

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
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NAME OF PROVIDER OR SUPPLIER HAMILTON GROVE	STREET ADDRESS, CITY, STATE, ZIP CODE 31869 CHICAGO TR NEW CARLISLE, IN 46552
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: August 16, 17, 18, 19 & 20, 2015</p> <p>Facility number: 000427 Provider number: 155672 AIM number: 100275150</p> <p>Census bed type: SNF/NF: 75 Residential: 80 Total: 155</p> <p>Census payor type: Medicare: 8 Medicaid: 55 Other: 12 Total: 75</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	F000 Neither the signing nor the submission of this plan shall constitute an admission of any deficiency, of any fact or conclusion set forth in the statement of deficiencies. This plan of correction is being submitted in good faith by the facility because it is required by law. The facility reserves the right to contest the statement of deficiencies.	
F 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop a care plan related to depression, the use of an antidepressant medication for 1 of 5 resident's reviewed for unnecessary medications. (Resident #90)</p> <p>Finding includes:</p> <p>On 8-19-15 at 9:14 A.M., a review of Resident #90's chart was conducted. She was admitted on 6-9-15 and had diagnoses including but not limited to anxiety and depression. A physician order dated 6-20-15 indicated "...Lexapro [a medication for depression] 5 mg [milligrams] tablet PO [by mouth] q AM</p>	F 0279	<p>F279</p> <p>It is the policy and practice of Hamilton Grove to develop comprehensive careplans for each resident that includes measurable goals and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. No residents were adversely affected by this alleged discrepancy. Resident number 90's care plan was updated for depression and the use of antidepressant medication on 8/19/2015.</p> <p>To enhance currently compliant operations and under the direction of the director of nurses, on 9/9/15 and 9/10/15 nursing</p>	09/17/2015

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	<p>[every morning]...."</p> <p>The MDS (Minimum Data Set) assessment, dated 7/3/15, indicated the resident received an antidepressant for 7 days during the reference period.</p> <p>The care plans for Resident #90 indicated no documentation of a care plan related to her depression or use of an antidepressant medication.</p> <p>On 8-19-15 at 11:00 A.M., an interview with the MDS RN (Registered Nurse) was conducted. The MDS RN indicated a care plan for depression and the use of antidepressant medication should have been started when the medication was started.</p> <p>On 8-20-15 at 9:20 A.M., review of the current undated "Care Plans" policy, received from the ADON (Assistant Director of Nursing) at this time, indicated "...The assigned nurse initiates the initial care plan within 24 hours following admission. The MDS nurse completes the care plan within the required time frame and no longer than seven days after the MDS is completed...."</p> <p>3.1-35(a)</p>		<p>staffwill receive re-inservice training regarding state and federal requirementsfor the development of care plan policy and procedures related to depressionand the use of antidepressant medications. The training willemphasize the importance of care plan review as well as noted currentconditions and interventions and reporting deficiencies to a licensed nurse orsupervisor immediately. Because all residents receiving anti-depressantmedications are potentially affected by the cited deficiency, the director ofnurses/designee will compile a list of all residents with a diagnosis of depressionand receiving anti-depressants. Thedirector of nurses/designee then will check all residents with depression toensure the care plans were updated. Thiswill be completed by September 17, 2015. No other residents were affected. Effective September, 8, 2015 aquality-assurance program was implemented under the supervision of the directorof nurses to monitor care plans. The director of nurses or designated qualityassurance representative will perform the following systemic changes: randomlychecking, weekly, three residents who are receiving</p>	

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F 0280 SS=D Bldg. 00	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview,</p>	F 0280	<p>anti-depressants to ensureresident's care plans reflect appropriate goals and interventions. Any deficiencies will be corrected on thespot, and the findings of the quality-assurance checks will be documented andsubmitted at the monthly quality-assurance committee meeting for further reviewor corrective action. This will be donemonthly for ninety (90) days then quarterly thereafter or until a 95% thresholdis met.</p> <p>F 280 No residents were</p>	09/17/2015

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	<p>the facility failed to update and revise a resident's care plan related to a fall for 1 of 2 residents reviewed for falls. (Resident #77) Finding includes: On 8/19/2015 at 9:45 A.M., an interview with the ADON (Assistant Director of Nursing), indicated Resident #77 complained of pain after getting up in the morning on 7/19/2015, and told the nurse she fell in the night. The ADON indicated the resident gets confused and the staff questioned if the resident really fell because there was a functioning bed alarm in place that did not alarm and the resident's explanation of what happened was confused. The ADON indicated the facility treated the incident as a fall because it was not witnessed. On 8/19/2015 at 10:08 A.M., the clinical record for Resident #7 was reviewed. The most recent quarterly MDS (Minimum Data Set) assessment, dated 6/01/2015, indicated the diagnoses, included but were not limited to; dementia, depression and history of falls. The Resident's BIMS (Brief Interview for Mental Status) score was 4, indicating the severe impairment.</p>		<p>adversely affected by this alleged discrepancy It is the policy of Hamilton Grove to complete a careplan within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>In order to enhance currently compliant operations resident number 77's care plan was updated on 8/20/2015. On 9/9/15 and 9/10/15 nursing staff will receive in-service training regarding state and federal requirements for the development of care plans policy and procedure related to falls. The training will emphasize the importance of real time care plan updating as falls occur as well as reporting deficits to a licensed nurse or supervisor immediately. Because all residents who have a propensity to fall are potentially affected by the cited deficiency, on 8/31/15, the director of nurses reviewed QI report for residents</p>	

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	<p>A Nurse's note, dated 7/19/2015 at 9:45 A.M., indicated a fall was reported by the resident. A head to toe body assessment was done and found a bruise to the resident's forearm 12 cm (centimeters) x 4 cm with a scratch in the middle 0.5 cm x 10.5 cm. No active bleeding noted. Full range of motion without difficulty. Cleansed with normal saline and Geri-Sleeves (protective arm wear) were applied to superficial scratch. The Administrator, family, and physician were notified. No new orders were received and neuro checks were initiated. The Resident #7's Falls Care Plan, dated 4/23/2015, indicated the resident was at risk for falls related to a history of falls in the past 30 days with a fracture, impaired cognition, decreased safety awareness, impaired vision, and decreased mobility and weakness. There were no indications of updates or revisions to the Falls Care Plan after it was initiated on 4/23/2015. On 8/20/2015 at 10:03 A.M., an interview was conducted with the ADON. The ADON indicated Resident #7's Falls Care Plan should have been updated immediately after the fall or with the next Falls Committee meeting.</p>		<p>who experienced a fall within the last 30 days. The director of nurses then checked all residents who fell within the last 30 days and updated their care plan to reflect new interventions. No other residents were affected. Effective 9/17/15, a quality-assurance program was implemented under the supervision of the director of nurses to monitor falls care plans. The director of nurses or designated quality assurance representative will perform the following systemic changes: randomly checking, weekly, all residents who have recently fallen to ensure resident's care plans reflect appropriate goals and interventions. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. This will be done monthly for ninety (90) days then quarterly thereafter or until a 95% threshold is met.</p>	

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F 0282 SS=D Bldg. 00	<p>On 8/19/2015 at 11:12 A.M., the ADON provided the Fall Prevention Policy and indicated it was the one currently used by the facility. The policy indicated the Falls Committee would meet daily Monday - Friday to review all falls, off hour, weekend and holiday falls would be reviewed on the next business day. 3.1-35(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure physicians orders were followed in regards to application of knee immobilizer for 1 of 1 residents. (Resident #90)</p> <p>Finding includes:</p> <p>On 8/18/15 at 11:34 A.M., a clinical record review was conducted for resident #90. Resident #90 was admitted to the facility on June 9, 2015. Diagnosis included, but was not limited to, Knee Joint Replacement by Other Means. A Physicians order, dated 6/9/15, indicated "... Wear knee immobilizer while</p>	F 0282	<p>F 282 No residents were adversely affected by this alleged discrepancy It is the policy of Hamilton Grove to ensure that services provided or arranged by the facility is delivered by qualified persons in accordance with each resident's written plan of care. In order to enhance currently compliant operations under the direction of the director of nurses, on 9/9/15 and 9/10/15 nursing staff will receive in-service training regarding state and federal requirements for the development of care plans policy and procedure related to the use of immobilizers. The training will</p>	09/17/2015

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	<p>walking may remove in bed...."</p> <p>Review of TAR (Treatment Administration Record) and Nurses Notes for June and July 2015 indicated no documentation for placement or removal of the immobilizer.</p> <p>During an interview on 8/18/15 at 3:18 P.M., the ADON (Assistant Director of Nursing) indicated "...order and documentation should be on the TAR for the immobilizer to be put on and taken off...."</p> <p>On 8/19/15 at 10:24 A.M., review of the current undated policy titled "Application of Brace, Immobilizer and Splints" provided by the ADON indicated "...6. Document initials and total minutes for the appropriate shift...."</p> <p>During an interview on 8/20/15 at 12:39 P.M., the ADON indicated "...yes, she had a immobilizer on...her immobilizer wasn't charted on the MAR (Medication Administration Record) or the TAR...there is no daily documentation that the immobilizer was put on or taken off...."</p> <p>3.1-35(g)(2)</p>		<p>emphasize the importance of real time care plan updating/documentingspecial orders related to the immobilizer as well as reporting deficits to alicensed nurse or supervisor immediately. For resident number 90 the immobilizer was discontinued on 7/2/2015 therefore,no correction is required.</p> <p>Because all residents with immobilizers andspecial instructions of its use are potentially affected by the citeddeficiency, on August 31, 2015, the director of nurses compiled a list of all residentswith immobilizers. The director of nursesthen checked all resident care plans to reflect specialized instructions.</p> <p>A quality-assurance program was implementedunder the supervision of the director of nurses to monitor immobilizer careplans. The director of nurses or designated quality assurance representativewill perform the following systemic changes: randomly checking, weekly, allresidents who have an immobilizer to ensure resident's care plans reflectappropriate goals and interventions specific to the physician orders. Any deficiencies will be corrected on the spot,and the findings of the</p>	

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F 0371 SS=F Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to prepare and serve food in a sanitary manner in regards to food storage, dish storage, hairnet use and food service in 1 of 1 kitchens and 1 of 5 dining rooms. Findings include:</p> <p>1. On 8/16/15 from 1028 A.M., to 11:03 A.M., during the initial kitchen tour with Cook #5 the following was observed:</p> <p>At 10:30 A.M., the clean dish rack was observed with the front cover pushed back up over the top of the rack leaving 50 plates, 50 dessert bowls, 50 small bowls, 20 salad plates, stored upright</p>	F 0371	<p>quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. This will be done monthly for ninety (90) days then quarterly thereafter or until a 95% threshold is met. The date this will be completed is 9/18/2015.</p> <p>F371 It is the policy and practice of Hamilton Grove to 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. No residents were adversely affected by this alleged discrepancy In order to enhance currently compliant operations under the direction of the dietary manager/designee the following corrections were made:</p> <p>Example 1a. The clean dish was re-covered on 8/16/2015 b. The rack</p>	09/17/2015	

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	<p>and uncovered. Cook #5 indicated at this time that the cover should be down.</p> <p>At 10:32 A.M., on a rack beside the clean dishes, 3 separator plates were observed stored uncovered and upright.</p> <p>At 10:40 A.M., a rack of clean dishes and utensils was observed by the three compartment sink. One (1)- ladle, 1- measuring cup and 1- scoop were observed upright with dirty water in them. Cook #5 indicated at this time that they were just out of the dishwasher and drying.</p> <p>At 10:42 A.M., next to the three compartment sink, a rack of clean pans was observed next to a cart full of dirty pans. Cook #5 indicated " the clean dishes where just out of the dishwasher...."</p> <p>At 10:44 A.M., in the reach in refrigerator the following was observed: a tomato and cheese sandwich with no date, an open bag containing 12 hard boiled eggs, with no date, an open bag of iceberg lettuce, with no date. Cook #5 indicated at this time "...yes, these should be dated ...personal food belongs in the employee refrigerator...."</p> <p>At 10:46 A.M., Food Service Assistant</p>		<p>beside the clean dishes were removed and covered 8/16/2015</p> <p>c. The rack of utensil were removed from the scullery and re-washed on 8/16/2015</p> <p>d. The rack of clean dishes were removed from the scullery and re-washed on 8/16/2015</p> <p>e. All food items identified in this example opened on 8/16/2015 were properly sealed in containers and dated on 8/16/2015</p> <p>f. The food service assistant was instructed to completely cover their head with the hairnet on 8/16/2015</p> <p>g. The sealed can of chicken and dumplings was removed from the stock rack on 8/16/2015</p> <p>h. The vegetable bowls were removed from the steam table on 8/16/2015</p> <p>i. Undated chicken opened on 8/16/2016 was properly contained and dated on 8/16/2015</p> <p>2a Sufficient time has elapsed to preclude staff from correcting the alleged deficiency on 8/16/2015 and 8/18/2015</p> <p>In addition, all dietary and nursing staff will receive</p>	

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	<p>#7 was observed with his hairnet only covering the top half of the back of his head.</p> <p>At 10:50 A.M., a can of chicken and dumplings with a dent on the bottom was observed on the can storage rack. Cook #5 indicated " ...that shouldn't be there..."</p> <p>At 10 53 A.M., 40 vegetable bowls were observed on the steam table sitting uncovered and upright.</p> <p>At 10:55 A.M., an open, undated box of frozen quartered chicken was observed in the walk in freezer.</p> <p>During an interview on 8/16/18 at 12:13 P.M., the ADM (Assistant Dietary Manager) indicated " ...clean dishes should be stored covered on the dish rack ... utensils, ladle, scoops should be face down to dry."</p> <p>During an interview on 8/17/15 at 10:03 A.M., the ADM indicated "... hairnets should worn covering all the hair..."</p> <p>On 8/19/15 at 1:04 P.M., review of the current policy titled " Dented Cans and Leftover Food" provided by the ED (Executive Director), revised 4/1/14 and 2/1/14, indicated "... Cans with a sharp</p>		<p>re-inservice training regarding state and federal requirements related to the storage of food, storage of serving vessels (i.e. dishes, plates utensils etc.), proper dating of refrigerated/frozen stored foods, hairnet placement, inspection of dented food cans, etc. The training will emphasize the importance of sanitation precautions to ensure the integrity of all food items, dishes, utensils, and personal hygiene reporting deficits Dietary manager/assistant or group leader.</p> <p>Effective September 17, 2015 a quality-assurance program will be implemented under the supervision of the dietary manager/assistant. The dietary manager or designated quality assurance representative will perform the following systemic changes: monitor daily for 30 days all the areas identified in this citation. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. This will be done monthly for ninety (90) days then quarterly thereafter or until a 95% threshold is met.</p>	

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	<p>dent or a dent that is located on the top,bottom, or side seam of a can are thrown out ...1. All opened food must be covered, labeled and dated...."</p> <p>On 8/19/15 at 1:10 P.M., review of the current policy titled "...Personal Hygiene" provided by the ED, revised 7/1/05, indicated "... 1. Hair Coverings: A hairnet or hair bonnet must be worn in the kitchen areas by all Dietary employees...."</p> <p>2. On 8/16/2015 at 12:50 P.M., during a lunch observation in West Hall, Employee #8 was observed opening a cardboard milk carton for Resident #79. Employee #8 grasped the carton and pulled open the container at the pour spout, by placing an ungloved finger inside the carton contacting the inside of the container. Employee #8 then poured the milk into the resident's glass, passing the milked over the contaminated area.</p> <p>On 8/18/2015 at 12:28 P.M., during a lunch observation in West Hall, Employee #9 was observed opening a cardboard milk carton for Resident #10. Employee #9 grasped the carton and pulled open the container at the pour spout, by placing an ungloved finger</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2015
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NAME OF PROVIDER OR SUPPLIER HAMILTON GROVE	STREET ADDRESS, CITY, STATE, ZIP CODE 31869 CHICAGO TR NEW CARLISLE, IN 46552
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R 0000 Bldg. 00	<p>inside the carton contacting the inside of the container. Employee #9 then poured the milk into the resident 's glass, passing the milked over the contaminated area.</p> <p>On 8/19/2015 at 11:27 A.M., during an interview, the ADON (Assistant Director of Nursing), indicated milk cartons should not be opened by inserting fingers into the containers and contaminating the inner surface.</p> <p>3.1-21(i)(3)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: August 16, 17, 18, 19 & 20, 2015</p> <p>Facility number: 000427 Provider number: 155672 AIM number: 100275150</p> <p>Residential census: 80</p> <p>Residential sample: 7</p> <p>Hamilton Grove was found to in</p>	R 0000	F000 Neither the signing nor the submission of this plan shall constitute an admission of any deficiency, of any fact or conclusion set forth in the statement of deficiencies. This plan of correction is being submitted in good faith by the facility because it is required by law. The facility reserves the right to contest the statement of deficiencies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2015
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	compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.				