNA, &quot;I need you to sit me up please.&quot; CNA #1 stated &quot;you are as high as you go.&quot; The CNA did not attempt to reposition the resident. The resident asked three more times to be raised up and the CNA repeated the above response and did not attempt to repositioned the resident.</td>
<td>The audits will be discussed during our monthly QA meeting.</td>
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<td>When interviewed on 10/23/16 at 6:35 p.m., the Director of Nursing indicated the resident was dependent on staff for transfers. The Director of Nursing indicated CNA should have repositioned the resident when requested.</td>
<td>QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</td>
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<td>5. Completion date systemic changes will be completed:</td>
<td>11/7/16</td>
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## Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION

**Date Survey Completed:** 10/25/2016

### Name of Provider or Supplier

LAKE COUNTY NURSING AND REHABILITATION CENTER

**Address:**

5025 MCCOOK AVE

EAST CHICAGO, IN 46312

### Summary Statement of Deficiencies

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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This Federal tag relates to Complaints IN00209696 and IN00210710.

3.1-38(a)(2)(B)

483.65

**INFECTION CONTROL, PREVENT SPREAD, LINENS**

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program

The facility must establish an Infection Control Program under which it -

1. Investigates, controls, and prevents infections in the facility;
2. Decides what procedures, such as isolation, should be applied to an individual resident; and
3. Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

1. When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

Based on observation, record review, and interview, the facility failed to ensure food was served under sanitary conditions related to hand washing not completed before assisting with feeding for 1 of 3 residents observed having meals in their rooms in a sample of 11.

Finding includes:

On 10/23/16 at 6:15 p.m., CNA #1 removed a meal tray from a Dietary cart. The CNA took the meal tray to Resident #G's room and placed the tray on the resident's over bed table. The CNA removed the lid from the tray. There was a sandwich on the plate. The CNA did not wash his hands, perform hand hygiene, or put on gloves prior to touching the sandwich while cutting it and placing pieces of the sandwich up to the resident's mouth.

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<td>PLAN OF CORRECTION</td>
<td>11/07/2016</td>
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Please accept the following as the facility’s plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.

1. The corrective action taken for the resident found to have been affected by the deficient practice:
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:** 155653

**MULTIPLE CONSTRUCTION**

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**LAKE COUNTY NURSING AND REHABILITATION CENTER**

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<tr>
<td>5025 MCCOOK AVE</td>
</tr>
<tr>
<td>EAST CHICAGO, IN 46312</td>
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</table>

The record for Resident #G was reviewed on 10/24/16 at 3:25 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, anemia, hemiplegia (weakness of an extremity), and a history of falling.

The 9/21/16 Minimum Data Set annual assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 15 and the resident's cognitive patterns were intact. The resident did not exhibit any behaviors during the reference period. The resident required extensive assistance of one staff member for eating.

When interviewed on 10/23/16 at 6:45 p.m., the Director of Nursing indicated the CNA should have washed his hands prior to feeding the resident.

3.1-18(l)

<table>
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<tr>
<th>RESIDENT</th>
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Resident G was found to not have been affected by this alleged deficiency.

C.N.A #1 was re-education regarding handwashing in regards to feeding residents and handling food.

2. The corrective action for those residents having the potential to be affected by the same deficient practice:

All residents have the potential to be affected by this alleged deficient practice.

No other residents were found to be affected by this alleged deficient practice.

3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:
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</table>

On 10/23/16 & 10/24/16 the DON re-educated nursing staff regarding hand washing before assisting with feeding and the handling of resident’s food.

4. To ensure the deficient practice does not reoccur, the monitoring system established is to:

DON / Designee will monitor 10 staff members weekly for 4 weeks on alternating shifts.

Then 5 staff members weekly for 3 months on alternating shifts to ensure proper hand washing before assisting with feeding and food handling.

Any issues will be addressed immediately.

The audits will be discussed during our monthly QA meeting.

QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.
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5. Completion date systemic changes will be completed:

11/7/16