

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155753	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/23/2014
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NAME OF PROVIDER OR SUPPLIER  HAMPTON OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 966 N WILSON RD SCOTTSBURG, IN 47170
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey date(s): September 17, 18, 19, 22 and 23, 2014</p> <p>Facility number: 004902</p> <p>Provider number: 155753</p> <p>AIM number: 200813130</p> <p>Survey team: Gwen Pumphrey, RN-TC (September 17,18, 22, and 23, 2014) Joshua Emily, RN Jennifer Sartell, RN Trudy Lytle, RN</p> <p>Census bed type: SNF: 25 SNF/NF: 42 Residential: 21 Total: 88</p> <p>Census payor type: Medicare: 26 Medicaid: 33 Other: 29 Total: 88</p>	F000000	<p>September 23, 2014 Hampton Oaks Health Campus 966 North Wilson Road Scottsburg, Indiana 47170 Survey Event ID 000011. The submission of this Plan of Correction does not indicate an admission by Hampton Oaks Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Hampton Oaks Health Campus. This facility recognized it's obligation to provide legally and medially necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health are facilities (for Title 18/19 programs). Attached you will find our Plan of Correction for Hampton Oaks Health Campus for our annual survey conducted on September 23, 2014. We initiated immediate interventions when concerns were identified on this date. We respectfully request paper review for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at (812)752-2694. Sincerely, Brandy Royalty, Executive Director.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000315 SS=D	<p>Sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September 29, 2014 by Randy Fry RN.</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident admitted to the facility with an indwelling Foley catheter was assessed for the necessity of use. This deficient practice affected 1 of 3 residents reviewed for Foley catheters. (Resident #159)</p> <p>Findings include:  On 9/17/14 at 3:00 p.m., Resident #159</p>	F000315	Resident # 159's physician was notified on 9/18/2014 and an order was obtained to discontinue indwelling urinary catheter. Residents assessment was updated to reflect current status on 9/18/2014 by the licensed nurse. All remaining residents with indwelling urinary catheters were reviewed and all have documented medical necessity of use ( see attached list of residents with noted indwelling catheters and audit completed), this	10/23/2014

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	<p>was observed to have an indwelling Foley catheter.</p> <p>On 9/18/14 at 9:50 a.m., RN #1 indicated Resident #159 was admitted to the facility with an indwelling Foley catheter. RN#1 stated she did not know the reason. After reviewing the clinical record, RN#1 stated the doctor would be contacted because the Foley catheter needed to be discontinued.</p> <p>On 9/18/14 at 10:20 a.m., RN#1 indicated the physician ordered the Foley catheter to be discontinued.</p> <p>On 9/18/14 at 11:30 a.m., Resident #159 indicated the Foley catheter was placed during a recent inpatient hospital stay. The resident indicated he was at the facility for rehabilitation services and planned to discharge home to live independently.</p> <p>On 9/18/14 at 11:00 a.m. Resident #159's clinical record was reviewed. He had diagnoses including but not limited to, acute renal failure, high blood pressure, pneumonia, and heart disease.</p> <p>The clinical record lacked documentation of a physician's order for the Foley catheter. There was also no assessment to indicate the reason the resident</p>		<p>was completed by the DHS on 9/18/2014. All licensed nurses were re-educated on policy and procedure for indwelling catheters and their appropriate uses. Education was conducted on 9/18/14 (see attached in-service record) by DHS/ADHS/Staff Educator. Education will be completed by 9/18/14</p> <p>New admission charts will be reviewed by the DHS/ADHS to verify admitting residents with a urinary catheter have a documented medical necessity for use of indwelling catheter if noted on admission. Newly admitted residents charts will be reviewed within 24 hours of admission. DHS/ADHS will audit all residents with indwelling urinary catheters to ensure on going compliance weekly X 1 month, then 2 X per month, then monthly X 3 months. The DHS/ADHS will report findings in QA monthly ongoing and an action plan will be developed for issues not in substantial compliance. These action plans will be ongoing until substantial compliance is achieved. Peer review is conducted every 6 months by home office support and this will serve as an additional monitoring process to insure compliance</p>				

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	<p>continued to have a Foley catheter.</p> <p>The care plan was reviewed. The care plan stated, ..."I am continent of Bladder..."</p> <p>On 9/18/14 at 4:24 p.m., the Director of Health Services (DHS) was interviewed. When asked why there was no physician order, the DHS stated the nurse who performed the admission assessment sent a text message to the physician requesting clarification of the resident's need for a Foley catheter. The DHS stated the physician did not return the message back. When asked what the reasonable expectation for nurses to follow up with the physician was, the DoN indicated the nurse should have tried to contact the physician no later than the next day. The DHS indicated the staff were aware the resident had a Foley catheter but was unable to provide an explanation regarding the lack of assessment for the residents Foley catheter.</p> <p>A copy of the undated policy titled, "Guidelines for the use of Indwelling Catheter" was provided by the Administrator on 9/20/14 at 9:00a.m. The policy stated, "An indwelling catheter is not used unless there is a valid medical justification."</p>						

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F000329 SS=D	<p>3.1-41(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure gradual dose reductions were completed in an effort to reduce and/or discontinue the anti-anxiety, anti-depressant and psychotropic medications for 2 of 5 residents reviewed for unnecessary medications. (Resident #34 and #51).</p>	F000329	Resident # 51's physician was notified on 9/22/2014 of need for further documentation and evaluation of the Celexa 20 mg. daily use for Depression by the DHS ( see attached documentation). Resident # 34's physician was notified in regard to Lexapro 10 mg. PO. Physicians order was received for diagnosis of Anxiety on 9/22/14 (see	10/23/2014

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	<p>Finding includes:</p> <p>1. On 9/22/14 at 10:34 a.m., the clinical record for Resident #51 was reviewed. Resident #51 had diagnoses including but not limited to, Diabetes, Coronary Artery Disease (CAD), and high blood pressure. There was no diagnosis of depression.</p> <p>Review of the September 2014 Monthly Physician Orders indicated the resident was prescribed Celexa [an anti-depressant medication] 20 milligrams every day for depression ordered on 1/21/13.</p> <p>The pharmacy recommendations for February 2014 requested the medication therapy to be evaluated. The response indicated Gradual Dose Reductions [GDRs] contraindicated due to mood dysregulation [sic].</p> <p>The record lacked documentation of any other evaluation of the medication or attempts at a GDR.</p> <p>The care plan included..., "I have a diagnosis of depression. I am on a psychotropic medicine related to this. I am at risk for mood changes as well as medicine side effects..."I may at times say rough or curse words to staff. I have a lifetime history of speaking my mind.</p>		<p>attached documentation). The physician has documented additional supporting documentation in the progress notes in regard to ongoing need for the medication without a GDR (see attached documentation). All active residents receiving psychotropic medication were reviewed by the DHS/ADHS/SS to verify that all residents are receiving GDR's as recommended supporting documentation by the physician if a GDR is contraindicated. In addition the residents receiving psychoactive medications have been reviewed to ensure appropriate diagnosis are active in the medical record to support the medication usage. Nursing staff will be re-educated on the policy and procedure for psychotropic medication usage and GDR by the DHS/SS/ADHS. Physician orders will be reviewed in Clinical Care Meetings daily by DHS/ADHS or SS to ensure all psychotropic medication have the appropriate diagnosis to support usage of the medication. During the weekly Clinical at Risk meeting residents medications will be reviewed to verify gradual dose reductions are being attempted according to regulation, unless contraindicated, in which case supporting documentation will be reflected in the resident's medical record by the physician. Education will be completed by 10/17/2014.</p>				

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	<p>This is who I am."</p> <p>Review of the, "Behavior Detail Report" between March 2014 and September 2014 indicated the resident had four episodes of verbally abusive behavior.</p> <p>On 9/23/14 at 9:19 a.m., CNA #1 stated, "If she's asleep we don't wake her. She is more agitated if she does not wake up on her own."</p> <p>On 9/23/14 at 1:52 p.m., LPN #4 stated, "The only symptoms of depression I know of are refusal of care and agitation. If she's asleep we don't bother her."</p> <p>On 9/23/14 at 2:26 p.m., the Social Services Director (SSD) indicated the resident has a baseline behavior of being "coarse but the MDS assessment indicated the resident had no mood or behavior issues"</p> <p>On 9/23/14 at 4:33 p.m., Director of Health Services (DHS) indicated the resident "just wants to sleep, is easily aggravated, and rarely leaves the room. [The resident] is more content at this point, more stable, and has no major issues."</p> <p>2. On 9/22/14 at 11:25 a.m., the clinical record for Resident #34 was reviewed. Diagnoses included, but were not limited</p>		<p>Random chart audits will be conducted by the DHS/ADHS or SS to verify ongoing compliance. DHS/ADHS or SS will review 8 random charts weekly X 1 month, then 4 random charts weekly X 1 month, then 2 random charts weekly X 3 months. The DHS/ADHS or SS will report findings in QA monthly and an action plan will be developed for issues not in substantial compliance. These action plans will be ongoing until substantial compliance is achieved. Peer review is conducted every 6 months by home office support and this will serve as an additional monitoring process to insure compliance.</p>	

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	<p>to depression, hypertension and diabetes.</p> <p>On 9/22/14 at 11:35 a.m., review of the Minimum Data Set quarterly assessment, dated 7/25/14, indicated Resident #34 was extensive assist of 2 with bed mobility, transfers and personal hygiene. It also indicated no mood or behaviors.</p> <p>On 9/22/14 at 11:45 a.m., the careplan for Resident #34 was reviewed. It included, but was not limited to the following: "Moods and Behaviors: I have a diagnosis of dementia as well as depression. I may not give an accurate account of history and may exaggerate stories. This (sic) may be in the form of exaggerating a story, feeling like a dream was real, or not hearing all of information correctly, or not being able to see facial expression or body language in relation to a conversation. This may also be related to my hearing and vision loss. I am also on medicines for depression, this places me at risk for med (medication) side effects and mood change. Please assure me, monitor me for changes in my mood and and (sic) side effects the medications may cause. My goals are not to have any increase in mood signs or symptoms, no side effects from my medicines, or to have any new or increased behaviors...."</p>				

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	<p>The clinical record for Resident #34 was reviewed on 9/22/14 at 2:00 p.m. The document titled, Initial Psychosocial Assessment/MDS Supportive Documentation Tool &amp; Progress Note, dated 6/8/14 and 7/25/14, indicated Resident #34 had no behaviors.</p> <p>The document titled, Resident First Conference Notes, Quarterly, dated 7/30/14, indicated Resident #34 had no behaviors exhibited.</p> <p>The document titled, Behavioral Healthcare Management, dated 5/15/14, included, but was not limited to the following: "Current Psychiatric Dx(s) (Diagnosis); Dementia...Anxiety, Depression...Current Psychotropic Medications: Aricept...Lexapro 10 mg for Dep/Anx (Depression/Anxiety)...Narrative: (Resident #34 name) up in w/c (wheelchair), pleasant &amp; (and) smiling. engaging (sic) mood ok...Assessment Plan:...hold on course...."</p> <p>The document titled, Behavioral Healthcare Management, dated 8/7/14, included, but was not limited to the following: "Current Psychiatric Dx(s) (Diagnosis); Dementia...Anxiety, Depression...Current Psychotropic Medications: Lexapro 10 mg qd (every</p>			

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	<p>day) - Dep/Anx (Depression/Anxiety)...Narrative: (Resident #34 name) up in w/c (wheelchair) today, she is pleasant with no c/o (complaints of) Mood has been good...Assessment Plan:...hold on course...."</p> <p>The document titled, Note To Attending Physician/Prescriber, dated 07/07/2014, indicated Resident #34 had been on Lexapro, 10 mg (milligrams) since August, 2013. It also indicated physician/prescriber disagreed to a gradual dose reduction related to long term anxiety and depression.</p> <p>The document titled, Note To Attending Physician/Prescriber, dated 8/05/2013 indicated Resident #34 had been on Lexapro, 10 mg daily since September 2012. It also indicated physician/prescriber disagreed to gradual dose reduction related to anxiety.</p> <p>On 9/22/14 at 4:00 p.m., the Director of Health Services indicated when a resident has a behavior, the CNA's (Certified Nursing Assistant) record it in the kiosk for the nurses to review. She indicated if a resident does have a behavior, a behavior circumstance is initiated with a 3 day follow up. She also indicated she spoke with the Nurse Practitioner</p>						

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	<p>regarding the pharmacy recommendation for Resident #34 and let her know there was not an active diagnosis on the chart for anxiety. She indicated she would have an anxiety careplan put in place.</p> <p>Resident #34's clinical record lacked an active diagnosis for anxiety and any behavior circumstances.</p> <p>On 9/23/14 at 10:00 a.m., the document titled Behavior Detail Report, dated 1/1/14 through 9/22/14 was reviewed. It indicated no behaviors for Resident #34.</p> <p>A copy of the undated policy titled, "Psychotropic Medication Usage and Gradual Dose Reductions" was provided by the nurse consultant on 9/23/14 at 4:20 p.m.. The policy stated..., "1. Resident shall receive psychotropic medication only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the resident's record and in the care planning process. 4. A GDR will be attempted for two separate quarters per the physician's recommendation. The Gradual dose reduction must be attempted annually thereafter, unless medically contraindicated."</p>			

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F000364 SS=E	<p>3.1-48(a)(3) 3.1-48(a)(4)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, record review, and interview the facility failed to ensure resident's food prepared in the kitchen were being served at the proper temperature. This deficient practice had the potential to effect 55 of 56 residents served meals from the kitchen.</p> <p>Findings include:</p> <p>On 9/23/2014 at 12:20 p.m., a test cup of tomato soup was provided by the Assistant Director of Food Services (ADFS). The soup was tasted, and temperature taken within one minute after the ADFS took the soup directly from the steam table. The temperature of the soup was cool when tasted. There was no steam observed from the soup. The ADFS used the facility thermometer and took the temperature of 114 degrees Fahrenheit, in the test cup of tomato soup.</p>	F000364	<p>DFS immediately checked floor carts to ensure soups were at right temperature. Findings included that 1 resident had requested soup for the lunch meal of all floor trays (tomato soup). Tomato soup was tempted at 128° degrees, Tuna Casserole 140°, Beets 140° by DFS which was within Hot/Cold guidelines for lunch meal. Dietary staff were educated immediately on Hot/Cold Temperature Holding Guidelines (see attached policy and in-service sign in sheet). Dietary staff currently log food temps for all meals daily, however soup was not an item listed to be logged. On 9/23/14 soup was added to the Food Temperature Log (see attached) and all dietary staff educated on changes made by DFS/ED (see attached in-service indicating sign in sheet for in-service). All dietary staff will be re-education on logging of food temperatures and ensure</p>	10/23/2014

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	<p>On 9/23/2014 at 12:21 p.m., the AFDS confirmed the test cup of tomato soup was taken directly from the steam table, that was on, before being tested. The AFDS indicated the residents have been served the same soup and at the same temperature. The AFDS indicated that the soup should have been warmer when served to the residents. The AFDS indicated the temperature of the soup would preferably be around 160 degrees Fahrenheit when served to the residents.</p> <p>Residents were observed in the dining room eating at this time.</p> <p>On 9/23/2014 at 1:35 p.m., during an interview, the AFDS indicated the reason for the low temperature of the tested tomato soup was the water in the steam table was not filled adequately enough to keep the temperature of the foods at a high enough temperature. The AFDS indicated the hot foods should be kept over 135 degrees Fahrenheit. The AFDS was unsure of how high the water level should be in the steam tables to ensure they worked properly, but knew the water level was too low earlier to heat the food to a correct temperature.</p> <p>On 9/23/2014 at 1:40 p.m., the Director of Food Services (DFS), provided a</p>		<p>understanding of guidelines for Hot/Cold temperature holding. Education will be completed by 10/17/14.</p> <p>DFS/ADFS will check food temps daily for each meal to ensure temperatures are at appropriate temperature per Hot/Cold Temperature Holding and log on designated temperature log. ED will monitor the temperatures in morning meeting. Interviews will be conducted in regard to food temperatures with 10 randomly selected residents, weekly X 8 weeks, then monthly X 3 months by the Director of Food Services to ensure that food temperatures are acceptable to residents. Review of food temperatures including soup temperatures, will be added to the topics of discussion for Resident Council Meetings to insure ongoing that food/soup is being served within an acceptable temp for the residents. DFS/ADFS will report findings to QA monthly ongoing and an action plan will be developed for issues not in substantial compliance. These action plans will be ongoing until substantial compliance is achieved. Peer review is conducted every 6 months by home office support and this will serve as an additional monitoring process to insure compliance.</p>	

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NAME OF PROVIDER OR SUPPLIER  HAMPTON OAKS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 966 N WILSON RD SCOTTSBURG, IN 47170		
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	<p>document indicating that on 9/23/2014 at 12:40 p.m., a temperature of 128 degrees Fahrenheit was taken on a floor tray on the 100 hall of the tomato soup. The DFS provided the document titled, "Hot &amp; Cold Temperature Holding Guideline", which indicated, hot foods should arrive approximately at greater than or equal to 120 degrees Fahrenheit when the resident is served.</p> <p>On 9/23/2014 at 1:40 p.m., during an interview with the Director of Food Services (DFS), the DFS indicated the reason for the low temperature for the tested cup of tomato soup was the steam table did not have a sufficient amount of water to produce the correct amount of heat to ensure proper food temperature. The DFS indicated that the water boiled itself out and would not be able to produce enough steam to adequately ensure proper food temperature. The DFS indicated the steam table is on all day and can run out of water. The DFS indicated the cooks for each shift have the responsibility to keep adequate water in the steam tables. The DFS was unsure of how high the water level should be in the steam tables to ensure they heat the food properly.</p> <p>The DFS indicated a second cup of tomato soup was tested by the facility on</p>				

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F000371 SS=E	<p>9/23/2014 at 12:40 p.m. The second cup was tested from a resident tray served on the 100 hall and was microwaved before being sent . The DFS indicated the soup was microwaved after the AFDS tested the temperature of the first cup of soup at 12:20 p.m. The DFS indicated the soup was now being microwaved and not just taken straight from the steam table, due to the low temperature of the soup that was taken by the AFDS. The DFS indicated the soup needed to be served at a higher temperature.</p> <p>3.1-21(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, facility staff failed to use proper handwashing before entering the kitchen. This deficient practice had the potential to affect 55 of 56 residents receiving meals from the kitchen.</p> <p>Findings include:  On 9/19/14, during the lunch meal</p>	F000371	<p>All staff will be re-educated that when entering the kitchen hand hygiene needs to be performed. Education will be conducted by Staff Educator/DFS and ED. Education will be completed by 10/17/14.</p> <p>DFS/ED/Staff Educator will do random checks to ensure proper hand hygiene is occurring 8 X weekly</p>	10/23/2014

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	<p>service, the following was observed in the kitchen:</p> <p>At 12:03 p.m., the Meal Manager #1 (MM) entered the kitchen to retrieve a drink. She did not wash her hands.</p> <p>At 12:05 p.m., during an interview with the Dietary Manager, she indicated the kitchen door is locked to keep non-dietary staff from entering the kitchen.</p> <p>At 12:10 p.m., the Director of Health Services (DHS) entered the kitchen, retrieved a grilled cheese and then left the kitchen. She did not wash her hands.</p> <p>At 12:15 p.m., the DHS entered the kitchen, retrieved several items from the reach-in refrigerator and left. She did not wash her hands.</p> <p>At 12:18 p.m., the DHS entered the kitchen, retrieved 3 items from the reach-in refrigerator and left. She did not wash her hands.</p> <p>At 12:20 p.m., CNA #4 entered the kitchen to retrieve resident trays. She did not wash her hands.</p> <p>At 12:25 p.m., CNA #4 entered the kitchen to retrieve a drink. She did not</p>		<p>X 1 month, then 8 X per month X 3 months. To minimize staff entering the litchen area, the meal manager and one Restorative Staff Member, has been designated to enter the kitchn when entrance is needed. The DFS will report findings in QA monthly ongoing and an action plan will be developed for issues not in substantial compliance. These action plans will be ongoing until substantial compliance is achieved. During Peer Review the dietary support will monitor compliance of hand hygiene in the kitchen and ensure minimal staff are entering kitchen. Peer review is conducted every 6 months by home office support and this will serve as an additional monitoring process to insure compliance.</p>	

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F000431 SS=D	<p>wash her hands.</p> <p>At 12:27 p.m., CNA #4 entered kitchen, retrieved a container filled with a dark liquid from the reach-in refrigerator and exited kitchen. She re-entered kitchen and placed the container back in the reach-in refrigerator. She did not wash her hands.</p> <p>At 12:28 p.m., MM #1 entered the kitchen, requested strawberry ice cream and exited the kitchen. She did not wash her hands.</p> <p>At 12:31 p.m., CNA #4 entered the kitchen, walked over to the reach-in refrigerator by the main dining room, opened the door and then closed it. She walked to the other side of the kitchen to the reach-in refrigerator by the Assisted Living dining room. She retrieved several small butter packets and exited the kitchen. She did not wash her hands.</p> <p>On 9/22/14 at 10:30 a.m., CNA #4 indicated you should wash your hands after serving trays and before entering and leaving the kitchen.</p> <p>3.1-21(i)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS</p>						

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	<p><b>&amp; BIOLOGICALS</b></p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review the facility failed to ensure medication carts were free of unnecessary items. This deficient practice affected 2 of 4 medication carts observed out of 5 carts in the facility.</p>	F000431	On 9/23/14 a \$25.00 dollar pouch was removed from the medication cart by the licensed nurse immediately and placed in a secured lock box in the medication room. The \$5.00 dollars and gait belt found	10/23/2014

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	<p>Finding include:</p> <p>1. On 9/23/14 at 10:15 a.m., the medication cart on the 300 hall was observed. In the narcotic drawer, a pouch with \$25.00 cash was observed.</p> <p>In an interview, LPN #2 stated the pouch contained money for the residents who had personal funds accounts with the facility. LPN #2 indicated this allows the residents to access their money when the business office is closed. LPN #2 indicated the 300 hall medication cart was the only cart that had money stored.</p> <p>2. On 9/23/14 at 10:30 a.m., the medication cart on the 200 hall was observed. In the narcotic drawer, a gait belt, and \$5.00 cash was observed.</p> <p>In an interview, LPN #3 indicated she does not normally work on this unit and was not aware of whom the items belonged to. LPN#3 removed the items from the cart.</p> <p>On 9/23/14 at 4:30 p.m., the Director of Health Services (DHS) was interviewed. She stated she was aware of the money being stored in the carts to allow residents access to their money after business hours. She indicated she would</p>		<p>in the 200 hall medication cart was removed by the licensed nurse immediately on 9/23/14. The \$5.00 dollars found in the 200 hall medication cart was returned to the resident on 9/23/14. All licensed nurses will be educated on the facility policy of "Medication Storage in the Facility" and ensure adequate understanding of keeping carts free from clutter ( see attached interview record). All 5 medication carts were inspected to ensure no other clutter was identified on 9/23/2014 with no other findings identified. Education will be completed by 10/17/2014.</p> <p>The DHS/ADHA/Staff Educator will do a cart audit 8 X per month X 3 months. DHS/ADHS/Staff Educator will report findings to QA monthly ongoing and an action plan will be developed for issues not in substantial compliance. These action plans will be ongoing until substantial compliance is achieved. Peer review is conducted every 6 months by home office support and this will serve as an additional monitoring process to insure compliance.</p>	

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F000492 SS=B	<p>work with the business office manager to determine a more appropriate location to store the money.</p> <p>A copy of the undated policy titled, "Medication Storage in the Facility" and undated was provided by the nurse consultant on 9/23/14 at 2:50 p.m. The policy stated,...Medication storage areas are kept, clean, well-lit, and free of clutter and extreme temperature..."</p> <p>3.1-25(m)</p> <p>483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.</p> <p>Based on record review and interview, the facility failed to ensure the Notice of Medicare Non-Coverage letter was received by 1 of 3 sampled residents within the 2 days after the effective date. (Resident # 83)</p> <p>Findings include:</p> <p>On 09/19/14 at 9:45 a.m., the Notice of Medicare Non-Coverage letters were</p>	F000492	<p>It was documented that resident # 83 did received a verbal notice on 4/15/14 however resident chose not to sign, documentation not provided of residents refusal nor was their a witness. Letter was mailed on 4/15/14 however not sent via certified mail so again no proof except of BOM signature of actions. BOM in serviced by ED on 9/19/2014 of regulations due to Notification of Medicare Noncoverage regulation ( see attached in-service).</p>	10/17/2014

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R000272	<p>provided by the Business Office Manager.</p> <p>On 09/19/14 at 12:15 p.m., Resident # 83's Notification of Medicare Noncoverage indicated his services would end on 04/18/14 and it was documented the resident's family was notified by phone on 04/15/14. It was also documented a notice was mailed on the same date. No documentation of witness to the phone call or the receipt of the letter through certified mail was provided.</p> <p>On 09/19/14 at 10:25 a.m., the Business Office Manager indicated the notice was not returned with a signature and no other attempts were made to obtain a signature. The Business Office Manager also indicated "I didn't know I was supposed to" (make another attempt to obtain a signature).</p> <p>3.1-13 (a)(1)</p> <p>410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature. Based on observation, record review, and interview the facility failed to ensure resident's food prepared in the kitchen was being served at the proper</p>	R000272	<p>Education was completed on 9/19/2014. BOM/ED will send Notification of Medicare Noncoverage letter via certified mail if unable to obtain actual signature from resident or family member. BOM will do a random audit of all Medicare residents who's benefits stopped prior to completion of 100 Medicare days. BOM will randomly audit 3 residents files per month X 3 months and report findings to QA monthly X 3 months and further recommendations if indicated based upon findings.</p> <p>DFS immediately checked floor carts to ensure soups were at right temperature. Findings included that 1 resident had requested soup for the lunch</p>	10/23/2014			

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	<p>temperature. This deficient practice had the potential to effect 55 of 56 residents served meals from the kitchen.</p> <p>Findings include:</p> <p>On 9/23/2014 at 11:10 a.m., during an anonymous resident interview, the resident indicated the soup was not served at the correct temperature; the soup was not hot at times.</p> <p>On 9/23/2014 at 12:20 p.m., a test cup of tomato soup was provided by the Assistant Director of Food Services (ADFS). The soup was tasted, and temperature taken within one minute after the ADFS took the soup directly from the steam table. The temperature of the soup was cool when tasted. There was no steam observed from the soup. The ADFS used the facility thermometer and took the temperature of 114 degrees Fahrenheit, in the test cup of tomato soup.</p> <p>On 9/23/2014 at 12:21 p.m., the AFDS confirmed the test cup of tomato soup was taken directly from the steam table, that was on, before being tested. The AFDS indicated the residents have been served the same soup and at the same temperature. The AFDS indicated that the soup should have been warmer when</p>		<p>meal of all floor trays (tomato soup). Tomato soup was tempted at 128° degrees, Tuna Casserole 140°, Beets 140° by DFS which was within Hot/Cold guidelines for lunch meal. Dietary staff were educated immediately on Hot/Cold Temperature Holding Guidelines (see attached policy and in-service sign in sheet). Dietary staff currently log food temps for all meals daily, however soup was not an item listed to be logged. On 9/23/14 soup was added to the Food Temperature Log (see attached) and all dietary staff educated on changes made by DFS/ED (see attached in-service indicating sign in sheet for in-service). All dietary staff will be re-education on logging of food temperatures and ensure understanding of guidelines for Hot/Cold temperature holding. Education will be completed by 10/17/14. DFS/ADFS will check food temps daily for each meal to ensure temperatures are at appropriate temperature per Hot/Cold Temperature Holding and log on designated temperature log. ED will monitor the temperatures in morning meeting. Interviews will be conducted in regard to food temperatures with 10 randomly selected residents, weekly X 8 weeks, then monthly X 3 months by the Director of Food Services to ensure that food temperatures are acceptable to residents. Review of food temperatures</p>				

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	<p>served to the residents. The AFDS indicated the temperature of the soup would preferably be around 160 degrees Fahrenheit when served to the residents.</p> <p>Residents were observed in the dining room eating at this time.</p> <p>On 9/23/2014 at 1:35 p.m., during an interview, the AFDS indicated the reason for the low temperature of the tested tomato soup was the water in the steam table was not filled adequately enough to keep the temperature of the foods at a high enough temperature. The AFDS indicated the hot foods should be kept over 135 degrees Fahrenheit. The AFDS was unsure of how high the water level should be in the steam tables to ensure they worked properly, but knew the water level was too low earlier to heat the food to a correct temperature.</p> <p>On 9/23/2014 at 1:40 p.m., the Director of Food Services (DFS), provided a document indicating that on 9/23/2014 at 12:40 p.m., a temperature of 128 degrees Fahrenheit was taken on a floor tray on the 100 hall of the tomato soup. The DFS provided the document titled, "Hot &amp; Cold Temperature Holding Guideline", which indicated, hot foods should arrive approximately at greater than or equal to 120 degrees Fahrenheit when the resident</p>		<p>including soup temperatures , will be added to the topics of discussion for Resident Council Meetings to insure ongoing that food/soup is being served within an acceptable temp for the residents. DFS/ADFS will report findings to QA monthly ongoing and an action plan will be developed for issues not in substantial compliance. These action plans will be ongoing until substantial compliance is achieved. Peer review is conducted every 6 months by home office support and this will serve as an additional monitoring process to insure compliance.</p>	

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	<p>is served.</p> <p>On 9/23/2014 at 1:40 p.m., during an interview with the Director of Food Services (DFS), the DFS indicated the reason for the low temperature for the tested cup of tomato soup was the steam table did not have a sufficient amount of water to produce the correct amount of heat to ensure proper food temperature. The DFS indicated that the water boiled itself out and would not be able to produce enough steam to adequately ensure proper food temperature. The DFS indicated the steam table is on all day and can run out of water. The DFS indicated the cooks for each shift have the responsibility to keep adequate water in the steam tables. The DFS was unsure of how high the water level should be in the steam tables to ensure they heat the food properly.</p> <p>The DFS indicated a second cup of tomato soup was tested by the facility on 9/23/2014 at 12:40 p.m. The second cup was tested from resident tray served on the 100 hall and was microwaved before being sent . The DFS indicated the soup was microwaved after the AFDS tested the temperature of the first cup of soup at 12:20 p.m. The DFS indicated the soup</p>						

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R000273	<p>was now being microwaved and not just taken straight from the steam table, due to the low temperature of the soup that was taken by the AFDS. The DFS indicated the soup needed to be served at a higher temperature.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, interview and record review, facility staff failed to use proper handwashing before entering the kitchen. This deficient practice had the potential to affect 55 of 56 residents receiving meals from the kitchen.</p> <p>Findings include:</p> <p>On 9/19/14, during the lunch meal service, the following was observed in the kitchen:</p> <p>At 12:03 p.m., the Meal Manager #1 (MM) entered the kitchen to retrieve a drink. She did not wash her hands.</p> <p>At 12:05 p.m., during an interview with the Dietary Manager, she indicated the kitchen door is locked to keep non-dietary staff from entering the</p>	R000273	<p>All staff will be re-educated that when entering the kitchen hand hygiene needs to be performed. Education will be conducted by Staff Educator/DFS and ED. Education will be completed by 10/17/14. DFS/ED/Staff Educator will do random checks to ensure proper hand hygiene is occurring 8 X weekly X 1 month, then 8 X per month X 3 months. To minimize staff entering the kitchen area, the meal manager and one Restorative Staff Member, has been designated to enter the kitchn when entrance is needed. The DFS will report findings in QA monthly ongoing and an action plan will be developed for issues not in substantial compliance. These action plans will be ongoing until substantial compliance is achieved. Peer review is conducted every 6 months by home office support and</p>	10/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155753	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2014
NAME OF PROVIDER OR SUPPLIER  HAMPTON OAKS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 966 N WILSON RD SCOTTSBURG, IN 47170		
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	<p>kitchen.</p> <p>At 12:10 p.m., the Director of Health Services (DHS) entered the kitchen, retrieved a grilled cheese and then left the kitchen. She did not wash her hands.</p> <p>At 12:15 p.m., the DHS entered the kitchen, retrieved several items from the reach-in refrigerator and left. She did not wash her hands.</p> <p>At 12:18 p.m., the DHS entered the kitchen, retrieved 3 items from the reach-in refrigerator and left. She did not wash her hands.</p> <p>At 12:20 p.m., CNA #4 entered the kitchen to retrieve resident trays. She did not wash her hands.</p> <p>At 12:25 p.m., CNA #4 entered the kitchen to retrieve a drink. She did not wash her hands.</p> <p>At 12:27 p.m., CNA #4 entered kitchen, retrieved a container filled with a dark liquid from the reach-in refrigerator and exited kitchen. She re-entered kitchen and placed the container back in the reach-in refrigerator. She did not wash her hands.</p> <p>At 12:28 p.m., MM #1 entered the</p>		<p>this will serve as an additional monitoring process to insure compliance.</p>		

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	<p>kitchen, requested strawberry ice cream and exited the kitchen. She did not wash her hands.</p> <p>At 12:31 p.m., CNA #4 entered the kitchen, walked over to the reach-in refrigerator by the main dining room, opened the door and then closed it. She walked to the other side of the kitchen to the reach-in refrigerator by the Assisted Living dining room. She retrieved several small butter packets and exited the kitchen. She did not wash her hands.</p> <p>On 9/22/14 at 10:30 a.m., CNA #4 indicated you wash your hands after serving trays and before entering and leaving the kitchen.</p>				