

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 08/15/2014
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NAME OF PROVIDER OR SUPPLIER HEARTH AT JUDAY CREEK LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6330 N FIR RD GRANGER, IN 46530
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R000000	<p>This visit was for a State Licensure Survey.</p> <p>Survey dates: August 14 and 15, 2014</p> <p>Facility number: 012229 Provider number: 012229 AIM number: N/A</p> <p>Survey team: Julie Baumgartner, RN-TC Shauna Carlson, RN Sharon Ewing, RN Pamela Williams, RN</p> <p>Census bed type: Residential: 121 Total: 121</p> <p>Census payor type: Other: 121 Total: 121</p> <p>Sample: 7</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review completed on August 23, 2014, by Brenda Meredith, R.N.</p>	R000000	<p>The statements made in this Plan of Correction are not an admission to, nor does it constitute an agreement with the alleged deficiencies herein. To remain in compliance with all state regulations, the community has taken or is planning to take the actions set forth in the following Plan of Correction. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.</p>	
R000092	410 IAC 16.2-5-1.3(i)(1-2)			

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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	<p>Administration and Management - Noncompliance</p> <p>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:</p> <p>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on observation, interview, and record review the facility failed to perform fire drills on all three shifts per quarter and complete fire drills in conjunction with the local fire department semi annually. This has the potential to affect 121 out of 121 residents.</p> <p>Findings include:</p> <p>An interview with the maintenance supervisor on 8/14/14 at 1:50 P.M.,</p>	R000092	<p>R 092 Administration and Management – fire drills</p> <p>1. The facility believes the fire drills were completed as scheduled for 1st shift 3rd quarter 2013 and 1st shift 2nd quarter 2014 but acknowledges paperwork was not found. All other drills were completed as scheduled. No residents were adversely affected by this deficiency.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice.</p> <p>3. A facility schedule has been</p>	09/30/2014			

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R000147	<p>indicated that "...fire drills are to be conducted quarterly on all shifts...I have not conducted a joint fire drill with the local fire department...."</p> <p>On 8/15/14 at 8:30 A.M., a record review of the facilities fire and disaster drill documentation indicated no fire drill was performed for the 1st shift of the 3rd quarter in 2013, and no fire drill was conducted for the 1st shift of the 2nd quarter in 2014. Further record review found no documentation of coordination of fire and disaster drills with the local fire department over the last year.</p> <p>An interview with the ED (Executive Director), on 8/14/14 at 9:42 A.M., indicated that "... the facilities shifts are, "...1st shift 6 A.M. to 2 P.M., 2nd shift 2 P.M. to 10 P.M., and 3rd shift 10 P.M. to 6 A.M...."</p> <p>On 8/15/14 at 11:32 A.M., review of the policy, "Fire," dated 9/7/11, provided by the ED who indicated this was the current policy, did not indicate fire drills should be done quarterly on all shifts or twice yearly with the local fire department.</p> <p>410 IAC 16.2-5-1.5(d) Sanitation and Safety Standards - Deficiency (d) The facility shall comply with fire and safety standards, including the applicable</p>		<p>created to ensure that fire drills are conducted quarterly on each shift to include at least twelve drills yearly and involvement semi-annually by the local fire department. The operations executive director will in-service the administrator and maintenance staff regarding the purpose and ongoing schedule for the facility fire drills and practices.</p> <p>4. The administrator and/or designee will conduct a monthly audit x3 months to verify that the fire drill has occurred as scheduled and documentation is in place. Review will be conducted monthly x3 and quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will make further recommendations accordingly.</p> <p>These changes will be completed September 30, 2014.</p>	

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	<p>rules of the state fire prevention and building safety commission (675 IAC) where applicable to health facilities.</p> <p>Based on observation and interview, the facility failed to comply with fire and safety standards regarding storage room sprinkler clearance. This affected 16 of 28 storage areas.</p> <p>Findings include:</p> <p>On 8/14/14 from 1:25 P.M. to 2:30 P.M., the environmental tour conducted with the Maintenance Supervisor. The following was observed:</p> <p>The Housekeeping Storage Room near Room 406 was observed to have 6 packages of paper towels, 22 rolls of toilet paper, and 1 roll of paper towels that were on the top shelf of a shelving unit, stacked 8 inches from the ceiling.</p> <p>An interview with the Maintenance Supervisor indicate that "...items should be at least 18 inches from the ceiling and 6 inches off the floor...."</p> <p>An unlabeled room, which the Maintenance Supervisor indicated was a storage room, was observed to have CNA (Certified Nursing Assistants) sheets and incident reports in card board boxes stored directly on the floor.</p>	R000147	<p>R 147 Sanitation and Safety Standards – storage roomsprinkler clearance</p> <ol style="list-style-type: none"> 1. Concernsidentified during survey regarding floor and ceiling clearance are beingresolved. The 16 storage rooms identifiedhave been reorganized to ensure compliance. 2. Allresidents have the potential to be affected by this alleged deficientpractice. The facility maintenance staffconducted a room by room audit, using a facility floor plan map, to ensure thatall storage rooms have the proper 18 inch ceiling clearance and that no itemsare stored on the floor. Any concerns were addressed. 3. Thefacility established a policy regarding the proper storage of items in storage,housekeeping and utility closets. Maintenancestaff has marked each storage area with a line indicating the 18 inch line thatneeds to be maintained. The administratorin-serviced staff on the new policy for storage room requirements to ensureongoing compliance. 4. Theadministrator/designee will conduct a facility walk through, randomly selectingten storage areas in various locations to ensure ongoing compliance. Review will be conducted weekly for onemonth, then monthly x two 	09/30/2014

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R000272	<p>An interview with the ED (Executive Director) on 8/15/14 at 9:30 A.M., indicated she did not have a policy for proper storage of supplies in closets.</p> <p>410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature. Based on observation, interview and record review, the facility failed to ensure milk was served at the proper temperature. This deficient practice affected 1 of 3 dining rooms.</p> <p>Findings include:</p> <p>On 8/15/14 at 11: 59 A.M., the Assistant Dietary Manager placed a thermometer into a glass of milk that was to be served to residents during meal times. The milk that was tested was removed from a gallon container of milk that was stored in the main dining room refrigerator. The temperature was taken immediately and was 48.7 degrees Fahrenheit. The Assistant Dietary Manager indicated, "... the milk is above the acceptable temperature...."</p> <p>On 8/15/14 at 1:15 P.M., review of the policy, dated 9/7/11, "Hearth</p>	R000272	<p>months, and quarterly thereafter. Results of these audits will be reviewed bythe QA Committee, who will make further recommendations accordingly.</p> <p>These systematic changes will be completed by September30, 2014</p> <p>R 272 Food and Nutritional Services – foodtemperature 1. Uponidentification of the concern, the milk was disposed of that was at anincorrect temperature. Maintenance wasnotified and they found the refrigerator to be operating properly. 2. Allresidents have the potential to be affected by this alleged deficientpractice. The facility maintenance staffconducted a temperature check of all facility owned refrigerators and foundthem to be operating at proper temperature. 3. TheFood Services Director/designee will in-service food service staff on thefacility's "Food Receiving and Storage Policy" including proper temperature toserve milk and the process for checking such temperatures and recording thosetemperatures. Beverages are kept on iceto ensure proper temperature during serving</p>	09/30/2014			

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R000273	<p>Management C-360," provided by the ED (Executive Director), as current policy. The policy indicated the following, "...Food Receiving and Storage Policy...6. Milk products shall be 40 [degrees] F [Fahrenheit] or below and the product should be used prior to the expiration date...."</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>A. Based on observation, interview, and record review the facility failed to ensure food was prepared and served in a sanitary manner related to the use of hairnets and beard guards, plates and pans stored in the kitchen. This deficient practice had the potential to affect all residents who ate their meals in the facility 1 of 1 kitchens.</p> <p>B. Based on observation, interview, and record review the facility failed to serve food under sanitary conditions in 1 of 3 dining rooms.</p>	R000273	<p>times.</p> <p>4. The administrator/designee will conduct an audit of food serving temperatures, atrandom serving times and meals, to ensure ongoing compliance. Review will be conducted x3 weekly for one month, then weekly x two months, andquarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will make further recommendations accordingly.</p> <p>These systematic changes will be completed by September30, 2014</p> <p>R 273 Food and Nutritional Services – safe foodpractices</p> <p>1. Upon identification of the concern, hair nets, caps, and beard guards are being wornby all who enter the kitchen. All plates, pans and coffee pots have beencorrectly stored and serving staff are following proper serving procedures.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice.</p> <p>3. TheFood Services Director/designee will in-service all food services staff on thefacility's policy for "Employee</p>	09/30/2014
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	<p>Findings include:</p> <p>A.1. On 8/15/14 between 11:15 A.M. and 11:55 A.M., a second tour of the kitchen was conducted with the Assistant Dietary Manager. The following observations were made during this tour:</p> <p>Employee # 4 was observed walking in the kitchen without a hairnet.</p> <p>Employee # 7 was observed working in the kitchen without a hairnet.</p> <p>Employee # 8 was observed walking in the kitchen without a hairnet.</p> <p>Employee #9 was observed going into the walk-in refrigerator unit to retrieve food. Employee # 9 was observed to have a long full beard and mustache and no beard guard.</p> <p>Employee # 10 was observed walking in the kitchen without a hairnet.</p> <p>An interview, that was conducted with the Assistant Dietary Manager at the time of the tour indicated, "... hairnets and beard guards should be worn in the kitchen...he [Employee # 9] does not wear a beard guard because he does not believe it is a state law...."</p>		<p>Hygiene" including that employees must keep hair from contacting exposed food, clean equipment, utensils or linens. The FSD/designee will also in-service food services staff on the facility's policies and practices for storage of clean dishes and serving materials and procedures for "Food Safety " and "Serving a Table..." including "proper finger placement" so as to avoid contact with food, utensils and tableware. The maintenance staff has cleared marked out the kitchen areas requiring a hairnet. All other staff will be in-serviced on kitchen boundaries and use of hair and beard net in kitchen area.</p> <p>4. The Administrator/designee will conduct an audit, to ensure ongoing compliance. Review will be conducted x3 weekly for one month, then weekly x two months, and monthly thereafter. Results of these audits will be reviewed by the QA Committee, who will make further recommendations accordingly.</p> <p>These systematic changes will be completed by September 30, 2014</p>				

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	<p>An interview was conducted with Employee #7 at the time of the tour. Employee #7 indicated, "...I believe I should be wearing a hairnet because I have a little bit of hair...."</p> <p>An interview was conducted with the Executive Director on 8/15/14 at 12:00 P.M.. The Executive Director indicated, "... it is my expectation that hairnets and beard guards be worn in the kitchen and while they (staff) are serving the residents meals...."</p> <p>On 8/15/14 at 12:00 P.M., an updated policy provided by the Executive Director titled, "Hearth Management C-330," was reviewed. The policy indicated, "...Employee Hygiene...6. Employees must keep hair from contacting exposed food, clean equipment, utensils and linens. All employees must wear a hair net and the hair must be off their neck...."</p> <p>On 8/15/14 at 12:25 P.M., the Executive Director was observed in the kitchen without a hairnet.</p> <p>A. 2. On 8/15/14 at 11:43 A.M., during a second tour of the kitchen the following was observed:</p>			
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	<p>35 clear plate covers stored upright on clean storage unit.</p> <p>Plastic Plates stored upright on clean shelf.</p> <p>11 Skillets and 1 pot stored upright on the metal shelf attached to the stove</p> <p>11 brown colored silverware holders stored upright on clean storage unit.</p> <p>2 coffee pots stored upright and hanging from a clean storage unit.</p> <p>On 8/15/14 at 11:50 A.M., an interview was conducted with the Assistant Dietary Manager. The Assistant Dietary Manager indicated the kitchen and serving materials should be stored upside down after being cleaned.</p> <p>On 8/15/14 at 1:00 P.M., an interview that was conducted with the Executive Director indicated she was unable to locate a policy related to the storage of clean dishes and serving materials.B.1. During the dining observation on 8/14/14 from 11:35 A.M. to 12:00 P.M., the following was observed:</p> <p>Server #3 was observed serving 2 residents cups of soup by the rim of the cup, with his open palm over the soup.</p>			

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	<p>Server #4 was observed picking up 3 fruit bowls off the food rack, with her fingers on the insides of the bowls, then serving them to 3 residents.</p> <p>Server #5 was observed serving 3 residents bowls of fruit by the rim of the cup, with her open palm over the fruit.</p> <p>Server #3 was observed serving 3 residents cups of soup by the rim of the cup, with his open palm over the soup.</p> <p>Server #3 was observed serving 2 residents plates of food, with his thumb on the inside of the plates.</p> <p>Server #4 was observed serving 3 residents bowls of fruit by the rim, with her open palm over the fruit.</p> <p>Server #4 was observed serving a resident a bowl of applesauce by the rim, with her open palm over the applesauce.</p> <p>Server #6 was observed serving dessert to a resident with his thumb on the inside of the plate.</p> <p>An interview with the ED (Executive Director) on 8/15/14 at 9:30 A.M., indicated it is her expectation that "...glasses and cups be handled by the</p>			

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R000358	<p>stem or handle and discreet with placement of hands on plates...."</p> <p>On 8/15/14 at 9:42 A.M., review of the undated "Serving a Table, Pre-Meal Hot Topics, and Service Order and Procedures", provided by the ED, who indicated this is what we use to train new wait staff, indicated "... When serving plates or glassware be discreet with finger placement. Ex: picking up a beverage glass by the base...handle plates by the rims. Never let you thumb go onto the plate...."</p> <p>410 IAC 16.2-5-8.1(k) Clinical Records - Nonconformance (k) The facility shall store inactive clinical records in accordance with applicable state and federal laws in a safe and accessible manner. The storage facilities shall provide protection from vermin and unauthorized use.</p> <p>Based on observation and interview, the facility failed to inactive clinical records in a protected manner. This affected 2 of 28 storage areas.</p> <p>Findings include:</p> <p>On 8/14/14 from 1:25 P.M. to 2:30 P.M., the environmental tour conducted with the Maintenance Supervisor. The following was observed:</p>	R000358	<p>R 358 Clinical Records – storage of records</p> <p>1. Upon identification of the concern, the medical records were placed in storage off the floor and placed in the same area as other stored medical records.</p> <p>2. All residents with inactive records have the potential to be affected by this alleged deficient practice.</p> <p>3. The facility maintenance staff has installed shelves in the designated inactive record storage room and gathered all inactive</p>	09/30/2014			

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	<p>1. An unlabeled room, which the Maintenance Supervisor indicated was a storage room, was observed to have 6 cardboard boxes that were labeled as DC (discharged) resident records. An interview with the Maintenance Supervisor at this time indicated, "those should not be stored there."</p> <p>2. An unlabeled room, which the Maintenance Supervisor indicated was a storage room, was observed to have 5 cardboard boxes that were labeled as DC (discharged) resident records 2010 and DC resident records 2011, directly on the floor.</p> <p>An interview with the ED (Executive Director) on 8/15/14 at 9:30 A.M., indicated she did not have a policy for proper storage of medical records.</p>		<p>records into one store room. The administrator/designee review the procedures for storage of inactive medical records with the Wellness Directors, Administrative Assistant and front office staff to ensure ongoing compliance.</p> <p>4. The administrator and/or designee will conduct a monthly audit x 3 months to verify that the inactive records are properly stored per guidelines. Results of these audits will be reviewed by the QA Committee, who will make further recommendations accordingly.</p> <p>These systematic changes will be completed by September 30, 2014</p>				