STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155753	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON OAKS HEALTH CAMPUS	966 N WILSON RD SCOTTSBURG, IN 47170

(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
F000000	This visit was for a Recertification and State Licensure Survey. Survey Date: 8/4, 8/5, 8/6, 8/7, 8/8, 8/12, 8/13, 8/14, 8/15, 8/19, 8/20, 2013 Facility number: 004902 Provider number: 155753 AIM number: 200813130 Survey team: Gwen Pumphrey RN,TC Joan, Laux, RN (8/12 8/13,8/14,8/15,8/20,2013) Gloria Reisert, MSW (8/12,8/19,8/20, 2013) Nicole Wright, RN (8/4,8/5,8/6, 8/7, 8/8, 8/12,8/20, 2013) Census bed type: SNF: 17 SNF/NF:45 Residential: 23 Total: 85 Census payor type: Medicare: 21 Medicaid: 38 Private: 26 Total: 85 These deficiencies reflect state	F000000	September 9, 2013 Hampton Oaks Health Campus 966 North Wilson Road Scottsburg, Indiana 47170 Survey Event ID KE5W11 The submission of this Plan of Correction does not indicate an admission by Hampton Oaks 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 Hampton Oaks 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 (for Title 18/19 programs). Attached you will find our Plan of Correction for Hampton Oaks Health Campus for our annual revisit survey conducted on August 20, 2013. We initiated immediate intervention when concerns were identified on this date. We respectfully request paper review for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at (812) 752-2694. Sincerley,Brandy Royalty Executive Director	

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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	findings cited in accordance with 410 IAC 16.2. Quality Review completed on August 28, 2013 by Brenda Meredith, R.N.			

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F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and	F000225	It was identified that resident # 8	09/19/2013

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	interview, the facility failed to ensure all allegations involving verbal abuse were thoroughly investigated and reported immediately along with the results of the investigations within 5 working days to the Administrator/Director of Health Services (DHS) and to other officials in accordance with State law (including the State survey and certification agency) and the alleged perpetrator suspended during the investigation for 2 of 2 reportable incidents involving 1 resident for 1 of 1 resident reviewed for verbal abuse in a sample of 35 residents. (Resident #8). Findings included: During an interview with Resident #8 on 8/6/13 at 11:24 a.m., the resident indicated she had been yelled at by CRCA #8 (Certified Resident Care Assistant) and that the aide was verbally abusive to her because she had spoken with her roommate's daughter when the daughter had asked her a question about her mom's care. She indicated the CRCA had taken care of her roommate and then came back and yelled at her, telling her to "Mind her own business." The resident also		had reported to the ADHS on 6/27/2013 that an employee was verbally abusive to her. The ADHS failed to report the finding to DHS or ED. ADHS did however discuss the issue with the resident and staff and found that a nurse was in the room with the CRCA and that the incident alleged did not occur. On 8/20/2013 the issue was investigated and found to be unsubstantiated and was reported to the ISDH per facility policy. The ADHS was counseled on the policy and procedure of Abuse and Neglect on 8/28/2013. All staff in-service was conducted with 100% completion on 8/9/2013 of Abuse, Neglect, and burnout by DHS and SS. All concerns identified will be reviewed to ensure the Abuse and Neglect policy is being followed by ED when arise. Follow-up report will be reviewed in QA every month until substantial compliance is achieved. Any continued noncompliance will require development of action plans to include re-education and/or counseling as necessary.	

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	indicated that she has taken an interest in her roommate who needed total help and as a result, had befriended the roommate's daughter also. Review of a "Resident Concern" form completed on 6/27/13 by the Assistant Director of Health Services (ADHS) indicated the resident reported that a CNA yelled at her stating the staff were doing their job by changing her roommate and then spoke to her again after changing the roommate yelling at her and told her she had changed and turned her roommate. Documentation was lacking of the CRCA having been removed from caring for any other residents, of the incident having been immediately reported to the Administrator, of an investigation having been conducted and of an initial and 5 day follow up report of the allegation to State agencies and local Ombudsman. During an interview with the Director of Health Services on 8/8/13 at 1:00 p.m., it was reported to her that two residents had complained to the surveyors of a staff member yelling at and being rude to them. A "Resident Concern" form had then been			

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	completed on that date and indicated she was now investigating the issue. During an interview with the ADHS on 8/19/13 at 3:03 p.m., she indicated that after the resident had told her about her concern with the CRCA, she spoke with the CRCA who had told her she was just informing the resident that she was taking care of her roommate and providing what she needed. The ADHS indicated she had not suspended the CRCA after speaking with her as she did not believe it was abuse. When queried why there was a 6 week delay in speaking with the resident, she indicated that a lot had been going on around the time the resident had made the report and that although she should had followed up with the resident sooner, the concern just feel through the cracks until 8/9/13. She also indicated she reported the resident's concern to the Executive Director the next morning during the department head meeting. Documentation was lacking of the CRCA having been removed from caring for any other residents, of the incident having been immediately reported to the Administrator, of an investigation having been conducted			

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	and of an initial and 5 day follow up report of the allegation to State agencies and local Ombudsman. During an interview with the Executive Director on 8/20/13 at 10:25 a.m., she indicated she was unsure as to when she first heard about the incident involving Resident #8; if the incident had been reported to State; and what had been done with the CRCA after the ADHS had spoken to the resident. She was also unaware of what was done with the investigation after it had been reported to the DHS again on 8/8/13. On 8/19/13 at 2:20 p.m., the DHS indicated nothing had been reported to State about the 6/27/13 incident. On 8/13/13 at 4:39 p.m., the Executive Director presented a copy of the facility's current policy and procedure titled "Abuse and Neglect Procedure Guidelines." Review of the facility policy, on 8/19/13 at 9:45 a.m., included, but was not limited to: "Purpose:...2. The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures...4....c. Prevention...5. Staff is required to report concerns, incidents and			

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	grievances immediately to your manager and/or executive Director and Director of Health Services. d. Identification: ...ii. Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal...vii. The Executive Director is responsible for: 1. Notification to the State Department of Health (per State guidelines) [sic] and other agencies, which include the Ombudsman, Adult Protective Services and/or local law enforcement agencies, as indicated. e. Protection:...iv. Suspend suspected employee(s) pending outcome of investigation...." During an interview with the ADHS and the DHS on 8/20/13 at 11:15 a.m., they indicated the resident has a tendency to elaborate on stories and that in talking with the nurse on duty the night of 6/27/13, the nurse indicated it did not happen. They indicated the CRCA happened to be off that night and that after talking to her, they determined the incident did not happen and therefore did not need to report it to the State. They also indicated no resident or other staff interviews had been completed on 6/27/13 when the incident had first occurred.			

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	The ADHS also indicated she did not make the Administrator aware after the initial incident as she had handled it. The DHS indicated she did not report it to the Administrator also and had just done resident interviews with random residents to gain their insight into staff treatment. 3.1-28(c) 3.1-28(d)			

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F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement their Abuse Policy and Procedure on 2 of 2 occasions for an allegation of verbal abuse towards a resident in that the Administrator had not been notified immediately, an initial and 5 day follow up report to State Agencies and local Ombudsman and an investigation into the incident had not been completed, and the alleged abuser had not been suspended pending the investigations. (Resident #8) Finding included: During an interview with Resident #8 on 8/6/13 at 11:24 a.m., the resident indicated she had been yelled at by CRCA #8 (Certified Resident Care Assistant) and that the aide was verbally abusive to her because she had spoken with her roommate's daughter when she had asked her a question about her care. She indicated the CRCA had taken care of her roommate and then came back	F000226	Facility failed to follow-up on resident concern and follow facility policy on Abuse and Neglect. All staff in-service was conducted on 8/9/2013-8/10/2013 to re-educate on Abuse and Neglect policy and procedure as well as reporting guidelines, inservice competed by DHS. ADHS counseled on Abuse and Neglect policy and procedure and failure to accurately report to immediate supervisor on 8/28/2013. Investigation completed during survey on 8/20/2013 initial and 5 day reported to ISDH. DHS will interview staff 5 X per week X 4 weeks, then 3 X per week X 3 weeks, then 2 X week X 2 weeks, then will evaluate 5 employees X 1 month or until 100% compliance is achieved. Will report results in QA monthly until substantial compliance is achieved. Any continued noncompliance will required development of action plans to include re-education and/or counseling as necessary.	09/19/2013

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	and yelled at her, telling her to "Mind her own business." The resident also indicated that she has taken an interest in her roommate who needed total help and as a result, had befriended the roommate's daughter also. Review of a "Resident Concern" form completed on 6/27/13 by the Assistant Director of Health Services (ADHS) indicated the resident reported that a CRCA yelled at her stating the staff were doing their job by changing her roommate and then spoke to her again after changing the roommate yelling tat her and told her she had changed and turned her roommate. Review of the concern form indicated the staff were educated and reminded staff of Trilogy's expectation and that the ADHS had spoken with CRCA r/t (related to)resident's concern. The CRCA indicated she was not yelling at her, but rather was informing the resident about taking care of her roommate. Documentation was lacking of the CRCA having been removed from caring for any other residents, of the incident having been immediately reported to the Administrator, of an investigation having been conducted and of an			

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	initial and 5 day follow up report of the allegation to State agencies and local Ombudsman. Attached to the 6/27/13 concern form was an "Addendum to Resident Concern" form completed by the ADHS on 8/10/13, which indicated "Spoke with res [resident]. Apologize [sic] and listen to res concern. Res feels like her concern was not addressed. Explain to res that CRCA was questioned r/t her attitude that night stating she was not yelling at res. CRCA states she was informing her she change and turn [name of Roommate]. I told res her concern was being addressed at that time. Again, apologize to res for the delay follow-up. Res states she does not want CRCA to lose her job. She just wants her to know that she does not like her yelling. Res stated apology accepted and she feels better about the situation. Res give this nurse a hug and states Thank You." On 8/10/13, the CRCA also went to talk with resident and apologized to her, to which the resident had replied that it was a by gone and that they were still friends. During an interview with the Director of Health Services (DHS) on 8/8/13 at			

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	1:00 p.m., it was reported to her that two residents had complained to the surveyors of a staff member yelling at and being rude to them. A "Resident Concern" form had then been completed on that date and indicated she was now investigating the issue. The form indicated continued education and continued monitoring of stress in employees would be provided as well as providing open communication with staff and residents. On 8/9/13, a memo by the DHS was sent out informing the staff of a mandatory inservice being provided that day to address the resident's concerns. When asked if she felt like residents could voice concerns without fear during an interview with Resident #13, on 8/7/13 at 1:00 p.m., she indicated "I feel like the nurses cover the aides backs and vise versa. If a concern is mentioned, they would give the resident a hard time to go. And they can do it without anybody knowing." Resident would not share why she feels this way. During an interview with the ADHS on 8/19/13 at 3:03 p.m., she indicated that after the resident had told her about her concern with the CRCA,			

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	she spoke with the CRCA who had told her she was just informing the resident that she was taking care of her roommate and providing what she needed. The ADHS indicated she had not suspended the CRCA after speaking with her as she did not believe it was abuse. When queried why there was a 6 week delay in speaking with the resident, she indicated that a lot had been going on around the time the resident had made the report and that although she should had followed up with the resident sooner, the concern just feel through the cracks until 8/9/13. She also indicated she reported the resident's concern to the Executive Director the next morning during the department head meeting. Documentation was lacking of the CRCA having been removed from caring for any other residents, of the incident having been immediately reported to the Administrator, of an investigation having been conducted and of an initial and 5 day follow up report of the allegation to State agencies and local Ombudsman. Review of the Concern Binder on 8/19/13 at noon, indicated 37 of 40 residents interviewed on 8/9/13			

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	regarding staff treatment of residents had no issues with the staff. Of the 3 others who had issues, one had issues in which she felt a CRCA had yelled at her, another had felt a CRCA was a little abrupt but did not want to pursue it due to believing the CRCA was just a bit moody that day; and, the third resident was upset because the CRCA did not read her bathing preferences. During an interview with the Executive Director on 8/20/13 at 10:25 a.m., she indicated she was unsure as to when she first heard about the incident involving Resident #8; if the incident had been reported to State; and what had been done with the CRCA after the ADHS had spoken to the resident. She was also unaware of what was done with the investigation after it had been reported to the DHS again on 8/8/13. On 8/19/13 at 2:20 p.m., the DHS indicated nothing had been reported to State about the 6/27/13 incident. On 8/13/13 at 4:39 p.m., the Executive Director presented a copy of the facility's current policy and procedure titled "Abuse and Neglect Procedure Guidelines." Review of the Policy on 8/19/13 at 9:45 a.m.			

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	included, but was not limited to: "Purpose: Trilogy Health Services, LLC (THS) [sic], has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. Purpose:...2. The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures...4....c. Prevention...5. Staff is required to report concerns, incidents and grievances immediately to your manager and/or executive Director and Director of Health Services. d. Identification: ...ii. Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal...vii. The Executive Director is responsible for: 1. Notification to the State Department of Health (per State guidelines) [sic] and other agencies, which include the Ombudsman, Adult Protective Services and/or local law enforcement agencies, as indicated. e. Protection:...iv. Suspend suspected employee(s) pending outcome of investigation...." During an interview with the ADHS and the DHS on 8/20/13 at 11:15 a.m., they indicated the resident has			

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	a tendency to elaborate on stories and that in talking with the nurse on duty the night of 6/27/13, the nurse indicated it did not happen. They indicated the CRCA happened to be off that night and that after talking to her, they determined the incident did not happen and therefore did not need to report it to the State. They also indicated no resident or other staff interviews had been completed on 6/27/13 when the incident had first occurred. The ADHS also indicated she did not make the Administrator aware after the initial incident as she had handled it. The DHS indicated she did not report it to the Administrator also and had just done resident interviews with random residents to gain their insight into staff treatment. 3.1-28(a)			

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	155753	A. BUILDING 00 B. WING	08/20/2013

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F000250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observations, interview, and record review the facility failed to develop comprehensive care plans for residents receiving psychotropic medications. This deficient practice affected 1 of 10 sampled residents reviewed for unnecessary medications. (Resident #15). Finding include: Review of the medical record on 8/12/13 at 2:00p.m. indicated Resident #15 had a previous medical history including but not limited to immobility syndrome, diabetes, hyperlipidemia, osteoarthritis, and hypothyroidism. Resident #15 was prescribed lorazepam 0.5 mg po (by mouth) tid (three times a day) for generalized anxiety disorder and Lexapro 20mg po (by mouth) for depression. Review of the care plan lacked documentation regarding assessment of Resident#15's need for psychotropic medications. The care plan also lacked documentation	F000250	Resident # 15 who takes psychotropic medications was identified as not having psychotropic medications care-planned. Resident # 15 receives lorazepam 0.5 mg po tid for diagnosis of Anxiety and Lexapro 20 mg po for Depression. Care plan was reviewed and updated on 8/24/2013, by SS. SS was re-inserviced on policy and procedure, "Guidelines for Care Plan Development." A complete audit is currently being conducted on all residents by SS and any errors identified corrected with completion date 9/9/2013. SS will review all new admissions with 14d to ensure comprehensive care-plan is accurate and meeting their psychosocial needs. SS will review 5 charts every week x 3 months and report findings to QA until substantial compliance is achieved. Any continued noncompliance will required development of action plans to include re-education and/or counseling as necessary.	08/24/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155753	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2013
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	regarding behaviors displayed by resident to indicate the need for the psychotropic medications. Multiple observations of Resident #15 on 8/6/13, 8/7/13, 8/8/13, 8/14/13, and 8/15/13, interacting appropriately with staff and residents. Resident observed participating in activities and actively engaged. A copy of the policy titled "Guidelines for Care Plan Development" was provided on 8/13/13 at 4:39p.m. from the Executive Director. This policy indicated the care plan should address the resident preferences, MDS triggers, diagnoses, risk factors, and other applicable care needs. In an interview on 8/20/13 at 11:00a.m., the Social Services Director (SSD) indicated the psychotropic medications are monitored by the psychiatrist and pharmacist. The SSD indicated she is responsible for updated the residents care plan to reflect the use of psychotropic medications. 3.1-34(a)(1) 3.1-34(a)(2)			

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F000253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation, interview and record review, the facility failed to ensure resident's rooms were clean and in good repair, as evidenced by divider curtains being stained and dirty, bathroom and entry room doors being scratched, with gouges in the doors. This deficient practice affected 9 out of 36 resident rooms in the facility. (Rooms 103, 111, 202, 203, 204, 206, 208, 209, and 311) Findings include: On 8/13/13 at 11:00 a.m.-11:30 A.M., during an observation of all rooms on 100, 200,and 300 Halls, the following was observed: Room 111 ' s bathroom and entry door had multiple scratches/gouges. Room 202 ' s divider curtain was dirty and stained. Room 203 ' s bathroom and entry door was scratched. Room 204 ' s bathroom door was scratched. Room 206 ' s divider curtain was dirty and stained. Room 207 ' s divider curtain was dirty	F000253	On review it was identified that 9 out of 36 residents had soiled room dividers. All room dividers were taken down and laundered. Any room divider identified as stained was replaced with a new divider. As of 9/5/2013 all room dividers have been cleaned. Housekeeping cleaning assignments have been reviewed to ensure room dividers are included with deep clean rooms. All housekeeping personnel have been re-educated on cleaning assignments by Housekeeping supervisors and the responsibility to inspect room dividers daily while cleaning rooms. Housekeepers have been educated that if a divider is identified as being soiled to remove it and replace with a clean room divider and send soiled divider to laundry to be washed or replaced by housekeeping supervisor. Housekeeping supervisor will look at room divider in 5 rooms every day X 4 weeks, then 3 X per week X 3 weeks, then 2 X week X 2 weeks, then weekly. Housekeeping supervisor will report findings in QA monthly until substantial compliance is achieved. Any continued noncompliance will required	09/19/2013

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	and stained. Room 311 ' s bathroom door was scratched. On 8/13/13 at 11:35 a.m., during observation and interview with residents of the facility, the following was observed: every blind in each hallway, front entrance area, library, physical therapy room, and conference room had a moderate to large amount of dust on them. When this surveyor wiped blinds with her finger, the tip of finger was covered in dust from each blind that was tested. On 8/13/13 at 12:00 p.m., during an interview with the Director of Plant Operations, he indicated: "I do room checks every month, I check doors, lights, receptacles, and flooring. I make sure no flooring is coming up in the room and the bathroom. Every room every month is done. A lot of rooms don ' t need checked every month. When someone moves out we check the room, doors, floors, everything to make sure it's all fixed. I paint as needed when I find a door that is scratched up or the walls, but as soon as a door or something is painted, it gets all scratched up right away and looks like we didn't do anything."		development of action plans to include re-education and/or counseling as necessary. On review it was identified that 9 out of 36 residents rooms were noted to have scratches or gouges on doors. A complete audit was completed of facility doors dated 9/2/2013 by DPO. DPO or ED will continue to use the Preventative Maintenance Procedures as required by company policy. ED, DHS, or SDC will give an all staff in-service to re-educate all staff on completing a maintenance request if a door is identified in needing repair with completion date 9/19/2013. All maintenance requests will be reviewed by ED as completed. DPO or will ED evaluate one complete hallway daily X five days to identify repair of doors. DPO will report all findings to QA monthly until substantial compliance is achieved. Any continued noncompliance will required development of action plans to include re-education and/or counseling as necessary. On review it was identified that dust was identified in common areas within the facility. The cleaning assignments have been re-evaluated by the housekeeping supervisor to ensure blinds are being cleaned in all common areas including hallways daily. All housekeeping staff have been re-educated on the cleaning assignments by the	

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	On 8/13/13 at 12:10 a.m. during an interview with Environmental Assistant #1, she indicated: "We do the blinds about once or twice a month or if we see they need it, we clean it with this real sticky green stuff." "The curtains and dividers in resident's rooms we clean probably 2 or 3 times a month unless a resident for example throws up on it, or wipes their noses on it, we take it down right then when we find it and change it. We send it to the laundry. We get a clean one from laundry and put it right straight back up. Weekly we do all the hallways, other rooms." On 8/13/13 at 2:18 p.m., a review of the "Deep clean task list," dated 6/17/13, indicated "monthly cleaning including cubical curtain tracks, curtains, wipe down doors inside and out." On 8/13/13 at 2:25 p.m., a review of the Director of Maintenance's personal help sheets that he keeps for himself to show him what was repaired, it was indicated from January, 2013 to August, 2013 that he wrote on the bottom of sheet "paint" during the months of January and August and drew a line through the 100, 200, and 300 halls without indicating which rooms had been		housekeeping supervisor on 9/9/2013. The housekeeping supervisor will evaluate blinds in all common areas including hallways 3X weekly and it will be on-going. Housekeeping supervisor will report to QA monthly until substantial compliance is achieved. Any continued noncompliance will required development of action plans to include re-education and/or counseling as necessary.	

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	painted. On 8/13/13 at 2:26 p.m., a review of the "Housekeeping cleaning schedule," dated 5/18/13, indicated " weekly cleaning of hallways, front entrance, nourishment room, work room, nurse ' s station, library, conference room, door windows, and beauty shop." On 8/13/13 at 2:43 p.m., a review of the "Resident room daily task checklist" indicated no timeframe for cleaning or checking the cleanliness of curtains or dividing curtains in the resident's room. On 8/13/13 at 3:03 p.m., a review of the "Monthly maintenance inspection checklist of resident rooms" indicated that walls and doors were painted on the 400 and 500 halls in May, 2013; 200 and 300 halls in June, 2013; and, doors were painted on the 100, 200, 300, and 400 halls in July, 2013. The checklist did not differentiate which rooms were painted, just which halls. On 8/13/13 at 4:44 p.m., a review of the "Preventive Maintenance Procedures" indicated: " an annual maintenance calendar is provided to each campus that lists each task to be performed, the recommended			

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	frequency, and the time of year to perform them. Building interior schedule provided in this policy indicated doors are to be checked every month in the calendar year." On 8/14/13 at 8:59 a.m., a review of the "Job description for housekeeper" indicated no area that addresses cleaning or changing of soiled window curtains or divider curtains in resident's room. On 8/14/13 at 9:04 a.m., during an interview with the Director of Plant Operations, he indicated that the way he does maintenance is "I walk up and down each hall and go in to each room. If I see something that needs fixed, I have my cart of supplies with me and just do repairs right then and there." He indicated that he does not write down which room has what problems, the dates they were repaired, or what was repaired. On 8/14/13 at 9:20 a.m., a review of the "work order/description sheets" between the months of April, 2013 to August, 2013, it was indicated that room 103 and 209 had had a large chunk of the door missing. No indication was on the sheets that the doors had been repaired.			

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	During an observation of rooms 103 and 209, on 8/14/13 at 9:26 a.m., room 103 had on the bottom right portion of the door, an area approximately 5 x 5 inches covered with chunky, tan spackle. No paint was covering the repaired area, nor was the area smoothed out. The door of room 209 had a small 1 inch by 3 inch gouge out of it on the side of the door. It looked to be painted over, but not repaired. On 8/14/13 at 9:34 a.m., during an interview with the Executive Director, she indicated that the facility had no policy and procedure for the Housekeeping Department. "All we have is the job description." 3.1-19(f)			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F000309	It was identified that resident # 15 did not have proper assessment either before going to dialysis or returning to dialysis on 10 days between 6/26/2013 to 8/12/2013. Currently the campus has one dialysis resident. All nursing staff have been re-educated by DHS and SDC on the use of the dialysis form and the facility policy for a dialysis resident titled, "Guidelines for dialysis provider communication." Education will include importance of obtaining vital signs and pain assessment before and when returning to facility. DHS, ADHS, SDC, or MR will review dialysis chart 3 x weekly x 3 months and report findings to QA monthly until substantial compliance is achieved. Any continued noncompliance will required development of action plans to include re-education and/or counseling as necessary.	09/19/2013
	Based on record review and interview, the facility failed to ensure the residents received proper assessment with dialysis services. This deficient practice affected 1 of 1			

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	residents receiving dialysis services currently residing in the facility. (Resident #15) Findings include: 1. Review of the medical record, on 8/12/13 at 2:00p.m., indicated Resident #15 had a history including but not limited to COPD, diabetes, hyperlipidemia, immobility syndrome and hypothyroidism. Resident #15 received dialysis three days each week. Review of care conference notes, dated 7/10/13, indicated "res had a lfa [left forearm] shunt which has had some problems with patency now also has rt [right] clerical shiley for dialysis." Review of the nursing notes, dated 6/26/13, 7/1/13, 7/3/13, 7/5/13, 7/6/13, 7/21/13, 8/2/13, 8/5/13, 8/7/13 and 8/12/13, lacked accurate documentation regarding pre and post dialysis assessment related to vital signs, pain and complications with access sites. In an interview, on 8/12/13 2:28pm, LPN#1 indicated the night shift nurse gets the resident ready for dialysis. LPN#1 indicated the facility uses a			

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	dialysis form that nurses are to complete for pre dialysis and when the resident returns from dialysis the day shift nurse completes the dialysis form. In an interview, on 8/12/13 at 2:48p.m., the Assistant Director of Health Services [ADHS] indicated pre and post vitals stay in the residents medical record. When asked about communication between the dialysis center and the facility, the ADHS indicated sometimes the resident's labs are sent back and forth. Review of the binder titled "[NAMED RESIDENT] DIALYSIS RECORDS" on 8/12/13 at 2:48pm., a form for the dialysis center to complete with each dialysis visit was enclosed. Review of this form indicated the residents pre and post dialysis weight was documented. The ADHS indicated Resident #15 takes binder back and forth and the dialysis center completes the form. The policy titled "Guideline for dialysis provider communication" was received from the executive director on 8/13/13 at 4:39p.m. Review of this form indicated upon return from dialysis the facility should provide ongoing monitoring of the shunt site			

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	for signs of complication. In an interview, on 8/14/13 at 2:49p.m., Resident #15 indicated the access site was checked every other morning, "usually they do [check my site every other morning] but not every time." 3.1.-37(a)			

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F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to provide personal oral hygiene for 1 of 40 sampled residents. (Resident #146) Findings included: On 8/12/13 at 11:00 a.m., during a review of Resident#146's medical record, indicated diagnosis including, but not limited to lack of coordination, muscle weakness, congestive heart failure, dementia, and atrial fibrillation. On 8/12/13 at 11:15 a.m., during an interview with Resident # 146, she indicated that she can brush her teeth by herself. "I don't remember if the CNA's come and help me do it. Don't know how often I brush my teeth. I don't pay that much attention to it." On 8/12/13 at 11:15 a.m., during an interview with Resident # 146, white matter was observed in the corners of her mouth and her tongue had a film on it.	F000312	It was identified that 1 out of 40 residents were identified as having improper oral care. A complete audit has been completed on all residents ensuring proper oral care has been provided with zero findings of having improper oral care, completed on 9/9/2013. 9/19/2013 All nursing personnel will have been re-educated on importance of proper oral care and how to perform the task by DHS or SDC. DHS, ADHS, SDC, or MR will evaluate 6 residents daily x 4 weeks, then 3 residents daily X 3 weeks, then 1 resident daily X 2 weeks, then will evaluate 5 residents monthly X 1 month. Will report findings to QA every month until substantial compliance is achieved. Any continued noncompliance will require development of action plans to include re-education and/or counseling as necessary.	09/19/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155753	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2013
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	On 8/12/13 at 11:18 a.m., during an observation of Resident # 146's room, no toothbrush was observed in the bathroom. On 8/12/13 at 11:25 a.m., a review of the "Nursing Admission Assessment and Data Collection" form, dated 7/31/13, indicated Resident # 146 required assistance of one staff person for oral care. On 8/12/13 at 11:30 a.m., during an interview CRCA #1 (Certified Resident Care Assistant) indicated that "We brush her teeth in the morning when she allows us to. Sometimes with her dementia she refuses to allow us to." On 8/12/13 at 11:30 a.m., during an observation of Resident #146's room, accompanied by CRCA #1, the toothbrush was found in the resident's drawer when CRCA #1 opened the top bedside table drawer. The toothbrush was still in the original packaging. CRCA #1 was unable to provide any toothbrush that had been used to brush the resident 's teeth. The CRCA #1 indicated "I sure hope they brushed her teeth." On 8/12/13 at 11:40 a.m. during an			

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	interview with CRCA #2, she indicated that "3rd shift got her up this morning and they should have brushed her teeth because they got her up. That is how it is done. Whoever gets the resident up does mouth care." On 8/12/13 at 1:44 p.m., a review of the "CNA Bathing and Skin Sheet," dated 8/12/13, indicated mouth care was checked off as done. This bathing sheet was signed by CRCA #2. 3.1-38(a)(3)(c)			

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F000371 SS=F	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 Based on observations, interview and record review, the facility failed to ensure sanitary conditions in storage areas of the kitchen. This deficient practice potentialy affected 85 residents currently residing the facility. Findings include: During an observation, with the Assistant Dietary Manager, in the kitchen on 8/4/13 at 11:13a.m., paper pieces and food debris was noted on the bottom shelf of the Dinex storage cart used to store clean plate warmer lids. Debris was also noted on the bottom shelf of the plate warmer and on the bottom of the clean plate/bowl holder. During an observation on 8/12/13 at 11:35a.m., paper pieces and food debris noted on the bottom of the lid holder, food debris noted on the bottom shelf of the plate warmer, and food debris noted on the bottom of	F000371	On survey it was identified that the Dinex storage cart, the plate warmer, and the plate/bowel holder were all noted with paper and food debris on it for more than one day. On 8/12/2013 the ADFS manager identified the issue and reviewed the cleaning assignment. It was identified that the Dinex storage cart was not on a cleaning schedule and was added on that day. All 3 storage areas are on the cleaning assignment to be cleaned daily. The DFS completed an all dietary staff in-service to ensure understanding of cleaning assignment. All carts have been cleaned to ensure no further debris were noted at time it was identified at survey. DFS/ADFS will review cleaning assignment to ensure it is being completed 5 X week on going and report findings to QA monthly until substantial compliance is achieved. Any continued noncompliance will required development of action plans to include re-education and/or counseling as necessary.	09/19/2013

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	the clean plate/bowl holder. An interview with the Assistant Dietary Manager #1 on 8-12-13 at 11:55a.m., indicated he does not have the Dinex storage cart on the cleaning list. Review of the cleaning lists indicated the Dinex Storage Cart was not listed. The Assistant Dietary Manager #1 asked if he could add the Dinex Storage Cart to the cleaning list. The Assistant Dietary Manager #1 provided copies of the cleaning lists for the kitchen on 8-12-13 at 1:23p.m. An additional comment was handwritten at the bottom of one cleaning list that stated "Need to add Dinex Storage Cart to list." 3.1-21(i)(2)			

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F000431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview and record review, the facility failed to ensure medications were properly stored and labeled, and were not	F000431	On review it was identified that 3 of 5 halls observed for 2 of 2 improper labeling of medications, one medication expired on 8/19/2013, and improper storage	09/19/2013

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	expired, on medications carts for 3 of 5 halls observed for 2 of 2 observations. (Hall 100, 300 and 400) Findings include: A. On 8/19/13 at 9:49a.m. the following was observed on the 300 hall medication cart: 1. A medication named Flurometholone ophthalmic suspension 0.1% was found out of the box with no label to indicate resident name, physician, or direction for use. 2. A Humalog flex pen was found to have handwritten resident's name with no label to indicate physician or direction for use. 3. Two Glucagen kits were found without resident name, physician name, or direction for use. 4. A box of 19 vials of Duonebs were found without a resident name, physician name, or direction for use. 5. A 8oz (ounce) can of Beneprotein was found without a resident name, physician name, or direction for use. The can had an expiration date of 02/2013. 6. A vial of bludgeoned was found out of the package without a resident name, physician, or direction.		of medications. A cleaning assignment was initiated to ensure audit of medication cart is perform weekly. All nursing staff have been educated on what to look for when auditing medication cart by DHS/SDC. Nursing will be educated by DHS/SDC on proper labeling of medications and what consists of proper labeling of all medications with completion date of 9/19/2013. Nursing is not to accept in proper labeled medications. All nursing staff have been educated by DHS/SDC on expiration dates completion date 9/19/2013. Reference sheet is available both in medication room and in MAR to ensure all vials and liquids opened have not been expired. Nursing staff have been educated by DHS/SDC that if a loose pill has been identified in the medication cart to dispose medication as indicated based upon medication found. Cart will be audited weekly by nursing staff where they will initial completion of audit. DHS, ADHS, SDC, or MR will audit medication carts weekly. All findings will be reported in QA every month until substantial compliance is achieved. Any continued noncompliance will require development of action plans to include re-education and/or counseling as necessary.	

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	The medication cart also had sediment and loose pills in the bottom of the drawers. In an interview on 8/20/13 at 10:00a.m., LPN#4 was unable to indicate who the medications belonged to. LPN#4 indicated the medication carts are supposed to cleaned by the night shift nurse. B. On 8/219/13 at 10:30a.m., the following was observed on the 100 hall medication cart: 1. Multiple medications loose in the bottom of the drawers, sediment in the drawer. In an interview, LPN #5 acknowledged the loose pills but did not remove them from the medication cart. LPN#5 indicated the medication carts are "deep cleaned every couple of weeks" C. On 8/19/13 at 3:45p.m., the following was observed on the 400 hall medication cart: 1. A vial of Novolog insulin with an open date 7/19/13. A label "Expiration in 28 days" was on the bottle. 2. An over the counter bottle of			

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	Fish Oil 100mg (milligrams) was without a label to indicate physician name and direction for use. 3. An over the counter medication, Hydrocortisone Cream was handwritten "401" In an interview on 8/19/13 at 3:35p.m., LPN#6 indicated over the counter medications were labeled with the name only. LPN#6 also indicated the Novolog insulin was expired. LPN#6 indicated the hydrocortisone cream should have been returned to the family because the medication from the pharmacy had arrived. A copy of the policy titled "Medication Storage in the Facility" was provided, on 8/20/13 at 11:12a.m., by the DHS. This policy indicated....outdated, contaminated, or deteriorated medications are immediately removed from stock.... The policy also indicated medication storage areas are to be kept clean. 3.1-25(j) 3.1-25(o)			

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F000441 SS=F	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 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. A. Based on observation, interview and record review, the facility failed to	F000441	It was identified that 2 of 5 residents were affected due to the	09/19/2013

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	properly clean glucometers in between use of residents requiring blood glucose monitoring. This deficient practice affected 2 of 5 residents observed for blood glucose monitoring. This deficient practice had the potential to affect 10 residents currently residing in the facility receiving frequent blood glucose monitoring. (Resident #17 and Resident #29) B. Based on observation, interview and record review, the facility failed to properly clean equipment for residents receiving nebulizer treatments. This deficient practice affected 1 of 1 residents observed. This deficient practice had the potential to affect 14 residents receiving nebulizer treatments currently residing in the facility. (Resident #8) C. Based on record review and interview, the facility failed to maintain an infection control program that effectively investigated and monitored trends of residents with infections not requiring antibiotics. The facility also failed to follow up with residents requiring antibiotics for infection. This deficient practice had the potential to affect all residents residing in the facility. (Resident #54)		deficient practice of disinfecting the glucometer in between each resident. All nurses re-educated on the policy of disinfecting the glucometer using the sani-wipes in between each resident by DHS/SDC, with completion date of 9/9/2013. Return demonstration was completed with 100% compliance. DHS, ADHS, SDC, or MR will audit 5 X weekly X 4 weeks, then 3 X weekly X 3 weeks, then 2 X weekly X 2 weeks, then 1 X weekly X 1 month and report findings to QA monthly until substantial compliance is achieved. Any continued noncompliance will require development of action plans to include re-education and/or counseling as necessary. It was identified that 1 of 1 resident did not have their nebulizer cleaned properly in between each use. Scheduled respiratory in-service will be completed by 9/19/2013 on the proper cleaning of the nebulizer based upon manufactures guidelines. Return demonstration was completed to ensure understanding of proper cleaning was learned with 100% compliance, competed by 9/19/2013. DHS, ADHS, SDC, or MR will audit 5 X weekly X 4 weeks, then 3 X weekly X 3 weeks, then 2 X weekly X 2 weeks, then 1 X weekly X 1 month and report findings to QA monthly until substantial compliance is achieved. Any	

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	Findings include: A.1. On 8/13/13 at 4:04p.m., LPN #4 was observed not cleaning the glucometer after use on Resident # 29 and before use on Resident #17. In an interview on 8/14/13 at 12:03p.m., LPN#5 indicated glucometers are to be cleaned with Sani-wipe cloths before and after each use. In an interview on 8/19/13 at 3:35p.m. LPN#6 indicated glucometers are to be cleaned with Sani-wipe cloths before and after each use. A copy of the policy titled, "Glucometer Cleaning Guidelines" was provided on 8/14/13 at 3:43p.m. by the DNS (Director of Health Services). The policy indicated if not visible organic material is present, disinfect after each use the exterior surfaces following the manufacturer's directions using a Sani-cloth bleach wipe. The policy also indicates alcohol should not be used. B.1. On 8/14/13 at 11:50a.m., LPN #3 administered a duoneb nebulizer treatment to Resident #8. LPN#3		continued noncompliance will require development of action plans to include re-education and/or counseling as necessary. It was identified that the Infection Control log did not have accurate information to ensure adequate tracking to identify trending on units or to identify different wounds. A new log has been created to help provide adequate tracking. DHS or ADHS will log all untreated infections and those infections being treated by identifying the residents name, type of organism, date of finding, location of organism, treatment order (to include: name of drug, route, dose, frequency, and stop date), room #, and follow-up, if indicated my MD. Infections will continue to be tracked daily. Findings will be reported in QA monthly by DHS/ADHS until substantial compliance is achieved. Any continued noncompliance will require development of action plans to include re-education and/or counseling as necessary.	

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	removed the face mask to empty vial of medication. Observed clear liquid substance in mask before LPN#3 emptied medication into canister. LPN#3 did not clean the nebulizer equipment before or after use. In an interview when asked how the face masks are cleaned, LPN#3 indicated the face masks "are changed out weekly." A copy of the policy titled,"Specific Medication Administration Procedures" was provided by the DHS on 8/20/13 at 11:12a.m. This policy indicated administering medications through a handheld nebulizer to rinse and disinfect the nebulizer equipment after treatment. C.1. In an interview with the DHS, on 8/14/13 at 2:11p.m., indicated the infection control program is monitored on the computer and meetings are held monthly. The DHS indicated she monitors physician orders and if a resident is prescribed an antibiotic "we find out why and see if there's a trend. If there is a trend we will address it in QA [Quality Assurance]. If a resident does not have an antibiotic, we will put it on the			

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	calendar but its not on the log ." The DHS indicated the computer system has been in use since January 2013. She provided a copy of the log for August 2013. Documentation was lacking about what type of follow up was done on those incidents. When asked to show how to tract different types of infections, she was unable to provide the information. When asked to show the trends of infections on the different units, she was unable to provide the information. On 8/14/13 at 3:10p.m., the DHS along with RN#1 indicated when a resident is prescribed an antibiotic a nurse completes a circumstance forms that the nurses document follow up information on. The DHS indicated if there was a need to update information into the computer "we will enter it there also. I use the circumstance binder every day in the morning and when the it [infection] is resolved I put the form in the resident's chart. The nurses know to chart on these for 72 hours." Review of the circumstance binder, on 8/14/13 at 3:16p.m., indicated			

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	Resident #54 was the only circumstance form in the binder related to infection control. The resident was prescribed an antibiotic, Keflex 500 mg (milligrams) po (by mouth) BID (twice daily) until 8/22/13. When the computer information was reviewed related to the resident's urinary tract infection, the only information documented was "Keflex." Documentation was requested from the DHS, on 8/14/13 and 8/15/13, related to infection control log, including trends, and follow up. Upon exiting the facility on 8/20/13 the information requested was not provided. A copy of the policy titled, "Infection Control Surveillance," was provided on 8/14/13 at 3:43p.m. by the DNS. The policy indicated the the facility should regularly conduct surveillance to collect, collate and analyze data on nosocomial infections to prevent rises, clusters, and to plan prevention control activities and educational programs. 3.1-18(b)(1)(A) 3.1-18(3)			

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R000000	The following residential deficiencies were cited in accordance with 410 IAC 16.2-5.	R000000	September 9, 2013 Hampton Oaks Health Campus 966 North Wilson Road Scottsburg, Indiana 47170 Survey Event ID KE5W11 The submission of this Plan of Correction does not indicate an admission by Hampton Oaks 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 Hampton Oaks 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 (for Title 18/19 programs). Attached you will find our Plan of Correction for Hampton Oaks Health Campus for our annual revisit survey conducted on August 20, 2013. We initiated immediate intervention when concerns were identified on this date. We respectfully request paper review for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at (812) 752-2694. Sincerley,Brandy Royalty Executive Director	

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R000117	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there was 1 staff member who was First Aid Certified on duty at all times for 8 of 17 survey days reviewed. This deficient practice had the potential to affect 23 of 23 Residential Residents currently residing in the facility. Findings included: Review of the Facility Staff	R000117	It was identified that 10 out of 17 days the facility failed to have at least one staff member scheduled that was first aide certified. On 8/20/2013 the SDC was educated on the state regulation. All nursing personnel was audited for first aide certification. SDC identified that and 12 out of the 78 were certified in first aide. As of 8/30/2013 there is at least one person on Assisted Living who is first aide certified. As of 9/19/2013 all nursing personnel	09/19/2013

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	As-Worked schedule between 8/4/13 and 8/20/13 on 8/20/13 at 3:00 p.m., indicated the following days had no personnel who were First Aid certified: - 8/5/13 = second shift - 8/8/13 = third shift - 8/9/13 = third shift - 8/10/13 = second and third shifts - 8/12/13 = second shift - 8/13/13 = second shift - 8/15/13 - second and third shifts - 8/16/13 = second shift - 8/19/13 = second and third shifts During an interview with the Staff Development Coordinator on 8/20/13 at 3:30 p.m., she indicated that the facility had a First Aid certification class scheduled for 8/6/13 with the local fire department but had canceled it due to the facility being in the middle of the survey process.		will have completed the first aide certification. SDC will review staff certification monthly to ensure certifications stay within compliance. SDC will review nursing schedule daily to ensure that at least one staff member every shift is certified in first aide. All nursing staff have been educated on maintaining certification. SDC will audit compliance monthly and report findings to QA monthly until substantial compliance is achieved. Any continued noncompliance will required development of action plans to include re-education and/or counseling as necessary.	

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R000273	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 observations, interview and record review, the facility failed to	R000273	On survey it was identified that the Dinex storage cart, the plate warmer, and the plate/bowel holder were all noted with paper and food debris on it for more than one day. On 8/12/2013 the ADFS manager identified the issue and reviewed the cleaning assignment. It was identified that the Dinex storage cart was not on a cleaning schedule and was added on that day 8/12/2013. All 3 storage areas are on the cleaning assignment to be cleaned daily. The DFS completed an all dietary staff in-service to ensure understanding of cleaning assignment on 9/6/2013. All carts have been cleaned to ensure no further debris were noted at time it was identified at survey. DFS or DFS assistant will review cleaning assignment to ensure it is being completed 5 X week on going and report findings to QA monthly until substantial compliance is achieved. Any continued noncompliance will required development of action plans to include re-education and/or counseling as necessary.	09/09/2013

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	ensure sanitary conditions in storage areas. This deficient practice affected 85 residents currently residing the facility. Findings include: During an observation in the kitchen on 8/4/13 at 11:37a.m., paper pieces and food debris were noted on the bottom shelf of the Dinex storage cart used to store clean plate warmer lids. Debris was also noted on the bottom shelf of the plate warmer and on the bottom of the clean plate/bowl holder. During an observation on 8/12/13 at 11:35a.m., paper pieces and food debris were noted on the bottom of the cart. Food debris was noted on the bottom shelf of the plate warmer and food debris was noted on the bottom of the clean plate/bowl holder. An interview with the Assistant Dietary Manager #1 on 8/12/13 at 11:55a.m., indicated he does not have the Dinex storage cart on the cleaning list. Copies of the cleaning lists that are used for the kitchen was requested. The Dinex Storage Cart is not on the list to be cleaned. Copies of the cleaning lists were			

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	received from the Assistant Dietary Manager on 8/12/13 at 1:23p.m. The lists include the plate warmer for cleaning and the plate/bowl holder for cleaning. The list does not include the Dinex storage cart. An additional comment is written at the bottom of one cleaning list that states "Need to add Dinex Storage Cart to list."			

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R000301	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, interview and record review, the facility failed to ensure medications were properly labled on 1 of 1 medications carts observed on 1 of 1 observations. This deficient practice had the potential to affect all residents currently residing the facility. Findings include: On 8/19/13 at 11:00a.m., an observation of the residential medication cart on indicated: 1. Two bottles of Lantanoprost ophthalmic solution hand written "Named resident." The back of the box had a partial pharmacy label with a different name. LPN #7 indicated the medications were from a mail	R000301	On review it was identified that 1 of 1 residents medication was labeled incorrectly. Medication pulled from the medication cart and a new supply of eye drops were ordered with accurate labeling. A complete audit was conducted to ensure that all residents medications were correctly labeled on 9/9/2013. A cleaning assignment was created for the nursing staff and the medication cart audit has been added. All nurses and QMAs will be in-serviced on cleaning assignment and proper way to audit medication carts for compliance by DHS or SDC. Pharmacy has been requested to review medication carts at least every quarter to ensure accuracy and provide report to DHS. DHS, ADHS, SDC, or MR will do cart audits weekly ongoing and report findings to QA every month until	09/19/2013

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	order pharmacy and were sent in a family members name.		substantial compliance is achieved. Any continued noncompliance will required development of action plans to include re-education and/or counseling as necessary.	

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R000302	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation, interview and record review, the facility failed to ensure medications were properly labled on 1 of 1 medications carts observed on 1 of 1 observations. This deficient practice had the potential to affect all residents currently residing the facility. Findings include: On 8/19/13 at 11:00a.m., an observation of the residential medication cart on indicated: 1. Over the counter Systane eye drops handwritten " Named Resident. " 2. One bottle of over the counter aspirin 325 mg (milligrams) with no label to indicate resident name, physician name, or direction direction for use. LPN #7 indicated the family brought in the wrong dose and it would be returned to the family at a later time. LPN#7 indicated extra medications should be stored in the	R000302	It was identified that 5 different medications were identified has being improperly labeled. All carts have been audited and all medications identified without the proper labeling have been removed from carts and medications re-ordered for proper labeling as of 9/9/2013. An all nursing staff in-service will be conducted by DHS and SDC to re-educate the nurses on making sure that all medications must include the residents name, Md, prescription #, name and strength of drug, directions of use, date of issue and expiration date, and name and address of pharmacy by 9/19/2013. A cleaning assignment has been initiated to ensure that auditing the medication cart for proper medication labeling was started and all nursing staff have been educated on new system as of 9/19/2013. The DHS, SDC, ADHS, or MR will do a weekly medication cart audit ongoing and report findings to QA every month until substantial compliance is achieved. Any continued noncompliance will required development of action plans to	09/19/2013

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	medication storage room. 3. A bottle of over the counter acetaminophen marked " Named Resident" on bottle twice and " TID " (three times a day) on the bottle cap. LPN#7 indicated she had just received a new new physician order and had just received the medication. 4. Rexall Ear Wax Remover Kit had no identifying information. LPN#7 was unable to identify who the medication belonged to. 5. Over the counter vision formula, over the counter hair, skin, nails and over the counter potassium gluconate had no identifying information. LPN #7 indicated the belong to Resident but the resident is no longer receiving the medications. LPN#7 indicated the medication should have been disposed of or sent back to the family.		include re-education and/or counseling as necessary.	