

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2015
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NAME OF PROVIDER OR SUPPLIER CREASY SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 S CREASY LN LAFAYETTE, IN 47905
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint #IN 00181374.</p> <p>Complaint # IN00181374- Unsubstantiated due to lack of evidence.</p> <p>Survey dates: August 31, September 1, 2, 3, 4, 8, 9, 2015</p> <p>Facility number: 0012285 Provider number: 155777 AIM number: 201006770</p> <p>Census bed type: SNF: 34 SNF/NF: 24 Residential: 51 Total: 109</p> <p>Census payor type: Medicare: 17 Medicaid: 17 Other: 24 Total: 58</p> <p>These deficiencies reflect state findings</p>	F 0000	<p>The submission of this Plan of Correction does not indicate an admission by Creasy Springs 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 Creasy Springs Health Campus. This facility recognized it's obligation to provide legally and medically 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 care facilities. To this end, this Plan of Correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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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F 0282 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1</p> <p>Quality review completed 09/10/2015 by 29479.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to administer medication within the parameters of physician orders. This deficient practice affected 2 of 5 residents reviewed for following plan of care (Residents #46 and Resident #71).</p> <p>Findings include:</p> <p>1. A record review for Resident #46 was completed on 9/3/15 at 8:44 a.m. Diagnoses included, but were not limited to, hypertension, congestive heart failure, falls, urinary retention, muscle spasms, dementia.</p> <p>Physician orders, dated 2/21/14, indicated "...carvedilol [blood pressure medication] 6.25 mg [milligram] tablet...give 1 tablet by mouth twice a day for heart rate/blood pressure...hold for</p>	F 0282	<p>CORRECTIVE ACTION: Nurses and QMAs were re educated regarding the lack of documentation of blood pressure and heart rate prior to giving the medication for resident #46 and #71. IDENTIFY OTHER RESIDENTS: Audits will be conducted for those residents who have physician ordered blood pressure and heart rate assessments prior to administration of hypertensive medication.</p> <p>MEASURES/SYSTEMIC CHANGES: Creasy Springs Health Campus will convert from a paper MAR TAR system to electronic MAR TAR system on October 6. Nurse and QMA's will attend electronic MAR TAR system inservices the week of September 28 - October 2. In addition, nurses and QMA's will be educated on policy of medication administration documentation. MONITOR CORRECTIVE ACTIONS: The</p>	10/09/2015

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	<p>SBP [systolic blood pressure] less than 90 or pulse below 60...."</p> <p>A review of medication administration records (MAR), dated 6/1/15 through 8/31/15, indicated the following:</p> <p>a. Resident #46 was administered carvedilol without first obtaining a pulse on 06/1/15, 6/8/15, 6/12/15,</p> <p>b. MAR documentation for 6/08/2015 and 6/28/15 indicated that Resident #46 was not administered carvedilol with no documented blood pressure or pulse which was outside of the parameters of the physician order. No explain for withholding the dose was indicated..</p> <p>c. Resident #46 was administered carvedilol without first obtaining a pulse on 7/23/15, 7/24/15 for the morning dose.</p> <p>d. Resident #46 was administered carvedilol without first obtaining a pulse on 8/7/15, 8/8/15, 8/29/15 for the morning dose.</p> <p>2. A record review for Resident #71 was completed on 9/3/15 at 9:00 a.m. Diagnoses included, but were not limited to, Atrial Fibrillation, hypertension, peripheral neuropathy, bladder cancer, alzheimer's dementia, congestive heart</p>		<p>Director of Health Services or designee will monitor those residents with blood pressure and heart rate orders during the Clinical Care Meeting 5 days per week. The findings will be reported to the QA meeting one time per month x 6 months.</p>	

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	<p>failure, cerebrovascular accident, coronary artery disease, depression, and anxiety.</p> <p>Physician orders, dated 1/9/13, indicated "...Coreg CR [blood pressure medication] 10 g [milligram] tablet...give 1 tablet by mouth daily for heart rate/blood pressure...hold for SBP [systolic blood pressure] less than 100 or pulse below 60...."</p> <p>A review of medication administration records (MAR), dated 6/1/15 through 8/31/15, indicated the following:</p> <p>a. MAR documentation on 6/1/15, 6/2/15, indicated no blood pressure, 6/4/15, 6/5/15, 6/10/15, 6/11/15,6/21/15, and on 6/22/15, no pulse documentation was indicated.</p> <p>b. MAR documentation for 7/23/15, no pulse indicated.</p> <p>During an interview with the Director of Health Services (DHS) on 09/3/15 at 2:55 p.m., she indicated physician orders should have been followed. She also indicated initials on the MAR indicated a medication was administered, unless the initials were circled.</p> <p>A review of the policy titled</p>			

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F 0325 SS=D Bldg. 00	<p>"Administration Procedures for all Medications," dated 9/1/13 obtained from DHS on 9/3/15 at 4:19 p.m. indicated "... obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration...."</p> <p>3.1-35(g)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review, and interview, the facility failed to assess and provide interventions to prevent significant weight loss for 2 of 4 residents reviewed for weight loss and nutrition (Resident #1 and Resident # 138).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #1 was</p>	F 0325	<p>CORRECTIVE ACTIONS: Resident #1 and Resident #138 were discharged prior to survey and thus cannot be corrected. IDENTIFY OTHER RESIDENTS: An audit of all current residents was conducted to identify residents with significant weight loss to ensure that the resident is assessed, receiving a therapeutic diet, the physician was notified, and interventions are implemented on the care plan.</p>	10/09/2015

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	<p>reviewed on 09/4/2015 at 1:00 p.m.</p> <p>Diagnosis included, but were not limited to, hypertension, chronic kidney disease, stage 4, hyperlipidemia, osteoporosis, anxiety, depression, generalized pain, anemia, and heart disease.</p> <p>A record review of Resident #1 weights indicated a 5.8% weight loss in 15 days. The resident's weight record indicated on 5/16/2015, Resident #1's weight was 120 pounds and on 6/2/2015, Resident #1's weight was 113 pounds.</p> <p>An admission care plan for resident #1 indicated, " ...please review my overall weight trends at least once monthly for any undesired weight change and make any necessary recommendations to my physician for consideration...I should maintain my weight at a healthy range for me without any unwarranted significant weight changes . I would like to remain within 90% of my usual weight...."</p> <p>No registered dietician (RD) consultant assessment was found in Resident #1's clinical record for the weight loss. The last RD assessment was an admission assessment on 5/16/2015.</p> <p>A record review of the nursing notes on 9/3/2015 at 12:45 p.m., did not indicate the physician was notified of the</p>		<p>MEASURES/SYSTEMIC CHANGES: Creasy Springs Health Campus will transition from a paper medical record to an electronic health record the week of September 22 - September 25. The previous tool used to monitor weight loss did not include admission weights. The electronic health record will include admission weights allowing the Registered Dietician to monitor significant weight loss beginning with admission as well as monthly weight. When a significant weight loss is identified, an assessment will be completed by the Registered Dietician, the physician will be notified, and interventions will be put in place as appropriate.</p> <p>MONITOR CORRECTIVE ACTIONS: The Registered Dietician will identify residents with significant weight loss and conduct audit to ensure that the physician is notified, that the dietician assessment is available in the chart with interventions in place to prevent further weight loss. The Director of Health Services will report the audit findings to the QA Committee one time per month x 6 months.</p>		

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	<p>residents' weight loss and did not indicate interventions were implemented to prevent additional weight loss.</p> <p>2. The clinical record for Resident #138 was reviewed on 09/4/2015 at 1:00 p.m. Diagnosis included, but were not limited to, right hip fracture, hypertension, diabetes, Chronic Kidney Disease (CKD) -Stage 3, and mild dementia.</p> <p>A record review of Resident #138 weights indicated a 7.9% weight loss in 60 days. The resident's weight record indicated on admission 6/15/2015, Resident #138's weight was 126 pounds and on 8/7/2015, Resident #138's weight was 116 pounds.</p> <p>An admission care plan for resident #138 indicated, " ... please review my overall weight trends at least once monthly for any undesired weight change...I should maintain my weight at a healthy range for me without any unwarranted significant weight changes...."</p> <p>No Registered Dietician (RD) consultant assessment was found in Resident #138's clinical record for the 7.9% weight loss. The last RD assessment was on 7/7/2015, which indicated a 4.2 pound weight loss from admission, intake 55-75%,and a diet change from controlled carbohydrates to</p>			

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	<p>regular diet with fortified foods.</p> <p>A record review of the nursing notes on 9/8/2015 at 1:45 p.m., did not indicate the physician was notified of the residents' weight loss and did not indicate revised interventions after additional weight loss in spite of regular diet with fortified foods.</p> <p>During an interview on 9/4/2015 at 1:58 p.m., with the RD, she indicated Resident #1 did not have a greater than 5% weight loss and she did not do an assessment for the weight loss on 6/2/2015 of 5.8% because Resident #1 was already on a supplement from admission on 5/16/2015</p> <p>During an interview on 9/4/2015 at 1:30 p.m., with the RD, she indicated Resident #138 did not have a greater than 5% weight loss and she did not do an assessment for the weight loss on 8/14/2015 of 7.9% because Resident #138 was already on a supplement from 7/7/2015.</p> <p>During an interview on 9/4/2015 at 3:p.m., with the Director of Nursing (DON), she indicated Resident #1 and Resident # 138 had weight loss and the nursing staff did not notify the physician of the weight loss.</p>			

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F 0329 SS=D Bldg. 00	<p>During an interview on 9/9/2015 at 9:53 a.m., with the Medical Director, he indicated Resident #1 and Resident #138, did not have harm associated with the weight loss.</p> <p>The policy and procedure titled "Guidelines For Weight Tracking", dated 11/07, received on 9/4/2015 at 2:04 p.m., from RD indicated, "...3. The facility dietician or representative will review the resident's nutritional status, usual body weight and current weight to implement a nutritional program when warranted...8. The physician, responsible party and dietician shall be notified of a weight variance of > [greater than] 5% (unless on a planned weight loss program)...."</p> <p>3.1-46(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>			

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	<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 vital signs were monitored to determine efficacy of medications prescribed to reduce blood pressure for 2 of 5 residents reviewed for unnecessary medications (Residents #46 and Resident #71).</p> <p>Findings include:</p> <p>1. A record review for Resident #46 was completed on 9/3/15 at 8:44 a.m. Diagnoses included, but were not limited to, hypertension, congestive heart failure, falls, urinary retention, muscle spasms, dementia.</p> <p>Physician orders, dated 2/21/14, indicated "...carvedilol [blood pressure medication] 6.25 mg [milligram] tablet...give 1 tablet by mouth twice a day for heart rate/blood pressure...hold for SBP [systolic blood pressure] less than</p>	F 0329	<p>CORRECTIVE ACTION: Nurses and QMAs were re educated regarding the lack of documentation of blood pressure and heart rate prior to giving the medication for resident #46 and #71. IDENTIFY OTHER RESIDENTS: Audits will be conducted for those residents who have physician ordered blood pressure and heart rate assessments prior to administration of hypertensive medication.</p> <p>MEASURES/SYSTEMIC CHANGES: Creasy Springs Health Campus will convert from a paper MAR TAR system to electronic MAR TAR system on October 6. Nurse and QMA's will attend electronic MAR TAR system inservices the week of September 28 - October 2. In addition, nurses and QMA's will be educated on policy of medication administration documentation. MONITOR CORRECTIVE ACTIONS: The Director of Health Services or</p>	10/09/2015

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	<p>90 or pulse below 60...."</p> <p>A review of medication administration records (MAR), dated 6/1/15 through 8/31/15, indicated the following:</p> <p>a. Resident #46 was administered carvedilol without first obtaining a pulse on 06/1/15, 6/8/15, 6/12/15,</p> <p>b. MAR documentation for 6/08/2015 and 6/28/15 indicated that Resident #46 was not administered carvedilol with no documented blood pressure or pulse which was outside of the parameters of the physician order. No explanation for withholding the dose was indicated.</p> <p>c .Resident #46 was administered carvedilol without first obtaining a pulse on 7/23/15, 7/24/15 for the morning dose.</p> <p>d. Resident #46 was administered carvedilol without first obtaining a pulse on 8/7/15, 8/8/15, 8/29/15 for the morning dose.</p> <p>2. A record review for Resident #71 was completed on 9/3/15 at 9:00 a.m. Diagnoses included, but were not limited to, Atrial Fibrillation, hypertension, peripheral neuropathy, bladder cancer, alzheimer's dementia, congestive heart failure, cerebrovascular accident,</p>		<p>designee will monitor those residents with blood pressure and heart rate orders during the Clinical Care Meeting 5 days per week. The findings will be reported to the QA meeting one time per month x 6 months.</p>	

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	<p>coronary artery disease, depression, and anxiety.</p> <p>Physician orders, dated 1/9/13, indicated "...Coreg CR [blood pressure medication] 10 g [milligram] tablet...give 1 tablet by mouth daily for heart rate/blood pressure...hold for SBP [systolic blood pressure] less than 100 or pulse below 60...."</p> <p>A review of medication administration records (MAR), dated 6/1/15 through 8/31/15, indicated the following:</p> <p>a. MAR documentation for 6/1/15, 6/2/15, no blood pressure, 6/4/15, 6/5/15, 6/10/15, 6/11/15,6/21/15, and on 6/22/15, no pulse was obtained.</p> <p>b. MAR documentation for 7/23/15, no pulse indicated.</p> <p>During an interview with the Director of Health Services (DHS) on 09/3/15 at 2:55 p.m., she indicated physician orders should have been followed. She also indicated initials on the MAR indicated a medication was administered, unless the initials were circled.</p> <p>A review of the policy titled "Administration Procedures for all Medications", dated 9/1/13 obtained from</p>			

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F 0371 SS=F Bldg. 00	<p>DHS on 9/3/15 at 4:19 p.m. indicated "... obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration..."</p> <p>3.1-48(a)(3)</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</p> <p>Based on observation, record review and interview, the facility failed to ensure food was labeled and dated in the refrigerators and the open kitchen area, food was disposed after date of expiration, and food was served with appropriate head covers utilized by facility staff in 2 of 2 kitchens in the facility. This deficient practice had the potential to affect 56 of 56 residents receiving food from the kitchen.</p> <p>Findings include: During the tour of the main and legacy</p>	F 0371	<p>CORRECTIVE ACTION: The Director of Food Service discarded current food items that were out of date and dated food items in the kitchen that were without a date. The Director of Food Service educated managers and food service employees regarding the policy for hairnets. IDENTIFY OTHER RESIDENTS: All residents have the potential to be affected by the deficient practice. MEASURES/SYSTEMIC CHANGES: The Director of Food Service will inservice the Food Service Department on September 29 regarding policies for Hair Restraint Guidelines and Food Labeling Guidelines.</p>	10/09/2015

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	<p>kitchens on 8/31/2015 at 9:15 a.m., with the Dietary Manager, the following observations were made:</p> <p>1.) The open kitchen area was observed to have expired, open, and not dated items:</p> <p>a.) a package of English muffins was opened and not dated</p> <p>b.) corn flakes in a container expired on 5/19/2015</p> <p>c.) bran flakes in a container expired on 7/16/2015</p> <p>d.) mini wheat cereal in a container expired on 8/29/2015</p> <p>e.) raisin bran cereal container opened and not dated</p> <p>f.) shredded wheat container opened and not dated</p> <p>2.) The reach in refrigerator was observed to have expired items which had not been discarded:</p> <p>a.) a container of ranch dressing expired on 8/29/2015</p> <p>b.) a container of Italian dressing expired on 8/29/ 2015</p> <p>c.) a container of honey mustard expired on 8/24/2015</p> <p>d.) a container of ranch dressing expired on 8/29/ 2015</p> <p>e.) a tray of jello expired on 8/28/2015</p> <p>3.) The reach in refrigerator located on</p>		<p>MONITOR CORRECTIVE ACTIONS: The Director of Food Service or designee will audit all open kitchen items and reach in refrigerators in the Health Campus and Legacy kitchens for food items that have not been dated five days per week. The Director of Food Service will report findings to the QA Committee monthly x 6 months. In addition, Director of Food Service or designee will immediately educate staff members to the Hair Restraint Guidelines per occurrence and follow up with Meal Managers to assist in monitoring hair net compliance. The Director of Food Service will monitor violations of the Hair Restraint Guidelines and report to the QA Committee one time per month x 6 months.</p>	

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	<p>the Legacy Unit (dementia unit) was observed to have expired, open and not dated items:</p> <p>a.) a container of natural laxative expired on 8/30/2015</p> <p>b.) a container of whipped cream opened and not dated</p> <p>During the second tour of the Legacy kitchen on 8/31/2015 at 11:55 a.m., with the Dietary Manager, the following observations were made:</p> <p>1. Certified Resident Care Assistant # 2 entered the kitchen area at 12:00 p.m., without the a hair net. She obtained the drinks cart for the legacy unit.</p> <p>2. Activities staff member #1 entered the legacy kitchen at 12:09 p.m., without wearing a hair net. He obtained a pot holder from above the stove/oven. The stove top was observed to have a pot of peas and carrots cooking with no lid on top of cooking pan.</p> <p>During an interview on 8/31/2015 at 1215 p.m., with activities staff member # 1, he indicated he did not wear an appropriate head covering for the kitchen.</p> <p>During an interview on 8/31/2015 at 12:20 p.m., with the Dietary Manager, he indicated that all open items should have</p>			

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F 0497 SS=D Bldg. 00	<p>been dated, that expired items should have been discarded, and the staff should have worn the appropriate head coverings for the kitchen.</p> <p>The "Hair Restraint Guideline", dated 08/2015, received on 9/2/2015 at 2:30 p.m., from the Dietary Manager, indicated " ...All Dining Service employees will be required to wear hair restraints as required by the 2009 Federal Food Code: Hair Restraints 2-402.11 Effectiveness...."</p> <p>The "Food Labeling Guideline", dated 4/14, received on 9/2/2015 at 2:30 p.m., from the Dietary Manager, indicated "... food must be date marked to assure that the food is either consumed or discarded within seven days ...date marking is required for ready- to- eat potentially hazardous food..."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome</p>			

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	<p>of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>Based on interview and record review, the facility failed to ensure employees were inserviced annually for resident right's, abuse, and dementia for 1 of 10 employees reviewed for inservices. This deficient practice had the potential to affect 58 of 58 residents in the facility. (Employee #3)</p> <p>Findings include:</p> <p>During a review of employee files on 9/3/15 at 1:00 p.m., the files indicated there were no annual inservices completed for Employee #3.</p> <p>During an interview with the Payroll Manager on 9/3/15 at 1:51 p.m., she indicated she could not find information on file to indicate Employee #3 completed her annual inservices.</p> <p>During an interview with the Administrator on 9/9/15 at 9:28 a.m., she indicated she could not locate a facility</p>	F 0497	<p>CORRECTIVE ACTIONS: Employee #3 will be complete inservices for Resident Right's, Abuse, and Dementia. IDENTIFY OTHER RESIDENTS: All residents have the potential to be affected by the deficient practics. MEASURES/SYSTEMIC CHANGES: Employees will be offered the option to attend a live inservice on the topics of Resident Right's, Abuse and Dementia on October 6 or attend and complete the on line electronic emerge inservices by October 9. The Executive Director or designee will audit attendance for inservices one time per week and October 9. Those employees who have not attended the inservices will not be able to work past October 9. MONITOR CORRECTIVE ACTIONS: The Executive Director will audit the list of employees who have completed the on line emerge inservices for attendance compliance and the live inservice sign in sheet. Those employees</p>	10/09/2015

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R 0000 Bldg. 00	<p>policy regarding annual inservices and the policy she could locate was outdated and not applicable at this time.</p> <p>3.1-14(k)(1) 3.1-14(k)(5) 3.1-14(l)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Sample: 8</p> <p>These state findings are cited in accordance with 410 IAC 16.2-3.1.</p>	R 0000	<p>who have not attended the inservices will not be able to work past October 9. The Executive Director will continue to audit additional inservices past October 9 for attendance compliance at least one time per month. The inservice compliance audit will be reported to the QA Committee monthly x 6 months.</p> <p>The submission of this Plan of Correction does not indicate an admission by Creasy Springs 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 Creasy Springs Health Campus. This facility recognized it's obligation to provide legally and medically 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 care facilities. To this end, this Plan of Correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The provider respectfully requests a desk</p>	

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R 0120 Bldg. 00	<p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance</p> <p>(e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows:</p> <p>(1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel.</p> <p>(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice.</p>		review with paper compliance to be considered in establishing that the provider is in sustantial compliance.	

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	<p>The employee will acknowledge attendance by written signature.</p> <p>Based on interview and record review, the facility failed to ensure employees were inserviced annually for resident right's, abuse, and dementia for 1 of 10 employees reviewed for inservices. This deficient practice had the potential to impact 51 of 51 residents in the facility. (Employee #4)</p> <p>Findings include:</p> <p>During a review of employee files on 9/3/15 at 1:00 p.m., the files indicated there were no annual inservices completed for Employee #4.</p> <p>During an interview with the Payroll Manager on 9/3/15 at 1:51 p.m., she indicated she could not find information on file to indicate Employee #4 completed her annual inservices.</p> <p>During an interview with the Administrator on 9/9/15 at 9:28 a.m., she indicated she could not locate a facility policy regarding annual inservices and the policy she could locate was outdated and not applicable at this time.</p>	R 0120	<p>CORRECTIVE ACTIONS: Employee #3 will be complete inservices for Resident Right's, Abuse, and Dementia. IDENTIFY OTHER RESIDENTS: All residents have the potential to be affected by the deficient practice. MEASURES/SYSTEMIC CHANGES: Employees will be offered the option to attend a live inservice on the topics of Resident Right's, Abuse and Dementia on October 6 or attend and complete the on line electronic emerge inservices by October 9. The Executive Director or designee will audit attendance for inservices one time per week and October 9. Those employees who have not attended the inservices will not be able to work past October 9. MONITOR CORRECTIVE ACTIONS: The Executive Director will audit the list of employees who have completed the on line emerge inservices for attendance compliance and the October 6 inservice sign in sheet. Those employees who have not attended the inservices will not be able to work past October 9. The Executive Director will continue to audit additional inservices past October 9 for attendance compliance at least one time per month. The inservice compliance audit will be reported to the QA</p>	10/09/2015

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R 0273 Bldg. 00	<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. Based on observation, record review and interview, the facility failed to ensure food was labeled and dated in the refrigerators and the open kitchen area, food was disposed after date of expiration, and food was served with appropriate head covers utilized by facility staff in 2 of 2 kitchens in the facility. This deficient practice had the potential to affect 51 of 51 residents receiving food from the kitchen.</p> <p>Findings include:</p> <p>During the tour of the main and legacy kitchens on 8/31/2015 at 9:15 a.m., with the Dietary Manager, the following observations were made:</p> <p>1.) The open kitchen area was observed to have expired, open, and not dated items: a.) a package of English muffins was opened and not dated b.) corn flakes in a container expired on 5/19/2015 c.) bran flakes in a container expired on</p>	R 0273	<p>Committee monthly x 6 months.</p> <p>CORRECTIVE ACTION: The Director of Food Service discarded current food items that were out of date and dated food items in the kitchen that were without a date. The Director of Food Service educated managers and food service employees regarding the policy for hairnets. IDENTIFY OTHER RESIDENTS: All residents have the potential to be affected by the deficient practice. MEASURES/SYSTEMIC CHANGES: The Director of Food Service will inservice the Food Service Department on September 29 regarding policies for Hair Restraint Guidelines and Food Labeling Guidelines. MONITOR CORRECTIVE ACTIONS: The Director of Food Service or designee will audit all open kitchen items and reach in refrigerators in the Health Campus and Legacy kitchens for food items that have not been dated five days per week. The Director of Food Service will report findings to the QA Committee monthly x 6 months. In addition, Director of Food Service or designee will</p>	10/09/2015

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	<p>7/16/2015</p> <p>d.) mini wheat cereal in a container expired on 8/29/2015</p> <p>e.)raisin bran cereal container opened and not dated</p> <p>f.) shredded wheat container opened and not dated</p> <p>2.) The reach in refrigerator was observed to have expired items which had not been discarded:</p> <p>a.) a container of ranch dressing expired on 8/29/2015</p> <p>b.) a container of Italian dressing expired on 8/29/ 2015</p> <p>c.) a container of honey mustard expired on 8/24/2015</p> <p>d.) a container of ranch dressing expired on 8/29/ 2015</p> <p>e.) a tray of jello expired on 8/28/2015</p> <p>3.) The reach in refrigerator located on the Legacy Unit (dementia unit) was observed to have expired, open and not dated items:</p> <p>a.) a container of natural laxative expired on 8/30/2015</p> <p>b.) a container of whipped cream opened and not dated</p> <p>During the second tour of the Legacy kitchen on 8/31/2015 at 11:55 a.m., with the Dietary Manager, the following observations were made:</p>		<p>immediately educate staff members to the Hair Restraint Guidelines per occurrence and follow up with Meal Managers to assist in monitoring hair net compliance. The Director of Food Service will monitor trends for employees who violate policy and report to the QA Committee one time per month x 6 months.</p>	

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	<p>1. Certified Resident Care Assistant # 2 entered the kitchen area at 12:00 p.m., without the a hair net. She obtained the drinks cart for the legacy unit.</p> <p>2. Activities staff member #1 entered the legacy kitchen at 12:09 p.m., without wearing a hair net. He obtained a pot holder from above the stove/oven. The stove top was observed to have a pot of peas and carrots cooking with no lid on top of cooking pan.</p> <p>During an interview on 8/31/2015 at 1215 p.m., with activities staff member # 1, he indicated he did not wear an appropriate head covering for the kitchen.</p> <p>During an interview on 8/31/2015 at 12:20 p.m., with the Dietary Manager, he indicated that all open items should have been dated, that expired items should have been discarded, and the staff should have worn the appropriate head coverings for the kitchen.</p> <p>The "Hair Restraint Guideline", dated 08/2015, received on 9/2/2015 at 2:30 p.m., from the Dietary Manager, indicated " ...All Dining Service employees will be required to wear hair restraints as required by the 2009 Federal Food Code: Hair Restraints 2-402.11</p>			

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	Effectiveness...." The "Food Labeling Guideline", dated 4/14, received on 9/2/2015 at 2:30 p.m., from the Dietary Manager, indicated "... food must be date marked to assure that the food is either consumed or discarded within seven days ...date marking is required for ready- to- eat potentially hazardous food..."				