| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED |
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| | 155667 | | 07/14/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| OAK GROVE CHRISTIAN RETIREMENT VILLAGE | 221 W DIVISION ST<br>DEMOTTE, IN 46310 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.<br><br>Survey dates: July 7, 8, 9, 10, 13, & 14, 2015<br><br>Facility number: 010823<br>Provider number: 155667<br>AIM number: 200236630<br><br>Census bed type:<br>SNF: 19<br>SNF/NF: 35<br>Residential: 32<br>Total: 86<br><br>Census payor type:<br>Medicare: 14<br>Medicaid: 26<br>Other: 14<br>Total: 54<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1 | F 0000 | This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is no tan admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by stateand federal law. Oak Grove Christian Retirement Village desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on August 13, 2015. The facility respectfully requests paper compliance. Please accept the attached as our credible allegation of compliance. | |

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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| F 0242<br>SS=D<br>Bldg. 00 | 483.15(b)<br>SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.<br>Based on record review and interview, the facility failed to ensure resident individual preferences were followed, related to not giving the resident a choice of the frequency of bathing they would prefer, for 3 of 3 residents reviewed for choices of the 5 who met the criteria for choices. (Residents #88, #89, and #93)<br><br>Findings include:<br><br>1. During an interview on 7/8/15 at 9:02 a.m. Resident #88 indicated she had not been given a choice for the frequency of showers she would like to receive. She indicated the facility had a shower schedule and she was scheduled for twice a week. The resident indicated she would prefer to receive a shower every night as that was what she was used to at home.<br><br>Resident #88's record was reviewed on 7/8/15 at 2:38 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure, hypertension, | F 0242 | It is the policy of this facility to ensure the resident has the right to choose activities, schedules, and health care consistent with his or her interests,assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.<br>**Specific Corrective Actions:** Residents #88, #89, and #93 were immediately given choices regarding what time of day they wanted to bathe; what day(s) of the week they would like to bathe; and what method shower, bath, or bed bath they preferred. **II. Identification and correction of others:** All residents have the potential to be affected by lack of choices regarding frequency of bathing. The CNA Form was updated to include all days of the week and each resident was interviewed and the form filled out regarding their preferences regarding time, frequency and type of bathing. [Attachment: CNA Form] **III. Systemic** | 08/13/2015 |

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| | and hyperlipidemia.<br><br>The Admission MDS (Minimum Data Set) assessment, dated 6/23/15, indicated the resident was cognitively intact and it was very important to her to choose her type of bathing.<br><br>Review of the Oak Leaf Shower Schedule, received from the Director of Nursing (DON) indicated the resident was scheduled for a shower on Sunday and Wednesday during the night shift.<br><br>Review of the "CNA Check Off List for New or Re-Admitted Residents", indicated the resident preferred to shower in the "early a.m." There was lack of documentation to indicate the resident's preference for frequency of bathing had been addressed.<br><br>Interview with CNA #2 and CNA #3 on 7/13/15 at 10:09 a.m. indicated the facility had a shower schedule they followed to know which day and shift a resident was to receive a shower.<br><br>Interview with the DON on 7/9/15 at 11:34 a.m. indicated the CNAs completed a check off list for new residents which indicated what time of day a resident preferred a shower. She | | **Changes:** The Oak Leaf Shower Schedule was updated indicating each residents' preferences. All new admissions will be interviewed and have a CNA Form completed indicating what time, what day(s) and what type of bathing he/she prefers. The nurses and aides will be in-serviced regarding the use of the CNA Form and the new Shower Schedule. [Attachment: InServiceAllStaffHCPOC2015] **IV. Monitoring:** The DON, ADON and/or designee will audit compliance by reviewing the shower schedule and interviewing residents to ensure their preferences are being followed. Each resident will be interviewed within the first week; then 5 random residentswithin the first month and 3 random residents over the next 5 months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance.<br>[Attachment: POCMonitoringbyNursing2015 & QATracking Log] | |

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| | indicated CNAs would tell the resident twice a week was the facility's usual schedule and they may or may not have asked the resident if they would like something different. She further indicated there was no documentation to indicate the resident was specifically asked how often they would like a shower.<br>2. Resident #89 was interviewed on 7/7/15 at 10:55 a.m. She indicated the residents were automatically put on a schedule for showers, hers being on Wednesdays and Saturdays. She further indicated she would like to have a shower three times a week instead.<br><br>Follow up interview with Resident #89 on 7/9/15 at 11:17 a.m. indicated she was never asked her shower frequency preference and would prefer three times weekly instead of her scheduled twice weekly.<br><br>Resident #89's record was reviewed on 7/8/15 at 2:46 p.m. Diagnoses included, but were not limited to, aftercare healing traumatic fracture, closed fracture cervical vertebra, history of falls, and muscle weakness.<br><br>Review of the "CNA Check Off List for | | | |

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| | New or Re-Admitted Residents" indicated she prefers her showers in the evenings. The checklist and resident record lacked documentation indicating a preference for shower frequency.<br><br>The DON (Director of Nursing) was interviewed on 7/9/15 at 11:34 a.m. She indicated CNAs ask what time of day each resident prefers showers. The CNA's tell them twice a week was the usual schedule and they may or may not ask the resident if they want something different. She further indicated there was no documentation to indicate residents were specifically asked how often they would like to shower.<br><br>3. Resident #93 was interviewed on 7/8/15 at 9:52 a.m. She indicated her showers were given two times a week per the unit schedule, but she would prefer every day like she did previously at home.<br><br>Resident #93's record was reviewed on 7/9/15 at 9:24 a.m. Diagnoses included, but were not limited to, rehabilitation, diabetes type 2, hypertension, retention of urine, vertigo, osteoarthritis, difficulty walking, muscle weakness, and lack of coordination.<br><br>Review of the "CNA Check Off List for | | | |

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| | New or Re-Admitted Residents" indicated Resident #93 preferred her showers "Early AM", but lacked documentation to indicate she was asked a preference for shower frequency.<br><br>The DON (Director of Nursing) was interviewed on 7/9/15 at 11:34 a.m. She indicated CNAs ask what time of day each resident prefers showers. The CNA's tell them twice a week was the usual schedule and they may or may not ask the resident if they want something different. She further indicated there was no documentation to indicate residents were specifically asked how often they would like to shower.<br><br>3.1-3(u)(1) | | | |
| F 0279<br>SS=D<br>Bldg. 00 | 483.20(d), 483.20(k)(1)<br>DEVELOP COMPREHENSIVE CARE PLANS<br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. | | | |

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| | The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). | | | |
| | Based on record review and interview, the facility failed to develop a care plan for bladder incontinence for 1 of 2 resident reviewed for urinary incontinence. (Resident # 24)<br><br>Finding includes:<br><br>The record for Resident #24 was reviewed on 7/9/15 8:33 a.m. Diagnoses included, but were not limited to, muscle weakness, difficulty in walking, morbid obesity and diabetes.<br><br>The resident's record lacked a care plan for bladder incontinence.<br><br>The Quarterly MDS (Minimum Data Set) assessment dated 5/30/15 indicated the resident was frequently incontinent of the bladder.<br><br>A bladder assessment was completed on 5/30/15 for bladder incontinence and indicated the resident was frequently incontinent. | F 0279 | It is the policy of this facility to ensure a resident has all required care plans in place including a care plan related to urinary/bladder incontinence. **I. Specific CorrectiveActions:** The Director of Nursing immediately implemented a care plan for Resident #24's bladder incontinence. **II. Identification and correction of others:** All residents have the potential to be affected by a missing care plan related to bladder incontinence or anything else. All residents had chart reviews for proper care plans related to bladder incontinence and any other pertinent issues. **III. Systemic Changes:** All nurses will be re-educated regarding the need for a care plan for any resident that has urinary/bladder incontinence or any other pertinent issue. [Attachment: InServiceAllStaffHCPOC2015] **IV. Monitoring:** The MDS nurse or designee will review at least four random charts per week to ensure all proper care plans are in place. After two months the audits will decrease to monthly for | 08/13/2015 |

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| | Interview with the MDS Coordinator on 7/9/15 at 10:12 a.m.. indicated there was not a current care plan for bladder incontinent and one should have been in place for Resident #24.<br><br>3.1-35(a)<br>3.1-35(b)(1) | | four more months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: POCMonitoringbyNursing2015 & QA TrackingLog] | |
| F 0356<br>SS=C<br>Bldg. 00 | 483.30(e)<br>POSTED NURSE STAFFING INFORMATION<br>The facility must post the following information on a daily basis:<br>o Facility name.<br>o The current date.<br>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>- Registered nurses.<br>- Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>- Certified nurse aides.<br>o Resident census.<br><br>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:<br>o Clear and readable format.<br>o In a prominent place readily accessible to residents and visitors.<br><br>The facility must, upon oral or written request, make nurse staffing data available | | | |

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| | to the public for review at a cost not to exceed the community standard.<br><br>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>Based on observation, record review, and interview, the facility failed to ensure the daily staffing pattern was posted throughout the facility.<br><br>Finding includes:<br><br>On 7/7/15 at 8:49 a.m., 11:23 a.m., and 2:04 p.m., the daily staffing sheets were observed posted at the Oak Leaf Nurses Station and on the wall across from the Oak Branch Nurses Station. The staffing sheets were dated 7/6/15.<br><br>Interview with the Director of Nursing on 7/7/15 at 3:29 p.m., indicated the staffing sheets were dated 7/6/15 and needed to be changed.<br><br>3.1-17(a) | F 0356 | It is the policy of this facility to post the daily staffing pattern throughout the facility. **I. Specific CorrectiveActions:** As soon as the DON realized the staffing sheets were from the previous day she corrected the postings with the current date and information. **II. Identification and correction of others:** All residents have the potential to be affected by incorrect data regarding current date and staffing pattern. All locations where staffing information is posted were checked for correct information. **III. Systemic Changes:** The staffing sheets were monitored and correct the rest of the week. Nursing staff will be re-educated on who is responsible to complete and post the daily staffing sheets. [Attachment: InServiceAllStaffHCPOC2015] **IV. Monitoring:** The DON, ADON and/or designee will check daily that the staffing sheets are correct and posted for one month. The audits will then decrease to weekly for five more months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All | 08/13/2015 |

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| | | | QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: POCMonitoringbyNursing2015 & QA TrackingLog] | |
| F 0364<br>SS=D<br>Bldg. 00 | 483.35(d)(1)-(2)<br>NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP<br>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.<br>Based on observation, record review, and interview, the facility failed to serve food at a warm temperature for 1 of 2 meals observed on 1 of 3 units. (The lunch meal, Oak Leaf Unit) This had the potential to affect 13 residents who received their lunch meal on the Oak Leaf Unit.<br><br>Finding includes:<br><br>In an interview with Resident #88 on 7/8/15 at 9:05 a.m., she indicated she ate all meals in the Oak Leaf Dining Room. The resident further indicated the food was not warm enough when it was served to her.<br><br>On 7/9/15 at 11:52 a.m. the Oak Leaf Unit cart of lunch trays was brought to the unit. At 12:09 p.m. the CNAs started serving the trays from the cart. | F 0364 | It is the policy of this facility to ensure 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. **I. Specific CorrectiveActions:** Resident #88 was followed up with at the next meal to ensure her food was warm enough and at all future meals. **II. Identification and correction of others:** All residents have the potential to be affected by food not being warm enough. The Food Services – Serving Line policy was updated to stress the importance of keeping the food cart door closed between servings to ensure the temperature in the cart remains in the 135 F range so when food is served it is at least 120 F when served. [Attachment: Food Services-Serving Line Policy] **III. Systemic Changes:** Dietary staff | 08/13/2015 |

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| | At 12:19 p.m. all the residents in the Oak Leaf Dining Room had been served. At that time, temperatures were taken of the food on the test tray that had been placed on the cart and delivered with the residents' trays. The rib sandwich was 114 degrees Fahrenheit (F), the polish sausage was 115.5 F, the potatoes were 115.1 F, and the baked beans were 119 F.<br><br>Interview with the Director of Dietary on 7/9/15 at 2:50 p.m. indicated the food temperatures may have been cold due to the cart door being left open while staff was serving the trays.<br><br>A facility policy titled "Food Temperatures-Serving Line", dated 2009, and received as current from the Director of Dietary, indicated, "...1. Hot foods in the steam table are maintained at > (greater than or equal to) 135 F so that items arrive at approx > (greater than or equal to) 120 F when resident is served..."<br><br>3.1-21(a)(2) | | will be educated on the new policy to ensure all residents 'warm food' is served at 120 degrees F or greater. [Attachment: InServiceAllStaffHCPOC2015] **IV. Monitoring:** The Dietary Manager and/or designee will audit compliance by taking the temperature of four random plates per day for one month. The audits will then decrease to weekly for one month then monthly times four months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facilityQAPI Meeting to ensure ongoing compliance. [Attachment: Test Tray Form & QA Tracking Log] | |
| F 0371<br>SS=F<br>Bldg. 00 | 483.35(i)<br>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br>The facility must -<br>(1) Procure food from sources approved or | | | |

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| | considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>Based on observation, record review and interview, the facility failed to ensure food was served and stored under sanitary conditions related to uncovered drinks served during meal service on Oak Branch One Hall, Oak Branch Two Hall and Oak Branch One Dining Room, unlabeled and uncovered food in food storage and improper dishwasher rinse temperature in the kitchen. This had the potential to affect 54 of 54 residents residing in the facility. (Oak Branch One Hall, Oak Branch Two Hall, Oak Branch One Dining Room, Kitchen)<br><br>Findings include:<br><br>1. During an observation of lunch service on 7/7/15 at 12:10 p.m., CNA #5 placed a glass of milk onto a room tray that was taken out of the meal cart located in the Oak Branch One Dining Room. CNA #5 then carried the room tray down the Oak Branch One Hall with the drink uncovered to Room 130, which was at the end of the hall.<br><br>Interview with CNA #5 on 7/7/15 p.m., at 12:13 p.m., indicated she did not usually cover the drinks when she passed room | F 0371 | It is the policy of this facility to procure food from sources approved or considered satisfactory by Federal, State or local authorities and store, prepare, distribute and serve food under sanitary conditions. **I. <u>Specific CorrectiveActions:</u>** The uncovered drinks during meal service were covered. The unlabeled and uncovered food in the food storage area was thrown out. The improper dishwasher rinse temperature in the kitchen was corrected. **II. <u>Identification and correction of others:</u>** All residents have the potential to be affected by uncovered drinks; unlabeled and uncovered food; and improper dish washer rinse temperatures. All drinks will now be covered during transport. There will not be any unlabeled and/or uncovered food in food storage. The water temp booster was replaced with a new unit in the dishwasher to permanently correct the improper dishwasher rinse temperature. **III. <u>Systemic Changes:</u>** All staff will be educated on procedures to cover all transported drinks. Dietary staff will be educated on unlabeled and uncovered food in food storage. [Attachment: InServiceAllStaffHCPOC2015] **IV. <u>Monitoring:</u>** The Dietary Manager and/or designee will | 08/13/2015 |

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| | trays.<br><br>Interview with the Director of Dietary on 7/9/15 at 9:32 a.m., indicated drinks should be covered when they are transported down the hall on the room trays.<br>2. During an observation of lunch service on 7/7/15 at 12:05 p.m. on the Oak Branch Two Hall, CNA #1 removed a tray from the cart and took the tray over to the counter. CNA #1 put a glass of water on the tray and carried the tray with the uncovered glass of water down the hallway to Room 113.<br><br>On 7/7/15 at 12:09 p.m. CNA #1 removed another tray from the cart and took the tray over to the counter. CNA #1 poured coffee from a carafe into a cup and set it on the tray. CNA #1 carried the tray with the uncovered coffee, an uncovered glass of tomato juice and an uncovered glass of water down the hallway to Room 113.<br><br>Interview with CNA #1 on 7/7/15 at 12:13 p.m. indicated she did not usually cover drinks when she delivered trays.<br><br>Interview with the Director of Dietary on 7/9/15 at 9:32 a.m. indicated the drinks should have been covered when delivered to the resident's room. She further | | audit compliance by rounding daily during meal service to ensure drinks are covered for one month. They will also check daily for one month that there is not unlabeled and uncovered food in food storage. Plus the Dish Machine Temperature Log for adequate temps. The audits will then decrease to weekly for one month then monthly times four months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: POCMonitoringbyDietary2015& QA Tracking Log] | |

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| | indicated plastic wrap was available on the unit to cover the drinks and staff should have used it.<br>3. During an observation on 7/9/15 at 11:33 a.m., CNA #4 delivered 3 uncovered drinks in cups, from the snack bar down the hallway to the Oak Branch 2 Dining Room.<br><br>Interview with the CNA #4 on 7/9/15 at 11:34 a.m., indicated the beverages should have been covered with a lid.<br><br>Interview with the Director of Dietary on 7/9/15 at 2:50 p.m., indicated drinks should have been covered when delivered to residents from the snack bar or on a room tray. She further indicated the old policy did not indicate to cover beverages.<br><br>4. During the Initial Kitchen Tour with the Director of Dietary on 7/7/15 from 8:46 a.m. to 9:00 a.m.:<br><br>a. There were two packages of Salisbury steaks in the freezer that were open to air and undated. Also observed in the freezer at that time, a used package of Salisbury steaks undated. During this observation, the Director of Dietary indicated all packages should be closed and dated. | | | |

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| | b. The dishwasher rinse cycle temperature was observed at 177 degrees Fahrenheit.<br><br>On 7/9/15 at 9:18 a.m. the dishwasher rinse cycle was observed at 177 degrees Fahrenheit.<br><br>The "Dish Machine Temperature Log" for July indicated the following rinse temperatures:<br><br>7/1/15 Breakfast 177<br>7/2/15 Dinner 152<br>7/3/15 Lunch 172<br>7/4/15 Breakfast 179<br>7/6/15 Lunch 170<br>7/9/15 Breakfast 179<br><br>Interview with the Directory of Dietary on 7/9/15 at 9:32 a.m., indicated the high temperature dishwasher rinse cycle should have been 180 degrees Fahrenheit.<br><br>The policy titled "Storage Procedures" provided by the Director of Dietary on 7/9/15 at 2:51 p.m. as current and indicated, "...FROZEN STORAGE...3. All foods in the freezer are wrapped in moisture proof wrapping or placed in suitable container, to prevent freezer burn. Items are labeled and dated.<br><br>The policy titled "Cleaning Dishes and | | | |

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| | Utensils-Dish Machine Operation" provided by the Director of Dietary on 7/9/15 at 3:30 p.m. as current and indicated, "...Procedure:...3. Start Up: G. Check that temperatures are appropriate: 1. High Temp-...Rinse tem (sic) should be 180-194 degrees Fahrenheit...."<br><br>3.1-21(i)(2)<br>3.1-21(i)(3) | | | |
| F 0441<br>SS=D<br>Bldg. 00 | 483.65<br>INFECTION CONTROL, PREVENT SPREAD, LINENS<br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with | | | |

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| | a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | | | |
| | Based on observation and interview, the facility failed to maintain proper infection control related to the storage and cleaning of residents' bedpans and respiratory equipment for 2 of 30 residents whose rooms were observed. (Room 91 and Room 126C)<br><br>Findings include:<br><br>1. On 7/8/15 at 10:13 a.m., a bedpan was observed sitting directly on the floor uncovered in the bathroom of Room 91. During the environmental tour on 7/14/15 at 1:20 p.m. with the Administrator and Plant Manager, the bedpan was again observed sitting directly on the floor uncovered in the bathroom of Room 91. The Administrator indicated at the time of the tour the bedpan should not have been stored on the bathroom floor. One resident resided in the room. | F 0441 | It is the policy of this facility to 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. **I. Specific CorrectiveActions:** The Administrator asked an aide to remove the bedpan as soon as learning that it was there. Immediately following the tour staff was asked to ensure the nebulizer, nebulizer mask and CPAP mask were covered and stored properly. **II. Identification and correction of others:** All residents have the potential to be affected by incorrect storage of equipment. All bed pans, nebulizer equipment and CPAP equipment was checked to ensure they were covered and stored properly. **III. Systemic Changes:** Nursing staff will be re-educated on the proper storage of bed pans, nebulizer | 08/13/2015 |

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| | 2. On 7/8/15 at 8:42 a.m., a mask used for nebulizer treatments was observed uncovered sitting on the table in Room 126C.<br><br>On 7/7/15 at 11:34 a.m., a mask used for a CPAP (respiratory sleeping aid) machine was uncovered sitting directly on the bedspread and the nebulizer mask remained uncovered on the table in Room 126C.<br><br>On 7/7/15 at 2:04 p.m., the CPAP mask remained sitting directly on the bedspread in Room 126C.<br><br>On 7/8/15 at 9:47 a.m., the nebulizer mask was observed on the table uncovered and the CPAP mask was on top of machine behind the bed uncovered in Room 126C.<br><br>During the environmental tour on 7/14/15 at 1:20 p.m. with the Administrator and Plant manager, the CPAP mask was observed sitting on top of the machine behind the bed uncovered. The nebulizer mask was on the table on a paper towel covered only by another paper towel in Room 126C. At the time of the tour, the Administrator indicated resident care equipment should be covered.<br><br>3.1-18(a) | | and CPAP equipment. [Attachment: InServiceAllStaffHCPOC2015]<br>**IV. Monitoring:** The DON, ADON and/or designee will check daily that above equipment is stored properly for one month. The audits will then decrease to weekly for one month then monthly times four months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: POCMonitoringbyNursing2015 & QA TrackingLog] | |

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| F 0465<br>SS=E<br>Bldg. 00 | 483.70(h)<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on observation and interview, the facility failed to maintain a functional and safe environment related to marred and gouged doors and walls, cracked sink caulk, and a dirty privacy curtain on 3 of 3 halls throughout the facility. (Oak Leaf, Oak Branch One, and Oak Branch Two)<br><br>Findings include:<br><br>An Environmental Tour was conducted on 7/14/15 at 1:20 p.m. with the Administrator and Plant Manager. The following areas were observed:<br><br>1. Oak Leaf<br>a. Room 93: The wall beside the bed was gouged. One resident resided in this room.<br><br>2. Oak Branch One<br>a. In Room 126, the privacy curtain between beds A and B was marked and dirty. Three residents resided in this room.<br><br>b. In Room 133, there were gouges on the | F 0465 | It is the policy of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. **I. Specific CorrectiveActions:** The marred and gouged doors and walls were immediately scheduled to be repaired. The sink caulk was replaced and the dirty privacy curtain taken down and replaced with a clean privacy curtain. **II. Identification and correction of others:** All residents have the potential to be affected by marred and gouged doors and walls, cracked sink caulk, and dirty privacy curtains. All rooms were checked for any of these issues. **III. Systemic Changes:** All staff will be re-educated on the notification of maintenance/housekeeping when there are repairs required and/or dirty privacy curtains. [Attachment: InServiceAllStaffHCPOC2015] **IV. Monitoring:** The Plant Manager and/or designee will round weekly to check for marred and gouged doors and walls, cracked sink caulk and dirty privacy curtains times one | 08/13/2015 |

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| | wall beside the bed. One resident resided in this room.<br><br>c. In Room 134, the inside bottom of the bathroom door was marred and the wall by the recliner was gouged and marred. One resident resided in this room.<br><br>3. Oak Branch Two<br>a. In room 107, the caulk was cracked around the bathroom sink and pulling away from the wall. One resident resided in this room.<br><br>Interview with the Administrator and Plant Manager at the time of the tour indicated all areas were in need of repair.<br><br>3.1-19(f) | | month. The audits will then decrease to bi-weekly for five more months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: POCMonitoringbyMaintenance.Housekeeping2015& QA Tracking Log] | |
| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey.<br><br>Residential Census: 32<br><br>Residential Sample: 8<br><br>The following State Residential findings cited is in accordance with 410 IAC | R 0000 | This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is no tan admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by stateand federal law. Oak Grove Christian Retirement Village | |

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| | 16.2-5. | | desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on August 13, 2015. The facility respectfully requests paper compliance. Please accept the attached as our credible allegation of compliance. | |
| R 0148<br><br>Bldg. 00 | 410 IAC 16.2-5-1.5(e)(1-4)<br>Sanitation and Safety Standards - Deficiency<br>(e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:<br>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility.<br>(2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes.<br>(3) All plumbing shall function properly and comply with state plumbing codes.<br>(4) At least yearly, heating and ventilating systems shall be inspected.<br>Based on observation and interview, the facility failed to ensure each resident had a functioning call system for 1 of 7 residents reviewed. (Resident #4)<br><br>Finding includes:<br><br>During a continuous observation on | R 0148 | It is the policy of this facility to maintain all buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public. **I. <u>Specific Corrective Actions:</u>**<br>The pendent (call system) of Resident #4 had the battery | 08/13/2015 |

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| | 7/14/15 from 10:21 a.m. to 10:51 a.m. for Resident #4, after the call light pendant was initiated, the pendant glowed yellow and then flashed yellow. The staff had not responded to the call light.<br><br>Interview with Director of Nursing (DON) on 7/14/15 at 11:00 a.m., indicated the call light pendant system should have called the phone for the CNA and if no response, then the system would have called the nurse's phone and if no response, then the system would have called the DON's phone, and then lastly, the system would have called the Plant Manager's phone.<br><br>Interview with the LPN #1 on 7/14/15 at 11:02 a.m., indicated the phone lacked a call from Resident #4.<br><br>Interview with the CNA #6 on 7/14/15 at 11:02 a.m., indicated the phone lacked a call from Resident #4.<br><br>Interview with the Plant Manager on 7/14/15 at 11:05 a.m., indicated the pendant had searched for a signal when the pendant light had glowed yellow. He further indicated, it was unknown to why the pendant had not functioned properly. | | "re-set"by the Plant Manager who ensured it was fully functional by testing it in various locations. **II. Identification and correction of others:** All residents have the potential to be affected by a malfunctioning pendent/call system. Each resident pendent was checked to ensure it was functioning properly. **III. Systemic Changes:** Besides reviewing the daily Low Battery Alert Report maintenance will do rounds on one hall a week to physically check the function of each pendent. [Attachment: Weekly Pendent Check] **IV. Monitoring:** The Plant Manager or designee will review all Pendent Check Logs weekly and do two random re-checks a week for one month; then one random re-check per week for five months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: POCMonitoringMaintenance.Housekeeping2015& QA Tracking Log] | |

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| R 0241<br><br>Bldg. 00 | 410 IAC 16.2-5-4(e)(1)<br>Health Services - Offense<br>(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows:<br>(1) Medication shall be administered by licensed nursing personnel or qualified medication aides.<br><br>Based on observation, record review and interview, the facility failed to ensure Physician's orders were followed related to, checking the pulse before administering a medication (Digoxin- a heart medication) and lack of Physician Orders for medications for 2 of 8 residents whose records were reviewed for medications, and the administration of an expired insulin to 1 of 5 residents observed for medication administration. (Residents #8 and #4)<br><br>Findings include:<br><br>1. Record review for Resident #8 was completed on 7/14/15 at 1:47 p.m. The resident's diagnoses included, but were not limited to, atrial fibrillation and hypertension.<br><br>Review of a Physician Order dated 5/25/15 indicated an order for Digoxin (heart medication) 250 mcg (microgram) every day, hold if pulse is below 60. | R 0241 | It is the policy of this facility to ensure the administration of medications and the provision of residential nursing care shall be as ordered by the resident's physician andshall be supervised by a licensed nurse on the premises. **I. <u>Specific Corrective Actions:</u>** The nurses who administered Digoxin without taking a pulse prior were educated about following physician orders. It was ensured that physician orders were in place for all residents being administered medications. The bottle of Humalog was discarded immediately. **II. <u>Identification and correction of others:</u>** All residents have the potential to be affected by failure to follow physician orders, lack of physician orders for medications, and the administration of expired insulin. All physician orders were reviewed to ensure they were being followed, all residents being administered medications were checked to ensure physician orders were in place, and all insulin was checked to ensure none were expired. **III. <u>Systemic</u>** | 08/13/2015 |

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| OAK GROVE CHRISTIAN RETIREMENT VILLAGE | 221 W DIVISION ST<br>DEMOTTE, IN 46310 |

| (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 |
|---|---|---|---|---|
| | Review of the June 2015 and July 2015 Medication Administration Record indicated the resident received the Digoxin on the following dates without a pulse taken before administering the medication:<br><br>6/4/15 at 7:36 a.m.<br>6/5/15 at 7:12 a.m.<br>6/8/15 at 7:11 a.m.<br>6/9/15 at 8:27 a.m.<br>6/10/15 at 9:06 a.m.<br>6/11/15 at 9:24 a.m.<br>6/12/15 at 7:27 a.m.<br>6/13/15 at 7:13 a.m.<br>6/14/15 at 7:10 a.m.<br>6/15/15 at 7:00 a.m.<br>6/18/15 at 7:25 a.m.<br>6/19/15 at 7:21 a.m.<br>6/22/15 at 7:01 a.m.<br>6/27/15 at 7:06 a.m.<br>6/28/15 at 7:11 a.m.<br>7/3/14 at 7:24 a.m.<br>7/4/15 at 7:21 a.m.<br>7/6/15 at 7:08 a.m.<br>7/11/15 at 8:15 a.m.<br>7/12/15 at 7:30 a.m.<br>7/13/15 at 7:07 a.m.<br><br>Interview with the Director of Nursing on 7/14/15 at 3:00 p.m., indicated she was unable to find any indication the pulse was taken before the Digoxin was | | **Changes:** All nursing staff will be re-educated regarding following physician orders, ensuring physician orders are in place for medication administration and the policy regarding insulin and expiration dates. [Attachment: InServiceAllStaffRP OC2015] **IV. Monitoring:** TheDON, ADON and/or designee will randomly audit 2 charts per week for 2 months for correct following of physician orders and physician orders in place for medications; plus that any insulin in the medication cart is not expired(weekly). This will then decrease to monthly for 4 months. Any concerns identified will be documented on a quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: POCMonitoringbyNursing2015 & QA TrackingLog] | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155667 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 07/14/2015 |
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| | administered to the resident on the above dates and times.<br>2. During a medication pass observation on 7/13/15 at 11:40 a.m., LPN #1 prepped and administered 8 units of Humalog (insulin) to Resident #8.<br><br>The Humalog container was labeled with a red sticker and indicated an open date of 6/1/15.<br><br>Interview with the LPN #1 on 7/13/15 at 1:30 p.m.., indicated the insulin had expired after 28 days of the open date.<br><br>The policy titled "Insulin Products" provided by the DON on 7/13/15 at 2:15 p.m., as current and indicated, "...Humalog-Discard 28 days after initial use or removing from refrigerator...." | | | |
| R 0273<br><br>Bldg. 00 | 410 IAC 16.2-5-5.1(f)<br>Food and Nutritional Services - Deficiency<br>(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.<br>Based on observation, interview and record review, the facility failed to ensure food was stored under sanitary conditions, related to undated and exposed food in the freezer. This had the | R 0273 | It is the policy of this facility to ensure that all food preparation and serving areas are maintained in accordance with state and local sanitation and safe food handling standards. **I. Specific** | 08/13/2015 |

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| | potential to affect 32 of 32 residents that were served from the main kitchen. The facility also failed to ensure proper dishwasher temperatures were reached to ensure sanitation in the kitchen for 1 of 1 kitchens observed. This had the potential to affect to 32 of 32 assisted living residents. (The Main Kitchen)<br><br>Findings include:<br><br>1. During the Initial Kitchen Tour with the Director of Dietary on 7/7/15 from 8:46 a.m. to 9:00 a.m.:<br><br>a. There were two packages of Salisbury steaks in the freezer that were open to air and undated. Also observed in the freezer at that time, a used package of Salisbury steaks undated. During this observation, the Director of Dietary indicated all packages should be closed and dated.<br><br>a. The dishwasher rinse cycle temperature was observed at 177 degrees Fahrenheit.<br><br>On 7/9/15 at 9:18 a.m. the dishwasher rinse cycle was observed at 177 degrees Fahrenheit.<br><br>The "Dish Machine Temperature Log" for July indicated the following rinse | | **CorrectiveActions:** The food that was open to air and undated was disposed of immediately. Maintenance immediately took action to fix the dishwasher rinse cycle temperature. **II. Identification and correction of others:** All residents have the potential to be exposed to food that is stored improperly and a dishwasher rinse cycle that is inadequate. All food storage areas were checked to ensure all food was being stored under sanitary conditions and the only dishwasher was immediately fixed by maintenance. **III. Systemic Changes:** Dietary staff was re-educated on the Dietary"Storage Procedures" Policy and on notifying maintenance when inadequate dish machine temperatures are recorded per the "Cleaning Dishes and Utensils-Dish Machine Operation" Policy [Attachment: InServiceAllStaffRPOC2015] **IV. Monitoring:** The Dietary Manager and/or designee will audit compliance by a daily check for one month that there is not unlabeled and uncovered food in food storage. The audits will then decrease to weekly for one month then monthly times four months. The rinse temperatures will be monitored after each dish machine rinse cycle, any low temps will be reported to maintenance. Any concerns identified will be documented on a | |

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| | temperatures:<br><br>7/1/15 Breakfast 177<br>7/2/15 Dinner 152<br>7/3/15 Lunch 172<br>7/4/15 Breakfast 179<br>7/6/15 Lunch 170<br>7/9/15 Breakfast 179<br><br>Interview with the Directory of Dietary on 7/9/15 at 9:32 a.m., indicated the high temperature dishwasher rinse cycle should have been 180 degrees Fahrenheit.<br><br>The policy titled "Storage Procedures" provided by the Director of Dietary on 7/9/15 at 2:51 p.m. as current and indicated, "...FROZEN STORAGE...3. All foods in the freezer are wrapped in moisture proof wrapping or placed in suitable container, to prevent freezer burn. Items are labeled and dated.<br><br>The policy titled "Cleaning Dishes and Utensils-Dish Machine Operation" provided by the Director of Dietary on 7/9/15 at 3:30 p.m. as current and indicated, "...Procedure:...3. Start Up: G. Check that temperatures are appropriate: 1. High Temp-...Rinse tem (sic) should be 180-194 degrees Fahrenheit...." | | quality assurance tracking log and corrected upon discovery. All QAPI tools and any findings will be reviewed monthly in the facility QAPI Meeting to ensure ongoing compliance. [Attachment: POCMonitoringbyDietary2015 & QA TrackingLog] | |