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
	155611		04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOOSIER CHRISTIAN VILLAGE	621 S SUGAR ST BROWNSTOWN, IN 47220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 30, 31, April 1, 4, 5, & 6, 2016. Facility number: 000277 Provider number: 155611 AIM number: 100290530 Census bed type: SNF: 8 SNF/NF: 84 Total: 92 Census payor type: Medicare: 4 Medicaid: 72 Other: 16 Total: 92 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 30576 on April 11, 2016.	F 0000	Please consider this plan of correction as Hoosier Christian Village's credible plan of correction. This plan of correction constitutes a written allegation of substantial compliance under Federal and Medicare requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the community agrees they were citied correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents solely as a requirement of the provision of Federal and State law. Please accept this evidence in lieu of an onsite follow-up for recertification and state licensure survey event ID IY4B11on April 6, 2016.	
F 0176 SS=D Bldg. 00	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE			

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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	An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. Based on observation, interview and record review, the facility failed to ensure a resident was properly screened prior to self administration of a medication for 1 of 4 residents reviewed for medication administration. (Resident #3) Findings include: During an observation and interview on 04/05/2016 at 8:14 A.M., LPN (Licensed Practical Nurse) #1 began Resident #3's nebulizer treatment and placed the nebulizer mask on the resident's face. The LPN then left the room after washing her hands. LPN #1 indicated Resident #3 was usually left unattended with her nebulizer treatment. During an interview on 04/05/2016 at 12:39 P.M., the DON (Director of Nursing) indicated if a resident was left with a breathing treatment it was considered self administration and a self administration checkoff should be completed. Clinical record review was conducted for Resident #3 on 04/05/2016 at 12:47 P.M. The Resident's diagnoses included, but were not limited to, Alzheimer's,	F 0176	Hoosier Christian Village does ensure residents are properly screened prior to self-administration of a medication. 1. On 4-05-16 the RN nurse manager completed a self-administration assessment on Resident #3 for using the nebulizer mask after the medication is inserted by the nurse. The Interdisciplinary team met with Resident #3's physician on 4-05-16 and received a written order for Resident #3 to self-administer the nebulizer treatment after the medication is inserted by the nurse. The nurse manager updated Resident #3's care plan to include resident may self-administer the nebulizer treatment after medication is inserted by the nurse. 2.Residents who receive nebulizer treatments have the potential to be affected by this alleged deficient practice. During the weeks of April 5,2016, April 11, 2016 and April 18,2016 residents receiving nebulizer treatments were audited by the Director of Nursing and Nurse Mangers for self-administration of drugs. Audits included ensuring self-administration assessments were completed per policy,physician orders were recorded in the chart, and the	04/22/2016

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	dementia, depression, chronic obstructive pulmonary disease, and blindness of both eyes. Resident #3 had a BIMS (Brief Interview for Mental Status) of 13, which indicated the resident was cognitively alert and oriented. There was no order for Resident #3 to self administer nebulizer treatments prior to 04/05/2016. Resident #3's care plan for a history of bronchitis did not include an intervention for self administration of nebulizer treatments prior to 04/05/2016. There was no "Self Administration of Medication Assessment Tool" completed for Resident #3 to be left with a nebulizer treatment. The current facility policy, titled "Self-Administration of Medications" and dated 12/7/11, was provided by LPN #2 on 04/05/2016 and was reviewed at that time. The policy indicated, "...The interdisciplinary team will determine the resident's ability to participate in self-administration of their medication via the self-medication assessment...A physician's order will be obtained and recorded in the chart...The interdisciplinary team will review the appropriateness at a minimum every		self-administration of nebulizer treatments were in the residents' care plan to be reviewed quarterly by the interdisciplinary team for appropriateness. There were no other residents found to be effected by this alleged deficient practice. 3.During the weeks of April 5, 2016,April 11, 2016 and April 18, 2016, nurses were re-educated on the facility Self Administration of Medications Policy that included the interdisciplinary team reviewing the self-administration of medications assessments to determine the ability of the resident to self-administer medications, obtaining a physician's order, and including the self-administration of medication in the care plan to ensure the interdisciplinary team will review at least quarterly for appropriateness. 4.The Director of Nursing and Nurse Managers will complete audits to ensure residents who self-administer medications have a current self-administration assessment, care plan includes self-administration of medication, a physician's order is present in the resident's chart and the interdisciplinary team has reviewed at least quarterly for appropriateness. These audits will be completed weekly for the first month, then every month for three months,then quarterly on-going. The audits will be brought to the CQI committee	

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	quarter...The care plan will reflect all details of self-administration..." 3.1-11(a)		monthly for review and any further recommendations. 5.Completion Date: April 22, 2016	
F 0272 SS=D Bldg. 00	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in			

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	assessment. Based on observation, record review and interview, the facility failed to develop an accurate annual comprehensive assessment related to dental status for 1 of 2 residents reviewed for dental status in a total sample of 35 residents reviewed. (Resident #72) Findings include: During an observation on 4/01/2016 at 8:34 A.M., Resident #72 had several missing teeth and two visible broken teeth. The annual MDS (Minimum Data Set) assessment, dated 01/14/2016, indicated Resident #72 had, "no obvious or likely cavity or broken natural teeth," and was severely cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 05. Clinical record review, on 04/04/2016 at 1:33 P.M., indicated Resident #72 was last seen by the facility contracted dentist on 7/29/2014. The report indicated the resident had ten missing teeth, four broken teeth and two decayed teeth. During an interview on 04/04/2016 at 1:56 P.M., MDS Coordinator #3 and MDS Coordinator #4 indicated they were	F 0272	HoosierChristian Village does conduct initially and periodically a comprehensive,accurate, standardized reproducible assessment of each resident's functionalcapacity. 1.On 4-01-2016 the RN MDS Coordinator re-assessed Resident #72 dental status, modified the annual MDS assessment and updated the care plan. 2. During the weeks of 4-04-2016, 4-11-2016, and4-18-2016 the RN MDS Coordinators audited residents' annual MDS to ensure accuracy with documentation of the residents' dental status. 3.On 4-04-16 the Dietary Manager was given 1:1 re-education that included referring to the RAI manual for accuracy with documenting resident dental status. The RN MDS Coordinators will audit MDS for accuracy with current dental assessment prior to signing of completion on-going. 4. The Administrator and Director of Nursing will complete audits to ensure accuracy of the MDS with dental assessments weekly for one month, then every month for three months, then quarterly. The audits will be brought to the monthly CQI meeting for review and recommendations. 5.Completion Date 4-22-2016	04/22/2016

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	responsible for signing off on all MDS assessments . MDS Coordinator #4 further indicated the DM (Dietary Manager) completed the dental area on the annual MDS assessment, but they were responsible to confirm the information was accurate. During an interview on 04/06/2016 at 1:54 P.M., the DM indicated she based Resident #72's MDS assessment dated 01/14/2016 off of the 2013 admission assessment. The DM further indicated she did not know she was to look at the resident's past dental exam or a current physical assessment of the resident. During an interview on 04/06/2016 at 2:30 P.M., the DON (Director of Nursing)indicated the DM did not do the direct physical assessment of a resident. The DON further indicated the DM was to input the information from the dentist exam and/or ask a nurse to do a physical dental exam. 3.1-31(c)(9) 3.1-31(i)			
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or			

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	considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure food was stored and served in a sanitary manner for residents related to dating open food, disposing of expired food, lack of expiration dates on food, and proper handwashing. This deficient practice had the potential to affect 90 of 92 residents who were provided food by the facility kitchen. Findings include: 1. The initial kitchen tour was conducted on 03/30/2016 at 11:12 A.M. with the DM (Dietary Manager). During an observation of the walk in refrigerator, two bags of salad, one opened and half full, had a use by date of 03/25/2016. One half full bag of slaw had a use by date of 03/15/2016. Two unopened bags of salad had a use by date of 03/17/2016. One large bag of leaf lettuce with a received date of 03/11/2016 was open, half used, with no open date and no expiration date. Two air vents, one located above the steam table and one above a food preparation table, had gray stains and dust hanging from them. Three handles on drawers under a preparation table had black stains and tan crumbs	F 0371	Hoosier Christian Village does procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare,distribute and serve food under sanitary conditions. 1. On 3/30/2016 the Dietary Manager disposed of the two bags of salad dated 3/25/2016, and the one bag of lettuce with received date of 3/11/2016. On 4/14/2016 the Maintenance Supervisor replaced three air vents, one located above the steam table,one above a food preparation table, and the 12"square vent located over the tray return area with new clean air vents. On 4/14/2016 the Dietary manager cleaned the three handles on drawers under the preparation table removing the black stains and ensured cleanliness of the crevice between drawers and handles. 2.All residents have the potential to be affected by this alleged deficient practice. On 4/14/16, Dietary manager and dietary staff ensured cleanliness of all areas of kitchen, including but not limited to three air vents, one above the steam table and above the food preparation table. The three handles on drawers under the preparation table were cleansed	04/22/2016

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	resting in the crevice between the drawers and handles. During an interview on 03/30/2016 at 11:30 A.M., the DM indicated the bags of salad and slaw should have been dated when opened and disposed of when they expired. The DM further indicated the slaw and salad had been served the previous day. The weekly menus were provided by the DM on 03/30/2016 at 12:17 P.M. and reviewed at that time. The menu indicated tossed salad had been served at lunch on 03/28/2016 and the DM indicated cole slaw had been substituted for zucchini salad at dinner on 03/28/2016. 2. The kitchen was observed on 04/05/2016 at 2:10 P.M. Two air vents, one located above the steam table, one above a food preparation table, had gray stains and dust hanging from them. Three handles on drawers under a preparation table had black stains and tan crumbs resting in the crevice between the drawers and handles. An open loaf of bread, an open package of lunch meat (turkey), both without open dates, a stack of cheese slices, and six pieces of cake were left uncovered on a food preparation table, unattended, from 2:10 P.M. to 2:34		and black stains and crumbs were removed. On 4/14, the maintenance supervisor replaced air vents in kitchen. Refrigerator walk-in was audited for any expired food items, and audits are in place to ensure no opened containers of food are left out or unattended in kitchen area. All food items were checked for appropriate received and expiration date. 3.During the week of 4/18/2016 the Administrator re-educated the Dietary Staff on cleanliness of kitchen, handwashing for 40-60 seconds, dating food for expiration and when received and opened, and not leaving food uncovered, unattended in the kitchen. During the week of 4/18/2016 the Administrator and D.O.N. completed the hand washing skills check for Dietary Staff. 4.The Administrator and Dietary Manger will complete audits to ensure cleanliness of vents, drawers, handles and all other areas of kitchen. The Administrator and Dietary Manager will complete audits of food in the kitchen to ensure expiration dates, date opened and date received. These audits will be completed weekly for one month then every month on-going. These audits will be brought to the CQI Committee monthly for review and recommendation. 5.Completion date: 4/22/2016	

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	P.M. During that time, a fly was crawling on the pieces of cake. DA (Dietary Assistant) #5 entered the kitchen at 2:23 P.M., washed her hands for 22 seconds, and started stacking dishes near the dishwasher. The DM (Dietary Manager) entered the kitchen at 2:27 P.M., washed her hands for 15 seconds then picked up a three ring kitchen binder. An unopened box containing several packages of hamburger buns had a received date of 03/18/2016 with no expiration date noted. An open rack contained four bags of hot dog buns, 2 bags of hamburger buns and 15 loaves of bread. None of the bread products on the rack had open dates, received dates or expiration dates noted on the packages. 3. The kitchen was observed on 04/06/2016 at 2:04 P.M. Two air vents, one located above the steam table and one above a food preparation table, had gray stains and dust hanging from them. Three handles on drawers under a preparation table had black stains and tan crumbs resting in the crevice between the drawers and handles. A 12" square vent located over the tray return area, near the dishwasher, was covered in gray dust. An open rack contained 22 unopened loaves of bread, 10 unopened bags of buns, two opened loaves of bread, and one opened bag of buns. None of the			

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	bread products on the rack had open dates, received dates or expiration dates noted on the packages. During an observation and interview on 04/05/2016 at 3:15 P.M., the DM dropped an empty bread tray off the rack onto the floor, picked it up and placed it back on the rack without washing or sanitizing it. The DM indicated she did not know what the expiration date of the bread was. She further indicated the bread was delivered frozen weekly but she did not keep it frozen at the facility. During an interview on 04/06/2016 at 1:36 P.M., the DM indicated, based on her research, frozen bread was good for 12-15 days but she did not have a policy specifically for the bread. The DM further indicated food preparation areas were cleaned at the end of each shift, shelves and cabinets were cleaned monthly and maintenance cleaned the ceilings. During an interview on 04/06/2016 at 1:56 P.M., the maintenance manager indicated vents were cleaned about once every 3 months and provided recent hand written documentation stating the vents had been cleaned. The current facility policy, titled			

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	"Prevention of Foodborne Illness", with a revised date of December 2008, was provided by the DON on 04/05/2016 at 2:40 P.M. and reviewed at that time. The policy indicated, "...Keeping track of when to discard perishable foods and covering, labeling, and dating all foods stored in the refrigerator or freezer..." The current facility policy, titled "How to Handwash?", was provided by LPN #2 on 04/05/2016 at 2:17 P.M. and was reviewed at that time. The policy indicated, "Duration of the entire procedure: 40-60 seconds..." 3.1-21(i)(3)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and			

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	corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview and record review, the facility failed to ensure proper infection control procedures were maintained in relation to washing hands, handling medications, and handling breathing treatment tubing for 1 of 4 residents observed during medication administration. (Resident #3) Findings include: During an observation on 04/05/2016 at 8:14 A.M., LPN (Licensed Practical Nurse) #1 used hand sanitizer and began preparing Resident #3's medications. While preparing the medication, LPN #1 opened two Potassium Chloride pills and	F 0441	HoosierChristian Village has established and does maintain an Infection ControlProgram designed to provide a safe, sanitary and comfortable environment and tohelp prevent the development and transmission of disease and infection. 1. On 4-05-2016 LPN #1 was re-educated by the nurse manager on medication administration that included hand washing and preparing medications for administration. On 4-05-2016 LPN #1was re-educated by the nurses manager on Insulin administration that included gloves and hand washing. On 4-05-2016 LPN #1 was re-educated by the nurse	04/22/2016

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	one Carvedilol pill into her bare hand and deposited them into the medication cup containing the rest of Resident #3's medications. The LPN entered Resident #3's room, set the medications and a pair of gloves on the resident's bedside table, washed her hands for seven seconds, and donned gloves. The LPN then used the bed remote to raise the head of the bed, dropped the remote on the floor, picked up the remote with her gloved hand, and reattached the remote to the bed. Without changing her gloves, LPN #1 lifted Resident #3's shirt, swabbed the resident's abdomen, administered the insulin injection, wiped away a drop of blood with the alcohol swab, removed her gloves, and laid the gloves on the resident's bedside table. LPN #1 then donned new gloves, handed a tissue to Resident #3, administered the resident's eye drops, removed her gloves, and carried the used supplies and the cup of oral medication back to the medication cart. Without washing her hands or using hand sanitizer, LPN #1 disposed of the used insulin in the sharps container, poured water from the pitcher on the medication cart into a cup for the resident, and put Resident #3's eye drops back into the medication cart. The LPN then used hand sanitizer.		manager on eye gtt administration that included hand washing. 2.Residents who receive medications have the potential to be effected by this alleged deficient practice. 3. During the weeks of 4-05-2016, 4-11-2016, and 4-18-2016 the director of nursing and nurses managers re-educated nurses on medication administration that included hand washing, nebulizer treatment administration that included changing tubing as needed, insulin administration that included hand washing and eye gtt administration that included handwashing. 4.The Director of Nursing and NurseManagers will complete the Medication Pass Skills Assessment Checklist on nurses weekly for one month then every month for three months then quarterly on-going. The Mediation Pass Skills Assessment Check lists will be brought to the monthly CQI meeting for review and recommendation. 5.Completion Date: 4-22-2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155611	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/06/2016
NAME OF PROVIDER OR SUPPLIER HOOSIER CHRISTIAN VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 621 S SUGAR ST BROWNSTOWN, IN 47220	

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	After reentering Resident #3's room, LPN #1 handed the resident her water and administered her oral medication. The LPN then listened to the resident's breath sounds and took the resident's heart rate. LPN #1 prepared Resident #3's nebulizer treatment by pouring the medication into the reservoir connected to the nebulizer mask. While lifting the mask towards the resident, the tubing connecting the nebulizer mask to the machine detached and hit the floor. LPN #1 picked up the tubing off the floor, reattached it to the nebulizer mask, and placed the mask on the resident for her treatment. Upon exiting the room, LPN #1 washed her hands for 13 seconds. During an interview on 04/05/2016 at 2:55 P.M., the DON (Director of Nursing) indicated medications were not to be handled with bare hands and that hands should be washed before and after glove use. She further indicated that gloves should be changed when picking something up off the floor and that oxygen tubing should be discarded if it hits the floor and new tubing should be used. The current facility policy, titled "How to Handwash?", was provided by LPN #2 on 04/05/2016 at 2:17 P.M. and was reviewed at that time. The policy			

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	indicated, "Duration of the entire procedure: 40-60 seconds..." The current facility policy, titled "Hand Hygiene" and dated 2013, was provided by the DON on 04/05/2016 at 3:10 P.M. and was reviewed at that time. The policy indicated, "...Hand hygiene must be performed after touching blood...after gloves are removed..." The current facility policy, titled "6.0 General Dose Preparation and Medication Administration" and dated 01/01/13, was provided by the DON on 04/05/2016 at 2:39 P.M. and was reviewed at that time. The policy indicated, "...Facility staff should not touch the medication when opening a bottle or unit dose package..." The current facility policy, titled "Ophthalmic Drops", was provided by the DON on 04/05/2016 at 2:40 P.M. and was reviewed at that time. The policy indicated, "...3. Wash hands...16. Document dose administered. Wash hands..." 3.1-18(l)			