

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 07/11/2014
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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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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: July 7, 8, 9, 10 and 11, 2014.</p> <p>Facility number: 000427 Provider number: 155672 AIM number: 100275150</p> <p>Survey Team: Julie Baumgartner, RN-TC Shauna Carlson, RN (7/7, 7/8 & 7/11, 2014) Sharon Ewing, RN (7/7, 7/9, 7/10 & 7/11, 2014) Pam Williams, RN</p> <p>Census bed type: SNF/NF: 84 Residential: 82 Total: 166</p> <p>Census payor type: Medicare: 17 Medicaid: 48 Private: 19 Other: 82 Total: 166</p>	F000000		

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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F000371 SS=D	<p>Residential Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on July 18, 2014, by Brenda Meredith, R.N.</p> <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 Based on observation, interview and record review the facility failed to ensure meals were being served under sanitary conditions in regards to food handling for 2 of 18 residents. (Resident #84 and #14) This had the potential to affect 18 residents that were served meals in 1 of 4 dining rooms.</p>	F000371	<p>This Plan of Correction constitutes Hamilton Grove's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law. It is the policy and practice of Hamilton Grove to</p>	08/10/2014

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	<p>Findings include:</p> <p>On 7/7/14 at 12:41 P.M., RN #2 was observed in the Center Hall dining room removing a roll from it's wrapper and buttering it with her bare hands. She then served it to resident # 84.</p> <p>On 7/7/14 at 12:47 P.M., RN #2 was observed in the Center Hall dining room removing a roll from it's wrapper and buttering it with her bare hands. She then served it to resident #14.</p> <p>On 7/7/14 at 12:53 P.M., QMA #2 was observed serving a resident her lunch plate with her right thumb on inside edge of plate, she was then further observed to serve the same resident a bowl of chocolate pudding by the rim of the bowl.</p> <p>During an interview on 7/9/14 at 2:21 P.M., the DON (Director of Nursing) indicated plates and bowls should be handled from the bottom, not rims, and coffee cups by the handle. The bread should be handled with gloved hands.</p> <p>On 7/11/14 at 10:35 A.M., a review of an undated "Dining Room Service" policy provided by the ED (Executive Director) and identified as current, indicated "... 2. ... E. Do not handle food with bare</p>		<p>store, prepare, distribute and serve food under sanitary conditions. No residents were adversely affected by this alleged deficiency. <i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient episode?</i> Sufficient time has elapsed to preclude corrective action for resident #84, #14, and the unidentified resident served by QMA #2 <i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</i> A review of nursing staff serving methods on all units did not identify any other resident to be affected by this alleged deficient practice. <i>How other residents having the potential to be affected by the same alleged deficient episode will be identified and what corrective actions will be taken:</i> 1. All nursing and ancillary staff tasked to serve resident meals will be re-inserviced on proper handling and serving techniques to safeguard against cross contamination. 2. Administration reviewed and revised the current policy to include the following: a. To avoid contact with resident's service ware each meal plate will be delivered inside a warmer pallet. The top (lid) of the pallet</p>				

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	hands.... " 3.1-21(i)(2)		will be removed but the bottom portion will remain as a barrier preventing servers from handling it. b. Rolls/bread will be served inside a wax paper container. To serve: the outside corner edge will be torn down the side and one end folded back. A fork and knife are to be used to apply condiments. c. Beverageware, bowls and saucers are to be served to residents holding the bottom of the service ware. The date these systemic changes will be completed: August 10, 2014 <i>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient episode does not recur.</i> The Director of Nursing/Designee will observe at least one meal pass daily on alternate shifts to ensure sanitary distribution and handling of resident meals complies with federal/state regulations and the policy of Hamilton Grove. The DON/designee will record their name, unit, date and type of meal being served (e.g. breakfast, lunch or dinner) the names of the servers, and whether the servers food distribution/handling techniques comply with the aforementioned regulations/policies. Anyone found to violate these guidelines will be immediately re-inserviced and replacement items will be provided to the resident. This monitoring procedure will be	

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R000000	Hamilton Grove was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R000000	implemented for at least one unit on alternating shifts daily, seven days a week for 30 days. Then on at least one unit weekly thereafter. The results of these audits will be submitted to the Administrator/Designee for review weekly for the first 30 days then monthly thereafter. The Administrator/designee will note any deficient practices and submit his/her findings to the Quality assurance committee for further review and recommendations or until a 95% compliance rate is achieved. The date these systemic changes will be completed: August 10, 2014	