

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155782	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/10/2015
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NAME OF PROVIDER OR SUPPLIER  WHITE OAK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: February 3, 4, 5, 6, 9, and 10, 2015</p> <p>Facility number: 012355 Provider number: 155782 AIM number: 201014410</p> <p>Survey team: Jennifer Redlin RN-TC Caitlyn Doyle RN (2/4, 2/5, 2/6, 2/9, 2/10) Heather Hite, RN Julie Ferguson, RN (2/3, 2/4, 2/5, 2/6)</p> <p>Census bed type: SNF: 18 NF: 17 SNF/NF: 25 Residential: 38 Total: 98</p> <p>Census Payor type: Medicare: 18 Medicaid: 17 Other: 25 Total: 60</p>	F000000	<p>Submission of this plan of correction and credible allegation does not constitute an admission by the provider that the allegations are a true and accurate portrayal of the provisions of care in this facility. White Oak Health Campus submits this plan of correction as its letter of credible allegation and requests a desk review with paper compliance be considered in establishing the provider is in substantial compliance. We appreciate your consideration of this request.</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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F000156 SS=C	<p>Residential sample: 8</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1</p> <p>Quality review completed on February 12, 2015, by Janelyn Kulik, RN.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which</p>			

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	<p>the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a</p>			

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	<p>complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure the residents were aware of their residents' rights. This had the potential to affect the 60 residents who resided in the facility.</p> <p>Findings include:</p> <p>Interview with Resident #32, the Resident Council President, on 2/6/15 at 9:45 a.m., indicated she was not aware of the residents' rights, was not aware of where she could find the information, and could not remember the information being discussed at the resident council meetings.</p> <p>Resident #32's record was reviewed on 2/6/15 at 10:40 a.m. The Annual</p>	F000156	<p>1. Resident #1 will be re-educated regarding residents' rights and where to find that information. 2. Residents residing at the facility have the potential to be at risk for the alleged deficiency. Monthly Resident Council meetings will include review of residents' rights with a focus on at least 1 right reviewed in detail at each monthly meeting. 3. Executive Director (ED) will in-service Life Enrichment Director (LED) on Resident Council format to include residents' rights. ED or designee will review Resident Council minutes and provide signature each month to ensure residents' rights are included in the meeting format. 4. Resident Council minutes will be brought to monthly Quarterly Assurance (QA) meetings. QA Committee</p>	03/12/2015	

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F000329 SS=D	<p>Minimum Data Set (MDS) assessment, dated 10/17/14, indicated a BIMS (Brief Interview for Mental Status) score of 15, which indicated the resident was cognitively intact.</p> <p>Review of the monthly Resident Council meeting minutes from January 2014 to January 2015 on 2/6/15 at 10:45 a.m., indicated the only discussion of residents' rights was during the meeting on 6/6/14, at which time the Life Enrichment Director "reviewed res. (resident) right of being able to see med (medical) records at any time." No documentation on any other month's minutes indicated any residents' rights or where to find them were discussed.</p> <p>Interview with the Life Enrichment Director on 2/6/2015 at 11:37 a.m., indicated she was the staff member in charge of resident council meetings. She further indicated she had no documentation to indicate resident rights were discussed regularly at the resident council meetings</p> <p>3.1-4(a)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free</p>		members will review minutes to ensure residents' rights are reviewed x 6 months or until 100% compliance is achieved.				

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	<p>from unnecessary drugs. An unnecessary 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.</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure a resident's drug regime remained free of unnecessary medications related to the lack of an Abnormal Involuntary Movement Scale (AIMS) assessment completed for a resident receiving an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medication. (Resident #107)</p> <p>Finding includes:</p> <p>A record review was completed on 2/5/15 at 4:04 p.m., for Resident #107.</p> <p>Diagnoses included, but were not limited</p>	F000329	<p>1. Resident #107 had no adverse affects. Abnormal Involuntary Movement Scale (AIMS) assessment was complete on Resident #107 during the time of the survey. 2. Residents receiving antipsychotic medication have the potential to be at risk of the alleged deficient practice. Medical Records of those residents receiving antipsychotic medication will be reviewed to ensure AIMS assessments have been completed. Any missing AIMS assessments will be completed as necessary. 3. Minimum Data Set (MDS) coordinator will be in-serviced by Director of Health Services (DHS) or designee on completing AIMS</p>	03/12/2015			

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	<p>to, depression, anxiety, hypertension and dementia. A Brief Interview for Mental Status (BIMS) was completed on 1/23/15 with a score of 13. The score indicated the resident was cognitively intact.</p> <p>The February 2015 Physician order summary indicated the resident was receiving Abilify (medication to treat psychotic conditions) 10 mg (milligrams) daily for depression.</p> <p>A review of the January and February 2015 Medication Administration Records (MAR) indicated the resident was receiving the Abilify daily since 1/23/15.</p> <p>The record lacked any information an AIMS (Abnormal Involuntary Movement Scale) assessment had been completed on the resident for the antipsychotic medication Abilify.</p> <p>An interview with the Minimum Data Set (MDS) coordinator on 2/6/15 at 2:33 p.m., indicated she did not do an Abnormal Involuntary Movement Scale (AIMS) assessment for the resident. She thought the Abilify was an antidepressant medication and not an antipsychotic medication. She further indicated since the medication was an antipsychotic she should have completed an AIMS assessment on the resident.</p>		<p>assessments on residents receiving antipsychotic medication. All new admissions and new physician's orders will be reviewed 5 days per week in Clinical Care Meeting (CCM) for antipsychotic medication by MDS coordinator or designee in order to complete AIMS assessment accordingly. DHS or designee will audit physician's orders 5 x's per week x 1 month, 3 x's per week x 1 month, and weekly x 4 months. 4. Audit results will be brought to monthly Quarterly Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved.</p>	

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F000363 SS=E	<p>The MDS coordinator completed an AIMS assessment on Resident #107 on 2/6/15 with a score of 0.</p> <p>3.1-48(a)(3)</p> <p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>Based on observation, interview and record review, the facility failed to follow the recipe for a therapeutic pureed diet. This had the potential to affect 5 of 5 healthcare residents in the facility who received a puree diet.</p> <p>Finding includes:</p> <p>On 2/5/15 at 11:30 a.m., Cook #1 was observed preparing pureed noodles.</p> <p>Cook #1 placed already cooked noodles into the puree blender, added 3/4 cup of hot milk, pureed noodles to "pudding like thickness." She then added another 1/4 cup of hot milk. At that time, there was</p>	F000363	<p>1. No adverse affects have been noted. 2. Residents receiving a pureed diet have the potential to be at risk of the alleged deficiency. An audit will be conducted by the Director of Food Services (DFS) to ensure that pureed items have recipes. 3. DFS or designee will in-service dietary staff on following a recipe when preparing pureed food. DFS or designee will audit recipes 5x's per week at random meal times to include all meals x 1 month, 3x's per week x 1 month and weekly x 4 months. Non-compliance with recipes will be addressed accordingly. 4. Audit results will be brought to monthly Quarterly Assurance (QA) meetings. Trends will be reviewed by the QA Committe x6</p>	03/12/2015

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	<p>no recipe available follow. Cook #1 indicated she did not use a recipe and used milk because it was fortified.</p> <p>The recipe for "Noodles Parsley Pureed," provided by the Administrator on 2/5/15 at 1:40 p.m., indicated ingredients included parsley noodles, chicken base and water. Milk was not in the recipe. Water and chicken base was not used in making the puree by Cook #1.</p> <p>Interview with the Administrator on 2/5/15 at 11:45 a.m., indicated there was a recipe and it should have been followed.</p> <p>On 2/5/15 at 1:40 p.m., the Administrator provided the policy titled, "Pureed Food Preparation." This current policy indicated, "...Procedure:...2. Standardized recipes will be used to produce pureed foods to maintain nutrient content...."</p> <p>3.1-20(i)(4)</p>		months or until 100% compliance is achieved.				

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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 ensure food was served and stored under sanitary conditions, related to undated and exposed food in the freezer and improper handling of food during meal preparation. This had the potential to affect 60 of 60 residents that were served from the main kitchen. The facility also failed to ensure proper sanitation of the puree blender in the kitchen for 1 of 1 kitchens observed. This had the potential to affect to 5 of 5 healthcare residents that have a pureed diet. (The Main Kitchen)</p> <p>Findings include:</p> <p>1. During the Brief Kitchen Tour, with the Director of Food Services on 2/3/15 from 10:15 a.m. to 10:32 a.m., the following was observed:</p>	F000371	<p>1. No adverse affects have been noted. 2. Residents residing at the facility have the potential to be at risk for the alleged deficiency. Food in the freezer has been observed for proper dating and exposure. Corrections were made as indentified. Proper handling of food during meal preparation was reviewed during the time of the survey by the Executive Director with the dietary staff. 3. Director of Food Services (DFS) or designee will in-service dietary staff on proper storage and dating of food in the freezer and proper handling of food during meal preparatin. Audits will be conducted by the DFS or designee for proper storage and labeling of food in the freezer 4x's per week x 1 month, 3 x's per week x 1 month and weekly x 4 months. Audits will also be conducted by DFS or designee for proper handling of food during meal preparation 5 x's per week at random meal times to include all meals x 1 month, 3 x's per</p>	03/12/2015
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	<p>a. In the walk-in freezer, there were bags of carrots, broccoli and hashbrowns not labeled with open dates. All were frozen to touch.</p> <p>b. Plastic bags of pork and hamburger patties were exposed and opened to air and undated. All were frozen to touch.</p> <p>Interview with the Director of Food Services at that time, indicated the vegetables and the patties should have been labeled with an open date and the patties should have been sealed.</p> <p>On 2/4/15 at 2:53 p.m. the Administrator provided the policy titled, "Storage Procedures." This current policy indicated, "Frozen Storage...3. All foods in the freezer are wrapped in moisture proof wrapping or placed in suitable containers, to prevent freezer burn. Items are labeled and dated...."</p> <p>2. On 2/5/15 at 11:30 a.m., after the preparation of the pureed noodles, Cook #1 washed the blender in the 3 compartment sink with soap and water, rinsed the blender with water, placed it in the sanitizer sink for 30 seconds, then removed it and carried it to the blender to use again for the next pureed food.</p> <p>Interview at that time with Cook #1,</p>		<p>week x 1 month and weekly x's 4 months. 4. Audit results will be brought to the monthly Quality Assurance (QA) meetings. QA Committe will review trends x 6 months or until 100% compliance is achieved.</p>				

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	<p>indicated she usually leaves the blender in the sanitizer for 30 seconds then re-uses the blender again for the next puree food.</p> <p>On 2/5/15 at 1:55 p.m. the Administrator provided the policy titled, "3-Compartment Sink." This current policy indicated, "...Procedures: Immerse dishes in 3rd sink sanitizing solution for a minimum of 60 seconds...."</p> <p>3. On 2/5/15 at 12:16 p.m., the following was observed: Cook #2, wearing gloves, handed an ice bucket to another Dietary Service Aide, then got a hot dog bun out of the bag, placed it on a plate, placed a slice of bread onto an egg salad sandwich on another plate and then handed that plate to another Dietary Service Aide. Cook #2 never changed his gloves or washing his hands.</p> <p>Interview with Cook #2 at that time, indicated he should have changed his gloves before and after touching food.</p> <p>On 2/6/15 at 10:50 a.m., the Administrator provided the policy titled, "Hand Washing." This current policy indicated, "...Procedures: Always wash your hands when:...Handling soiled objects...."</p>						

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F000465 SS=E	<p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional and safe environment related to gouged doors and walls, marred walls, chipped paint, and stained privacy curtains on 3 of 3 hallways throughout the facility. (100, 200 and 300 hallways)</p> <p>During the environmental tour with the Director of Plant Operations and the Environmental Services Director on 2/9/15 at 10:35 a.m., the following was observed:</p> <p>1. 100 hallway</p> <p>a. Room 108 had gouges to the inside bottom of the bathroom door. One resident resided in this room.</p> <p>b. Room 110 had black mars to the wall behind the entry door, gouges to the bottom inside of the bathroom door, and chipped paint to the bathroom door frame. One resident resided in this room.</p>	F000465	<p>1. Observations #1, #2 and #3 were addressed during the time of the survey. No adverse affects were noted. 2. Residents residing at the facility have the potential to be at risk of the alleged deficiency. Rounds will be conducted to inspect doors for gouges, walls for marring, door frames for paint chips and cleanliness of privacy curtains. Areas that are identified that do not provide a safe and functional environment will be repaired or replaced. 3. Director of Plant Operations (DPO) and Environmental staff will be in-serviced by Executive Director (ED) or designee on providing a functional and safe environment. DPO or designee will audit doors for gouges, walls for marring, door frames for paint chips and privacy curtains 3x's per week x 1 month and weekly x 5 months. 4. Audit results will be brought to monthly Quality Assurance (QA) meetings. QA Committe will review trends x6 months or until 100% compliance is achieved.</p>	03/12/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155782	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/10/2015
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R000000	<p>2. 200 hallway</p> <p>Room 208 had black mars to the wall beside the entry door, gouges to the bottom inside of the bathroom door, and a large stained area to the privacy curtain which surrounded bed A. Two residents resided in this room.</p> <p>3. 300 hallway</p> <p>Room 314 had gouges to the walls by the bed and in back of the recliner. One resident resided in this room.</p> <p>The Director of Plant Operations and the Environmental Services Director indicated at the time of the tour, all of the above areas were in need of repair or cleaning. The Director of Plant Operations further indicated those were things he looked for in each room for his preventative maintenance, but just had not gotten to those rooms yet.</p> <p>3.1-19(f)</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p>	R000000	Submission of this plan of correction and credible allegation does not constitute an admission by the provider that the	

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R000241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on record review and interview, the facility failed to ensure Physician's orders were followed, related to sliding scale insulin administration for 1 of 5 residents whose records were reviewed for medications in a sample of 8. (Resident #5)</p> <p>Findings include:</p> <p>The record for Resident #5 was reviewed on 2/9/15 at 1:45 p.m. The resident's diagnoses included, but were not limited to, Diabetes Mellitus (DM), dementia,</p>	R000241	<p>allegations are a true and accurate portrayal of the provisions of care in this facility. White Oak Health Campus submits this plan of correction as its letter of credible allegation and requests a desk review with paper compliance be considered in establishing the provider is in substantial compliance. We appreciate your consideration of this request.</p> <p>1. Resident #5 had no adverse affects. 2. Residents with physician's orders for sliding scale insulin administration have the potential to be at risk of the alleged deficiency. Residents with physician's orders for sliding scale insulin administration will have Medication Administration Records (MARs) reviewed for compliance with physician's orders. Physicians will be notified for non-compliance. 3. Nursing staff will be in-serviced by Director of Health Services (DHS) or designee on following physician's orders for sliding scale insulin administration. DHS or designee will audit MARs 3x's</p>	03/12/2015

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	<p>hypertension, weakness, pacemaker, and cardiac disease.</p> <p>Review of the February 2015 Physician's Order Summary (POS) included the following orders related to diabetes management:</p> <ul style="list-style-type: none"> <li>- Lantus Solostar (long-acting insulin) 100 u (units)/ml (milliliter) inject 14 units Sub-Q (subcutaneous, under the skin) every morning. *Do not mix with other insulins*</li> <li>- Novolog (short-acting insulin) flexpen inject 2 units Sub-Q every morning with breakfast for DM</li> <li>- Novolog flexpen, glucometer QID (four times daily) SSI (sliding scale insulin): BS (blood sugar) 70-110 = 0 BS 111-150 = 1 unit BS 151-200 = 2 units BS 201-250 = 4 units BS 251-300 = 6 units BS 301-350 = 8 units BS 351-400 = 10 units BS above 400 = 12 units and call physician</li> </ul> <p>Review of the MARs (Medication Administration Records) for January and February 2015 indicated incorrect doses of insulin were given to Resident #5 on the following dates: 1/10/15 11:00 a.m. - BS 353, 8 units given (should have received 10 units)</p>		<p>per week x 1 month, 2x's per week x 1 month and weekly x 4 months for compliance with physician's orders. 4. Audit results will be brought to monthly Quarterly Assurance (QA) meetings. Trends will be reviewed by the QA Committe x6 months or until 100% compliance is achieved.</p>	

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R000270	<p>1/10/15 4:00 p.m. - BS 321, 6 units given (should have received 8 units) 1/23/15 bedtime - BS 239, 6 units given (should have received 4 units) 2/2/15 4:00 p.m. - BS 400, 12 units given (should have received 10 units)</p> <p>Interview with the Director of Health Services on 2/10/15 at 12:15 p.m., indicated the above insulin doses documented on the MAR were all incorrect and nursing staff should have followed the Physician's orders for sliding scale insulin administration.</p> <p>410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident 's room.</p> <p>Based on observation, interview and record review, the facility failed to follow the recipe for a therapeutic pureed diet. This had the potential to affect 4 of 4 assisted living residents in the facility who received a puree diet.</p> <p>Finding includes:  On 2/5/15 at 11:30 a.m., Cook #1 was observed preparing pureed noodles.</p>	R000270	<p>1. No adverse affects have been noted. 2. Residents receiving a pureed diet have the potential to be at risk of the alleged deficiency. An audit will be conducted by the Director of Food Services (DFS)to ensure that pureed items have recipes. 3.DFS or designee will in-service dietary staff on following a recipe when preparing pureed food. DFS or designee will audit recipes 5x's per week at random meal times to include all meals x 1 month,</p>	03/12/2015

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R000273	<p>Cook #1 placed already cooked noodles into the puree blender, added 3/4 cup of hot milk, pureed noodles to "pudding like thickness." She then added another 1/4 cup of hot milk. At that time, there was no recipe available follow. Cook #1 indicated she did not use a recipe and used milk because it was fortified.</p> <p>The recipe for "Noodles Parsley Pureed," provided by the Administrator on 2/5/15 at 1:40 p.m., indicated ingredients included parsley noodles, chicken base and water. Milk was not in the recipe. Water and chicken base was not used in making the puree by Cook #1.</p> <p>Interview with the Administrator on 2/5/15 at 11:45 a.m., indicated there was a recipe and it should have been followed.</p> <p>On 2/5/15 at 1:40 p.m., the Administrator provided the policy titled, "Pureed Food Preparation." This current policy indicated, "...Procedure:...2. Standardized recipes will be used to produce pureed foods to maintain nutrient content...."</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency</p>		<p>3x's per week x 1 month, and weekly x 4 months. Non-compliance with recipes will be addressed accordingly. 4. Audit results will be brought to monthly Quarterly Assurance (QA) meetings. Trends will be reviewed by the QA Committee x6 months or until 100% compliance is achieved.</p>		

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	<p>(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, interview and record review, the facility failed to ensure food was served and stored under sanitary conditions, related to undated and exposed food in the freezer and improper handling of food during meal preparation. This had the potential to affect 38 of 38 residents that are served from the main kitchen. The facility also failed to ensure proper sanitation of the puree blender in the kitchen for 1 of 1 kitchens observed. This had the potential to affect to 4 of 4 assisted living residents that have a pureed diet. (The Main Kitchen)</p> <p>Findings include:</p> <p>1. During the Brief Kitchen Tour, with the Director of Food Services on 2/3/15 from 10:15 a.m. to 10:32 a.m., the following was observed:</p> <p>a. In the walk-in freezer, there were bags of carrots, broccoli and hashbrowns not labeled with open dates. All were frozen to touch.</p> <p>b. Plastic bags of pork and hamburger patties were exposed and opened to air</p>	R000273	<p>1. No adverse affects have been noted. 2. Residents residing at the facility have the potential to be at risk for the alleged deficiency. Food in the freezer has been observed for proper dating and exposure. Corrections were made as identified. Proper handling of food during meal preparation was reviewed during the time of the survey by the Executive Director with the dietary staff. 3. Director of Food Services (DFS) or designee will in-service dietary staff on proper storage and dating of food in the freezer and proper handling of food during meal preparation. Audits will conducted by the DFS or designee for proper storage and labeling of food in the freezer 4 x's per week x 1 month, 3 x's per week x 1 month and weekly x 4 months. Audits will also be conducted by the DFS or designee for proper handling of food during meal preparation 5 x's per week at random meal times to include all meals x 1 month, 3 x's per week x 1 month and weekly x's 4 months. 4. Audit results will be brought to monthly Quarterly Assurance (QA) meetings. QA Committee will review trends x6 months or until 100% compliance is achieved.</p>	03/12/2015

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	<p>and undated. All were frozen to touch.</p> <p>Interview with the Director of Food Services at that time, indicated the vegetables and the patties should have been labeled with an open date and the patties should have been sealed.</p> <p>On 2/4/15 at 2:53 p.m. the Administrator provided the policy titled, "Storage Procedures." This current policy indicated, "Frozen Storage...3. All foods in the freezer are wrapped in moisture proof wrapping or placed in suitable containers, to prevent freezer burn. Items are labeled and dated...."</p> <p>2. On 2/5/15 at 11:30 a.m., after the preparation of the pureed noodles, Cook #1 washed the blender in the 3 compartment sink with soap and water, rinsed the blender with water, placed it in the sanitizer sink for 30 seconds, then removed it and carried it to the blender to use again for the next pureed food.</p> <p>Interview at that time with Cook #1, indicated she usually leaves the blender in the sanitizer for 30 seconds then re-uses the blender again for the next puree food.</p> <p>On 2/5/15 at 1:55 p.m. the Administrator provided the policy titled,</p>			

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	<p>"3-Compartment Sink." This current policy indicated, "...Procedures: Immerse dishes in 3rd sink sanitizing solution for a minimum of 60 seconds...."</p> <p>3. On 2/5/15 at 12:16 p.m., the following was observed: Cook #2, wearing gloves, handed an ice bucket to another Dietary Service Aide, then got a hot dog bun out of the bag, placed it on a plate, placed a slice of bread onto an egg salad sandwich on another plate and then handed that plate to another Dietary Service Aide. Cook #2 never changed his gloves or washing his hands.</p> <p>Interview with Cook #2 at that time, indicated he should have changed his gloves before and after touching food.</p> <p>On 2/6/15 at 10:50 a.m., the Administrator provided the policy titled, "Hand Washing." This current policy indicated, "...Procedures: Always wash your hands when:...Handling soiled objects...."</p>				