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
	155357		05/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS HOUSE HEALTH & LIVING COMMUNITY	300 J H WALKER DR PENDLETON, IN 46064

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F 000 Bldg. 00	This survey was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: May 11 - 15 & 18, 2015 Facility number: 000248 Provider number: 155357 AIM number: 100291470 Census bed type: SNF/NF: 85 Residential: 52 Total: 137 Census payor type: Medicare: 19 Medicaid: 59 Other: 59 Total: 137 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. -3.1.	F 000	This plan of correction is to serve as Fall Creek Retirment Village's credible allegation of compliance. Fall Creek Retirment Village respectfully requests a desk review from the Indiana State Department of Health to confirm the facility has achieved compliance by June 9, 2015. Submission of this plan of correction does not constitute an admission by Fall Creek Retirment Village or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	
F 329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary			

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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	drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, record review, and interview, the facility failed to ensure a resident who received psychoactive medications had behavior indicators for the use of the medications for 1 of 5 residents reviewed for unnecessary medications. (Resident #53) Findings include: During an observation on 5/12/15 at 7:49 a.m., Resident #53 was lying in bed with her eyes closed. During an observation on 5/15/15 at 10:35 a.m., Resident #53 was lying in bed with her eyes closed.	F 329	This plan of correction is to serve as Rawlin's House Community's credible allegation of compliance. Rawlin's House respectfully requests a desk review from the Indiana State Department of Health to confirm the facility has achieved compliance by June 9, 2015. Submission of this plan of correction does not constitute an admission by Rawlin's House Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations l. Resident # 53 has had medication review by	06/09/2015

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	During an observation on 5/14/15 at 1:48 p.m., Resident #53 was sitting in the dining room when invited to attend an activity and began walking down the hallway with staff. During an observation on 5/18/15 at 8:44 a.m., Resident #53 was sitting in the dining room, eating her breakfast. The clinical record for Resident #53 was reviewed on 5/13/15 at 1:42 p.m. Diagnoses for Resident #53 included, but were not limited to, Alzheimer's disease, bipolar, and depression. Current physician's orders for Resident #53 included, but were not limited to the following orders: a. Celexa (an anti-depression medication) 0.5 milligrams (mg) by mouth every day. The original date of this order was 12/22/14. b. Seroquel (an antipsychotic medication) 25 mg by mouth every bedtime. The original date of this order was 4/30/15. Resident #53 had a, 11/13/14, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was rarely or		MD with documention placed in the medical record to include behavioral indicators appropriate for the prescribed use of seroquel II. Other residents who use antipsychotic medications have the potential to be affected by the deficient practice. Those residents with antipsychotic medication use were reviewed on for the presence of appropriate behavioral indicators to ensure compliance Education will be provided to licensed nurses regarding F329 Unnecessary Drugs and Facility Behavior Management Program. Social service director or designee does review of above with all new licensed nurses upon hire during orientation. III. Education will be provided to licensed nurses regarding F329 Unnecessary Drugs and Facility Behavior Management Program. Social service director or designee does review of above with all new licensed nurses upon hire during orientation. IV. The DON or designee will audit all residents with current orders for an antipsychotic medication for appropriate behavioral indicators weekly x 4 weeks, then monthly x 5 months, then quarterly x 6 months to total 12 months of monitoring. Results of report findings will be reported to the QA committee quarterly. After 100% compliance is reached the QA committee will determine the frequency of continued	

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	never understood. The assessment indicated the resident showed no signs or symptoms of delirium. The staff mood assessment of Resident #53 indicated no symptoms of depression were present. Resident #53 had a 1/26/15, quarterly, MDS assessment which indicated Resident #53 had severe cognitive impairment. The assessment indicated the resident showed no signs or symptoms of delirium. The resident mood interview completed for Resident #53 indicated no symptoms of depression were present. Review of the "Post Behavior IDT [Interdisciplinary Team]" forms, from December 2014, indicated Resident #53 had 2 behaviors (12/14/14 at 8:14 a.m., refused meals, and 12/15/14 at 9:47 a.m., resident not feeling good and refused to get up). Resident #53 refused 3 meals out of 93 meals in the month of December. A nurse's note entry, dated 12/22/14 at 10:00 a.m., indicated Resident #53 had a new order of Celexa 5 mg once a day by mouth. A fax to the physician for Resident #53 dated 11/21/14 indicated "Celexa 5 mg GDR [Gradual Dose Reduction] was successful. Can we d/c [discontinue]" The physician agreed. A		monitoring. The compliance date for this tag is June 9thth, 2015. The facility respectfully disagrees with this citation. The facility feels that the behavior indicators displayed by the resident were appropriate for the use of the medication.	

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	sticky note on the fax, undated, indicated Celexa decreased in fall 2014, discontinued in 11/2014, restarted in 12/2014 with behaviors in notes. A nurse's note entry, dated 12/23/14 at 11:39 a.m., indicated writer spoke with Resident's #53 daughter "who states she has noticed a decline in residents [sic] level of function since d/c of Celexa, dtr [daughter] wishes for order to not be changed again and document as failed GDR. MD [Medical Doctor] agrees" Nurse note entries, dated 12/1/14 at 2:49 a.m., 12/1/14 at 3:02 p.m., 12/2/14 at 2:42 a.m., 12/2/14 at 2:07 p.m., 12/2/14 at 8:44 p.m., 12/3/14 at 9:05 a.m., and 12/4/14 at 6:55 p.m., indicated no signs, symptoms, or verbal expression of depression. A nurse's note entry, dated 12/8/14 at 9:31 p.m., indicated Resident #53 was complaining of not feeling well. The resident had a hoarse voice, cough and temperature of 100.2. New order from physician for an antibiotic. Nurses notes reviewed from 12/9/14 to 12/21/14, indicated Resident #53's daughter had asked if resident should be sent to the hospital due to lethargy and decline. Intravenous (IV) fluids had been			

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	ordered. Resident #53 removed the IV on her own. Resident #53 continued to have a poor appetite and moist cough. An antibiotic for a upper respiratory infection was ordered on 12/11/14, then another antibiotic was ordered later in the day for seven days. An as needed medication was ordered for nausea. Resident #53 continued to have a moist, non-productive cough and confusion on 12/13/14. Resident #53 found sitting on the floor at 4:30 a.m. on 12/13/14. Laboratory tests ordered, and moist, non-production cough continued. An entry on 12/21/14 indicated the resident was no longer on the antibiotic. Review of the "Post Behavior IDT [Interdisciplinary Team]" forms, for April 2015, indicated Resident #53 had 4 behaviors (4/2/15 at 8:13 a.m., refused breakfast, 4/13/15 at 12:05 p.m., refused breakfast, 4/20/15 at 1:00 p.m., refused shower, and 4/29/15 at 10:11 a.m., resident complained of stomach ache and refused lunch). Resident #53 refused one shower and 3 meals out of 90 meals in the month of April. A fax to the physician for Resident #53, dated 4/29/15, indicated "Resident having increased behaviors of refusing meals, sleeping all day, increased confusion, and agitation. Resident had Seroquel 25 mg			

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	po [by mouth] q [every] HS [bed time] D/c'd [discontinued] on 4/4/15 as GDR, behaviors slowly increasing this week, urine dipstick was normal, may we restart Seroquel? [per Dtr request]" The physician agreed. New order for Seroquel 25 mg by mouth every bedtime. Nurse note entries, dated 4/4/15 at 1:27 p.m., 4/5/15 at 2:26 p.m., 4/5/15 at 12:28 p.m., 4/6/15 at 7:07 a.m., 4/6/15 at 3:46 p.m., 4/7/15 at 2:53 a.m., 4/7/15 at 2:33 p.m., 4/8/15 at 12:49 a.m., 4/9/15 at 5:25 a.m., 4/9/15 at 4:08 p.m., 4/10/15 at 2:05 a.m., 4/10/15 at 10:00 a.m., 4/11/15 at 2:18 a.m., 4/11/15 at 4:10 p.m., 4/12/15 at 4:44 a.m., 4/12/15 at 9:44 a.m., 4/13/15 at 4:57 a.m., 4/14/15 at 10:15 a.m., 4/15/15 at 3:33 a.m., 4/15/15 at 11:31 a.m., 4/16/15 at 6:19 a.m., 4/16/15 at 1:27 p.m., 4/17/15 at 12:11 a.m., 4/17/15 at 10:46 p.m., 4/18/15 at 1:34 p.m., 4/19/15 at 1:34 a.m., 4/20/15 at 2:15 a.m., 4/20/15 at 12:33 p.m., and 4/21/15 at 5:16 a.m., indicated no behaviors for Resident #53. A Social Services progress note, dated 4/28/15, at 11:40 a.m., indicated the Social Services Assistant met with Resident #53 for her Quarterly assessment. The assessment indicated "Resident has no hallucinations, delusions, or delirium noted in nursing			

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	notes or observed in the last 7 days." The assessment further indicated "Resident has no behaviors noted in progress notes in last 7 days. Resident has no mood indicatiors [sic] noted in nursing notes in last 14 days." An assessment for depression was completed which indicated the resident did not exhibit any signs of depression. During an interview on 5/13/14 at 2:11 p.m., the Director of Nursing (DON) indicated they were working on reducing the antipsychotic medications and then they will move to the anti-depressant medications. During an interview on 5/18/15 at 10:43 a.m., the DON indicated the refusals and isolation were the behavior indicators for Resident #53's Celexa and Seroquel. She indicated they did not want the resident to lose weight or her behaviors to worsen. Review of the current facility policy, dated 10/2013, titled "Behavior management program", provided by the DON on 5/18/15 at 9:29 a.m., included, but was not limited to, the following: "...Unnecessary drugs Each resident has the right to be free from unnecessary drug consumption			

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	which is defined as:... ...Ineffective monitoring No indication for use... ...Anti-psychotic medications... ...Criteria The diagnosis alone does not support the ongoing use of anti-psychotic medications, the resident must also meet one of the following criteria: The symptoms are identified as being caused by the diagnosis. The behavioral symptoms are putting the resident, family, other residents or staff at risk for harm. The resident is experiencing one or more of the following distressful behaviors: fear, continuously yelling, screaming, crying, significant decline in function and withdraw from fundamental care and health needs like eating, bathing or hygiene that could result in a negative outcome.... ...Reduction... ...If a dose reduction is clinically contraindicated the physician will document the clinical rationale why a reduction would likely impair the residents ability to function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder which may lead to the resident being in danger of harming self or others...."			

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	3.1-48(a)(4)			
F 371 SS=F Bldg. 00	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 observation, interview and record review, the facility failed to serve food under safe sanitary conditions related to the disposal of out-dated food items, cleanliness of the kitchen, and dry storage room floors and the food handling during preparation and serving. This deficient practice had the potential to impact 84 of 84 residents who ate meals which were prepared in the facility's kitchen. Findings include: 1. During the initial kitchen tour on 5/11/15 at 9:13 a.m., the following concerns were noted: a. Dried brown debris spots on the kitchen floor b. Multiple (greater than 20 linoleum) damaged floor tiles (broken and cracked)	F 371	I. No residents were identified as having been affected. II. All residents who are served their meals from the kitchen have the potential to be affected. a. The dried brown debris spots on the kitchen floor have been cleaned and removed b. The damaged floor tiles have been fixed or replaced and the debris in the cracks has been cleaned and removed c. The wall in the dry storage room has been repaired and the plaster has been replaced d. The expired buttermilk was immediately discarded	06/09/2015

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	with dark brown/black debris noted in the cracks c. The wall in the dry storage room had an area of missing plaster approximately 20 inches by 10 inches along the baseboard d. Eight half gallon containers of buttermilk in the refrigerator had a received date of 4/8/15 and expiration date of 4/29/15 e. One opened bag of diced meat was not labeled and had no open date f. One opened bag of bread sticks had no open date g. One opened package of unlabeled sliced meat had no open date h. Dark brown/black debris was noted along the baseboards in kitchen and supply room. i. The kitchen floor was sticky j. Cook #3 had facial hair noted in prep area with no facial hair covering k. Debris under racks in dry storage and behind kitchen storage along the baseboards.		e. The opened bag of diced meat was discarded f. The opened bag of bread sticks was discarded g. The opened package of unlabeled sliced meat was discarded h. The dark brown and black debris was noted along the baseboards in the kitchen and supply room was cleaned and removed i. The kitchen floor was cleaned and is no longer sticky j. Cook #3 was instructed to wear facial hair covering while in the kitchen area and donned a facial hair covering immediately k. The debris under the racks in dry storage and behind kitchen storage along the baseboards was cleaned and is no longer there l. Cooks #2 and #3 were re-educated on the policy to wear facial hair covering while serving food III. All dietary staff will be offered education on the following:	

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	During an interview on 5/11/15 at 9:13 a.m., the Director of Dining Services indicated food handlers with facial hair should wear facial hair covering. The Director of Dining Services acknowledged the floors were not clean and in need of repair. The Director of Dining Services was unable to provide the date the floors had last been stripped and waxed. During a kitchen tour on 5/11/2015 at 11:30 a.m., Cook #2 and Cook #3 were observed plating food. Both cooks had facial hair and neither of them were wearing facial hair covering. During an observation on 5/15/15 at 8:00 a.m., Cook #3 was observed plating breakfast while not wearing facial hair covering. Review of the cleaning schedule for May 2015 was provided by the Director of Dining Services on 5/18/15 at 9:00 a.m., and indicated the floor in the kitchen and the dry storage had last been swept and mopped on 5/10/15. Review of the housekeeping floor cleaning schedule for March, April, and May, 2015 was provided by the Administrator on 5/14/15 at 2:00 p.m.		. Food labeling and dating . Discarding outdated food items .Cleaning schedules .Facial hair covering The systemic change includes the following: a. The dried brown debris spots on the kitchen floor have been cleaned and removed b. The damaged floor tiles have been fixed or replaced and the debris in the cracks has been cleaned and removed c. The wall in the dry storage room has been repaired and the plaster has been replaced d. The expired buttermilk was immediately discarded e. The opened bag of diced meat was discarded f. The opened bag of bread sticks was discarded g. The opened package of unlabeled sliced meat was discarded h. The dark brown and black debris was noted along the	

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	The Administrator indicated housekeeping was responsible for stripping and waxing floors in the facility. The cleaning schedules indicated the kitchen and dry storage room floors had not been on the schedule for stripping and waxing. Review of the current 2012, policy titled "Cleaning of Floors", provided by the Director of Dining Services on 5/18/15 at 9:00 a.m., indicated the following: "...Policy: Floors in the department are kept free of debris and cleaned daily. Procedure: ...3. Spills are wiped up immediately...." Review of the current 2012 , policy titled "Personal Hygiene", was provided by the Director of Dining Services on 5/18/15 at 9:00 a.m., and indicated the following: "...Policy: Staff involved in storing, preparing, distributing and serving food to residents practice habits of good personal hygiene to protect residents from contamination and food borne illness. Standards of personal hygiene reflect federal, sate and local requirements. Procedure: ... 2. A hair restraint that effectively covers head and/or facial hair (moustache and/or beard), is worn in food preparation areas. Hair is arranged to prevent contamination		baseboards in the kitchen and supply room was cleaned and removed i. The kitchen floor was cleaned and is no longer sticky j. Cook #3 was instructed to wear facial hair covering while in the kitchen area and donned a facial hair covering immediately k. The debris under the racks in dry storage and behind kitchen storage along the baseboards was cleaned and is no longer there l. Cooks #2 and #3 were re-educated on the policy to wear facial hair covering while serving food m. A schedule is in place to ensure tasks for cleaning the environment, labeling and dating foods, discarding outdated foods and facial hair covering are completed routinely and ongoing. . The schedule of the task being completed on a quarterly basis was given to surveyor. IV. The Dietary Service Manager or designee will monitor the refrigerator and freezer for outdated and unlabeled food, completion	

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(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
	of food, equipment and utensils...." Review of the current 1-2015, policy titled "Guide to Storage Times and Temperatures", was provided by the Director of Dining Services on 5/18/15 at 9:00 a.m., and indicated the following: "...Policy: Foods are stored at correct refrigerated/frozen temperatures for specific lengths of time. Procedure: Recommended Storage Times and Temperatures for Foods Stored in Refrigerator or Freezer ...opened packages of luncheon meats - Refrigerate at 41 degrees Fahrenheit or below - 5 days Tightly seal in plastic, label with name of item and use by date..." 3.1-21(i)(2)(3)		of assigned cleaning duties, and use of facial hair coverings on a daily basis. The Administrator or designee will conduct a weekly kitchen audit X4 weeks and monthly thereafter for 6 months to ensure a 95% threshold is achieved. The Dietary Consultant will conduct monthly sanitation audits. All audits will continue until the Quality Assurance Committee determines a change in frequency is necessary or continued compliance is achieved by demonstrating a consistent score of 95% compliance or higher on audits. The administrator is responsible for compliance and the date of compliance will be June 9th, 2015.	
F 520 SS=F Bldg. 00	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.			

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	The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.			
	Based on observation, interview and record review, the facility failed to successfully implement a plan of action to address safe and sanitary conditions in the kitchen regarding cleanliness of the kitchen and disposal of out-dated food items. This deficient practice had the potential to impact 84 of 84 residents who consumed meals prepared in the facility's kitchen. Findings include: On the previous annual survey, F371 had been a deficiency with opened container labeling and soiled areas identified. The action plan was no longer in place as identified in an interview with the Dietary Consultant.	F 520	It is the intent of the facility to ensure that the Quality Assessment and Assurance Committee develop and implement appropriate plans of action to address deficient practices. I. No residents were identified as having been affected. II. All residents who are served their meals from the kitchen have the potential to be affected. III. The dietary staff, dietary consultant and the administrative staff of the facility will receive education on how to implement a plan of action to address safe and sanitary conditions in the kitchen regarding cleanliness of the kitchen and disposal of out-dated food items. The previous action plan for the annual survey in 2014 will be reviewed in the quality assurance meeting in the facility to revise the problem statement,	06/09/2015

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	During an interview on 5/11/15 at 9:13 a.m., the Director of Dietary Services acknowledged the floors were not clean and in need of repair. The Director of Dining Services was unable to provide the date the floors had last been stripped and waxed. Review of the housekeeping floor cleaning schedule for March, April and May 2015, was provided by the Administrator on 5/14/15 at 2:00 p.m. The Administrator indicated housekeeping was responsible for stripping and waxing the floors in the facility. The cleaning schedules indicated the kitchen and dry storage room floors had not been on the schedule for stripping and waxing. During an interview on 5/18/15 at 11:02 a.m., the Administrator indicated the corporate dietary consultant had been in the facility in February 2015. Concerns had been identified at that time. The facility developed an action plan which contained a component for monitoring which included the Administrator completing kitchen rounds once a week, and the corporate dietary consultant completing kitchen rounds monthly. The Administrator indicated some of the damaged floor tiles had been identified during her rounds and replaced. She		revise the interventions and put the action plan back into place until the facility achieves a compliance audit/monitoring score of 95% or greater and resolves the root cause of the problems identified in this survey and the annual survey from 2014. The director of dietary services has received education that he/she must acknowledge when the floors are not clean and are in need of repair and take action to resolve the problem. A schedule has been put into place to ensure floors in the facility are stripped and waxed routinely. Housekeeping has received education to ensure they know the stripping and waxing schedule and that the work is performed according to the schedule that is in place. The action plan that was put into place by the corporate dietary consultant in February 2015 will be reviewed in a quality assurance committee meeting and the problems, goals will be updated, the interventions will be revised and the monitoring for compliance will be reviewed until a threshold of auditing success of 95% compliance is achieved and the root cause of the non-compliance is resolved. The new housekeeping/laundry supervisor has been educated on the deep cleaning schedule for the kitchen area. IV. The Dietary Service Manager or designee will monitor the refrigerator and freezer for	

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	indicated the floor was on a deep clean schedule but had been missed due to the transition of a new housekeeping/laundry supervisor. 3.1-52(b)(2)		outdated and unlabeled food, completion of assigned cleaning duties, and use of facial hair coverings on a daily basis ongoing. The Administrator or designee will conduct weekly kitchen audits for 8 weeks and monthly after that for 6 months until a 95% success threshold is met or the action plan will be revised until the areas of concern are resolved. The Dietary Consultant will conduct monthly sanitation audits. All audits will continue until the Quality Assurance Committee determines a change in frequency is necessary or continued compliance is achieved. The regional director of operations from the corporation will review the quality assurance progress monthly x 3 months to ensure corrective actions are successful and meet the threshold for compliance. The date of compliance is June 9, 2015. This facility respectfully disagrees with this deficiency. The facility feels the QA committee does develop and implement appropriate plans to identify quality deficiencies.	
R 000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 52	R 000	This plan of correction is to serve as Fall Creek Retirment Village's credible allegation of compliance. Fall Creek Retirment Village respectfully	

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	Residential sample: 7 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-5.		requests a desk review from the Indiana State Department of Health to confirm the facility has achieved compliance by June 9, 2015. Submission of this plan of correction does not constitute an admission by Fall Creek Retirment Village or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	
R 273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to serve food under safe sanitary conditions related to the disposal of out dated food items and the cleanliness of the kitchen. This deficient practice had the potential to impact 50 of 50 residents who eat meals which are prepared in the facility's kitchen. Findings include: 1. During the initial kitchen tour on 5/18/15 at 12:15 p.m., the following	R 273	This plan of correction is to serve as Rawlin's House Community's credible allegation of compliance. Rawlin's House respectfully requests a desk review from the Indiana State Department of Health to confirm the facility has achieved compliance by June 9, 2015. Submission of this plan of correction does not constitute an admission by Rawlin's House Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor	06/09/2015

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	concerns were noted: a. Four bags of fresh produce broccoli had a used by date of 5/3/15. The broccoli had several areas of brown discoloration. b. Freezer and refrigerator doors had a sticky substance on them c. Dust and debris was noted on top of the heating unit in the dry storage room d. Dark brown/black debris was noted along baseboards in kitchen and supply room During an interview on 5/18/15 at 1:10 p.m., the Dietary Manager indicated the cleaning was on a schedule. The Dietary Manager also acknowledged the floors were not clean and the broccoli was outdated and should have been discarded. The Dietary Manager was unable to provide the date the floors had last been stripped and waxed. During an interview on 5/18/15 at 1:44 p.m., the Administrator indicated the kitchens for both Rawlins House Rehabilitation Center and Fall Creek Residential Center used the same policies. The Administrator also indicated the Housekeeping Departments		does this submission constitute an agreement or admission of the survey allegations. This plan correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 9, 2015. I. No residents were identified as having been affected. II. All residents who are served their meals from the kitchen have the potential to be affected. III. All dietary staff will be offered education on the following: - Discarding of outdated food items - Cleaning procedures and cleaning schedules The systemic change includes the following: - The broccoli was thrown away. - The freezer and refrigerator doors were cleaned immediately - The dust and debris on top of heating unit was cleaned - Kitchen floor was mopped immediately IV. The dietary manager or designee will perform sanitation audits daily for the first 30 days, then 5 days per month for 150 days then 3 days per month for 180 days to total 12 months of monitoring. Results of the audit will be reported to the QA committee monthly for 12 months to assist with additional recommendations if necessary.	

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	were responsible for the stripping and waxing of the floors in both facilities. Review of the cleaning schedule for May 2015, was provided by the Dietary Manager on 5/18/15 at 1:20 p.m., and indicated the floor in the serving area and the cooking and prep area had last been swept and mopped on 5/10/15. The dry storage area was not noted on the cleaning schedule. Review of the housekeeping floor cleaning schedule for March, April and May 2015, was provided by the Administrator on 5/18/15 at 1:44 p.m. The Administrator indicated housekeeping was responsible for stripping and waxing floors in the facility. The cleaning schedules indicated the kitchen and dry storage room floors had not been on the schedule for stripping and waxing. Review of the current 2012, policy titled "Cleaning of Floors", indicated the following: "...Policy: Floors in the department are kept free of debris and cleaned daily. Procedure: ...3. Spills are wiped up immediately...." Review of the current 2012, policy titled " Receiving of Food Products", was			

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	provided by the Administrator on 5/18/15 at 1:44 p.m., and indicated the following: "...Policy: The Dining Services department receives food for residents' meals from pre-approved vendors. It is wholesome, undamaged and received at the proper temperature. Procedure: ... 8. Fresh produce is inspected for the following: Blemishes Spoilage or signs of decay Appropriate color Signs of pest infestation Cleanliness, no sign of visible soil ... 11. For both perishable and non-perishable items, the use -by and expiration dates are checked. Foods marked within 3 days of these dates are not accepted...." Review of the current 1-2015, policy titled "Guide to Storage Times and Temperatures", was provided by the Dietary Manager on 5/18/15 at 9:00 a.m., and indicated the following: "...Policy: Foods are stored at correct refrigerated/frozen temperatures for specific lengths of time. Procedure: Recommended Storage Times and Temperatures for Foods Stored in Refrigerator or Freezer ...Prepared salads - Refrigerate at 41 degrees Fahrenheit or below - 3 days			

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	after opening, labeled with used by date...." 3.1-21(i)(2)(3)			