

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155714	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  OAK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: January 4, 5, 6, 7, and 8, 2016</p> <p>Facility number: 000517 Provider number: 155714 Aim number: 100266770</p> <p>Census Bed Type: SNF/NF: 22 Total: 22</p> <p>Census Payor Type: Medicare: 4 Medicaid: 10 Other: 8 Total: 22</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on January 13, 2015.</p>	F 0000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective January 26, 2016 to the annual licensure survey completed on January 8, 2016. The facility also respectfully request that this survey be considered for paper review.</p>	
F 0156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES,			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155714	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  OAK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	<p><b>CHARGES</b></p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155714	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OAK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155714		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  01/08/2016	
NAME OF PROVIDER OR SUPPLIER  OAK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Based on observation, interview, and record review, the facility failed to ensure resident choices were followed in regards to code status for 1 of 20 residents reviewed in stage 1. (Resident #32)</p> <p>Findings include:</p> <p>On 1/6/16 at 9:44 A.M., Resident #32 was observed ambulating in the hallway, with Physical Therapy staff. Resident #32 was observed to be in no apparent distress.</p> <p>The clinical record, for Resident #32 was reviewed on 1/4/16 at 1:56 P.M., diagnoses included, but were not limited to, hypertension, depression and a history of colon cancer.</p> <p>The signed physicians orders dated 12/1/15, 11/1/15 and 10/21/15 were reviewed and included, but were not limited to "...ADVANCE DIRECTIVES...FULL [full code]..."</p> <p>An "STATE OF INDIANA OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER" form dated 10/22/15 was signed by Resident #32. The documentation lacked the physician's signature.</p> <p>During an interview with the Director of</p>	F 0156	<p><b>F156</b></p> <p><b>It is the practice of this facility to assure that resident's advanced directives are honored as part of their right to choice.</b></p> <p><b>The correction action taken for those residents found to be affected by the deficient practice include:</b></p> <p>Resident #32 physician was contacted and the code status order was changed to reflect the resident's advanced directive</p> <p><b>Other residents that have the potential to be affected have been identified by:</b></p> <p>All residents' code status has been reviewed to assure that their advanced directives were honored and reflected in the physicians' order. No additional issues were identified.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>An in-service will be conducted with nurses related to assuring that residents' advanced directives are honored when obtaining the code status order. Please see systems below for monitoring.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 residents to assure that the advanced directive related</p>	01/26/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155714		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  01/08/2016	
NAME OF PROVIDER OR SUPPLIER  OAK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Nursing (DON) on 1/5/16 at 10:00 A.M., she indicated, when residents were admitted they were educated about advance directives and each resident had the right to choose the code status of their choice. She further indicated an advance directive form, indicating the choice, as well as an State DNR (Do Not Resuscitate) form would be signed by the Resident or representative and the physician. The DON indicated Resident #32 was admitted in October and had chosen to be a DNR. She further indicated a DNR consent order form was signed by the resident and not by the physician. The DON further indicated the order would need to be clarified, and the physician would need to sign the new order.</p> <p>An undated policy titled "CODE STATUS POLICY" was provided by the DON on 1/8/16 at 10:17 A.M., it included, but was not limited to, "...It is the policy of this facility to assure all residents have an order for code status at the time of admission...The decision will be identified on the facility form related to choice and a signature requested by the determining party...If a resident chooses to be a DNR, the physician will be notified and orders obtained..."</p> <p>An undated policy titled "RESIDENT</p>		<p>to code status is honored and the physician's order is written accordingly. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with additional recommendations as needed based on the outcome of the tools.</p> <p><b>The date the systemic changes will be completed:</b> January 26, 2016</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155714	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OAK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0241 SS=E Bldg. 00	<p>RIGHTS" was provided by the Administrator on 1/8/16 at 10:30 A.M., it included, but was not limited to, "...You have the right and freedom to exercise your rights as a resident of this facility and as a citizen or resident of the United States without fear of ...interference...You have the right to formulate an advance directive in accordance with facility policy..."</p> <p>On 1/8/16 at 10:40 A.M., the DON indicated the order had been clarified and Resident #32 and the physician had been notified of the error.</p> <p>3.1-4 (b)(5)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to ensure services were provided to maintain the dignity of residents during dining for 1 of 2 dining observations . (Resident #8, Resident #10, Resident #13, Resident #18).</p>	F 0241	<b>F241 It is the practice of this facility to assure that residents' dignity is maintained both during the provision of care and dining services. The correction action taken for those residents found to be affected by the deficient practice include: Residents #8, #10, #13, and #18 are receiving dining</b>	01/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155714	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  OAK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Findings include:</p> <p>During a dining observation in the facility restorative dining room on 1/4/16 from 11:57 A.M., to 12:35 P.M. the following was observed:</p> <p>At 11:57 A.M., two of the four residents seated at a table were served and staff began to assist them with the meal. At that time Resident #8 and Resident #13 were observed to not be served.</p> <p>At 12:02 P.M., the RN #4 was observed to serve and assist Resident #18 and Resident #10, while standing over them.</p> <p>At 12:23 P.M., RN #4, was observed to serve trays to Resident #8 and Resident #13. RN #4 was then observed to assist Resident #8 and Resident #13 to eat while standing over them.</p> <p>A policy titled "Meal Service" and dated 10/5/15 was provided by the Director of Nursing on 1/8/16 at 10:17 A.M. It included, but was not limited to, "All residents seated at a table will be served before serving the next table....Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity...Not standing over residents while assisting them with meals...".</p> <p>During an interview with the</p>		<p>servicesin a manner that assures that their dignity is maintained. <b>Other residents that have the potential to be affected havebeen identified by:</b> Potentially all residents could be affected. All residents are receiving dining servicesin a manner that assures that their dignity is maintained. <b>The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur include:</b> The nursing staff has been in-serviced related to assuringthat dining services are completed in a manner that enhances the residentdignity. The in-service includedassuring that all residents at one table are served prior to starting another table and assuring that staff is seated while assisting a resident to eat. <b>The corrective action taken to monitor performance to assurecompliance through quality assurance is:</b> A Performance Improvement Tool has been initiated thatrandomly reviews 5 meal services to assure that residents' dignity is beingmaintained during the dining process. The Director of Nursing, or designee, willcomplete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediatelycorrected. The Quality AssuranceCommittee will review the tools at the scheduled</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155714	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  OAK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0465 SS=D Bldg. 00	<p>Administrator on 1/8/16 at 10:23 A.M., she indicated it was the policy of the facility to ensure all residents maintained dignity during their dining experience.</p> <p>3.1-3(t)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure housekeeping services were provided to residents whose room's carpeting had a strong, pervasive odor of urine during 4 of 5 survey days for 1 of 19 resident rooms observed. (Resident #16, Resident #6) (Resident room #121)</p> <p>Findings include:</p> <p>1. During an observation on 1/4/16 at 9:40 A.M., the carpeted area of resident room #121 had a strong urine odor. Resident #6 and Resident #16 resided in room #121. Stains were observed throughout carpeted areas.</p> <p>During an observation on 1/5/16 at 10:29</p>	F 0465	<p>meetings with recommendations as needed based on the outcome of the tools. <b><i>The date the systemic changes will be completed:</i></b> January 26, 2016</p> <p><b>F465 It is the practice of this facility to assure that residents are provided a clean and odor free environment. The facility has been in the process of replacing floor throughout the facility. The correction action taken for those residents found to be affected by the deficient practice include:</b> Room #121 has had the carpeting replaced with hardwood flooring. This affected residents #16 and #6. <b><i>Other residents that have the potential to be affected have been identified by:</i></b> All resident rooms have been reviewed to assure that additional carpeting was not affected. No other areas were identified. <b><i>The measures or systematic changes that have been put into place to ensure that the</i></b></p>	01/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155714	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  01/08/2016
NAME OF PROVIDER OR SUPPLIER  OAK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>A.M. and at 2:15 P.M., the carpeted area of resident room #121 had a strong urine odor. Stains were observed throughout carpeted areas.</p> <p>During an observation on 1/6/16 at 10:53 A.M. and at 2:00 P.M., the carpeted area of resident room # 121 had a strong urine odor. Stains were observed throughout carpeted areas.</p> <p>During an observation on 1/7/16 at 9:19 A.M., the carpeted area of resident room # 121 had a strong urine odor. Stains were observed throughout carpeted areas.</p> <p>2. During an interview on 1/7/16 at 10:23 A.M., Housekeeper (HK) #1 indicated that housekeeping cleaned the carpet almost every day in resident room #121 because of the urine odor. HK #1 indicated that, while the shampooing helped minimize the urine odor, the odor always returned. HK#1 further indicated that she saw some brown spots on the carpet near Resident #16's bed and that she needed to clean the carpet again.</p> <p>3. During an interview on 1/7/16 at 11:35 A.M., CNA #5 indicated she had noticed the urine odor in resident room #121 and thought the odor was caused because Resident #6 sometimes spilled his urinal on the carpet and Resident #16</p>		<p><b>deficient practice does not recur include:</b> The Housekeeping Department will be in-serviced related to assuring that the rooms are odor free. The in-service included communication with the administrator if the routineservices or daily cleaning of the areas are not controlling the odors. If that is the case additional interventionswill be implemented to address the issue. <b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated thatrandomly reviews 5 resident rooms/areas to assure that they are clean and odorfree. The Administrator, or designee,will complete these tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediatelyaddressed. The Quality AssuranceCommittee will review the tools at the scheduled meetings with recommendations fornew interventions as needed based on the outcomes of the tools. <b>The date the systemic changes will be completed:</b> January 26, 2016</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155714	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OAK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0495 SS=D	<p>sometimes dribbled urine on the carpet.</p> <p>4. During an interview on 1/8/16 at 9:33 A.M., the Director of Nursing (DON) indicated she had noticed a urine odor in resident room #121. The DON indicated Resident #6 spilled his urinal on the carpet and Resident #16 would dribble on the carpet on his way to the bathroom. The DON further indicated that housekeeping attempted to minimize urine odor in the carpet by cleaning daily.</p> <p>The "PROBLEM AREAS" policy dated 8/05 was provided by the DON on 1/8/16 at 11:14 A.M., and it read as follows: "...WHEN A RESIDENT HAS A PROBLEM WITH URINATING ON CARPET, BED ECT...HOUSEKEEPING IS TO DEEP CLEAN THE AREA AND CONTINUE DAILY ON A PREVENTIVE ROUTINE OF SHAMPOOING OR CLEANING THE AREA UNTIL THE PROBLEM IS TAKEN CARE OF AND THERE ARE NO MORE OFFENSIVE ODORS."</p> <p>3.1-19(f)</p> <p>483.75(e)(4) NURSE AIDE WORK &lt; 4 MO -</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155714		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/08/2016	
NAME OF PROVIDER OR SUPPLIER  OAK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
Bldg. 00	<p><b>TRAINING/COMPETENCY</b> A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual is a full-time employee in a State-approved training and competency evaluation program; has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or has been deemed or determined competent as provided in §§483.150(a) and (b). Based on interview and record review, the facility failed to ensure an employee (who had provided patient care for residents) completed the required competency evaluation and was certified as a Certified Nursing Assistant before she had completed her 4th month of employment for 1 of 4 CNA's reviewed for current certification. (CNA #3)</p> <p>Findings include:</p> <p>On 1/8/16 at 10:56 A.M., employee files for the facility were reviewed. Documentation for CNA #3's certification was lacking.</p> <p>During an interview on 1/8/16 at 11:00 A.M., the Director of Nursing (DON) indicated CNA #3 was not a Certified Nursing Assistant because she had not yet taken her test. The DON indicated CNA #3 had been hired on 4/28/15 and</p>	F 0495	<p><b>F495 It is the practice of this facility to assure that employees are either licensed/certified or are scheduled for proper testing in the timeframe required by regulation. The correction action taken for those residents found to be affected by the deficient practice include:</b> No specific residents were identified. CNA #3 was removed from the schedule. <b>Other residents that have the potential to be affected have been identified by:</b> All other nursing employees were reviewed to assure proper licensure/certification. No additional issues were identified. <b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b> The Director of Nursing and HR will work together to assure that all NAs are scheduled for their testing within the timeframe required by law. It</p>	01/26/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155714	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  01/08/2016
NAME OF PROVIDER OR SUPPLIER  OAK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	had provided patient care for residents until 1/4/16. The DON further indicated she was not aware CNA #3 had 120 days from the date of employment to obtain a CNA certification.  3.1-14(b)(2)		will be reiterated that the testing must be completed within 4 months of the employment date as required. Failure to become certified timely will result in removal from the schedule or a change in work duties. <b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> A Performance Improvement Tool has been initiated that will review all new hires that are NA to assure that the proper testing has occurred in a timely manner and that the NA becomes certified appropriately. The Administrator, or designee, will complete this tool for any NA to assure the process of testing occurs appropriately. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools. <b>The date the systemic changes will be completed:</b> January 26, 2016		