

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/09/2014
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 S INDIANA ST GREENCASTLE, IN 46135
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint #'s IN00150819, IN00148918, and IN00148123. This visit resulted in a partially-extended survey-immediate jeopardy.</p> <p>Complaint #IN00150819 substantiated. Federal/state findings cited at F225 and F226.</p> <p>Complaint #IN00148123 substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint #IN00148918 Unsubstantiated due to lack of evidence.</p> <p>Survey dates: July 1, 2, 3, 4, and 7, 2014. Extended survey dates: July 8 and 9, 2014.</p> <p>Facility number: 000418 Provider number: 155565 AIM number: 100274870</p> <p>Survey team: Laura Brashear, RN-TC Lora Brettnacher, RN (July 1, 2, 3, 2014) Megan Burgess, RN (July 1-3, 7-9, 2014) Kewanna Gordon, RN (July 1, 2014)</p>	F000000	<p>F_000000 This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However submission of 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 the requirements established by state and federal law. Hickory Creek at Sunset desires this Plan of Correction to be the facilities Allegation of Compliance. Compliance is effective 7/18/14.</p>	
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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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F000225 SS=J	<p>Brenda Marshall, RN (July 2, 2014)</p> <p>Census bed type: SNF/NF 47 Total: 47</p> <p>Census payor type: Medicare: 3 Medicaid: 33 Other: 11 Total: 47</p> <p>This deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1</p> <p>Quality review completed 7/10/14 by Brenda Marshall, RN.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of</p>						

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	<p>law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure an allegation of staff sexual abuse to a resident was reported to State officials and/or investigated and further potential abuse was prevented for 1 of 1 sampled resident reviewed for abuse related to a staff allegedly having a sexual relationship with a resident (Resident #58). This deficient practice had the potential to</p>	F000225	F_225 It is the policy and standard of care for this facility that all allegations of abuse including sexual abuse are immediately reported to all proper authorities. The Federal Regulations in question are F225 and F226. Hickory Creek at Sunset believes that it has met the intent of these regulations regarding the actions taken by the facility staff in response to	07/18/2014

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	<p>affect all 47 residents in the facility.</p> <p>The immediate jeopardy that began on 4/14/14 was removed on 7/4/14 when the facility initiated 15 minute checks on Resident #58, revised its abuse policy to more specifically address recognition and reporting of allegations of sexual abuse, initiated and completed a thorough investigation of the alleged abuse, and in-serviced all staff regarding the aforementioned interventions and policy revisions. The noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>During an interview on 7/2/14 at 10:57 A.M. Resident #8 indicated he felt staff did not treat him with dignity because he reported to staff he witnessed his roommate having sex with a female staff in a chair in his room. He stated, "They "wrote me off as a liar."</p> <p>During an interview on 7/2/14 at 12:08 P.M., the Administrator was queried regarding knowledge of Resident #8's allegations regarding his roommate having had sex with a female staff. The Administrator indicated he was aware</p>		<p>specific residents' activities and statements, with the resulting validation by both facility management and the surveyors that no episode of sexual abuse occurred. We request Face to Face IDR. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. On 4/14/14 a statement was made by resident #8 against resident #58 who was not in the facility at the time the statement was made. Resident #58 was discharged on 4/10/14 and did not return to the facility until 4/17/14. Resident #8, a vision impaired resident with a history of making false statements, after speaking with a visitor to the facility, whom had instructed him that his roommate was a sexual predator, stated he thought his roommate was going out the side door to have sex with a staff member. The facility did not report this alleged non event due to the fact that the door is not an exit. It has a keypad and once outside, it cannot be reentered. The staff member as described would have been in violation of dress code. He could not tell why he thought they were having sex other than to state the visitor said Resident #58 was a sexual predator. Resident #58, #8's roommate, was not in the facility at the time the statement of the alleged non event took place. Resident #58 was discharged on 4/10/14 and</p>	

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	<p>and he would have the Director of Nursing (DoN) provide the details.</p> <p>During an interview on 7/2/14 at 12:09 P.M., the Director of Nursing indicated Resident #8 reported he saw his roommate having sex with a female staff. The DoN indicated she did not report or investigate the allegations of Resident #58 having sex with a female staff because Resident #8 had a history of making false accusations. The DoN indicated Resident #58 was ambulatory at the time of the allegation.</p> <p>During an interview on 7/3/14 at 9:41 A.M. with the Administrator and DoN present, the Administrator indicated he was aware of Resident #8's allegation of a female staff and Resident #58 having sex. The Administrator indicated nothing was done about the allegation because Resident #8 was unable to describe a staff member who worked at the facility and because the allegation was Resident #58 had been the "perpetrator" by taking the staff member out of the building to have sex. The Administrator indicated he was not aware of Resident #8's allegation regarding the staff member having sex with Resident #58 in a chair in a room. The Administrator stated, "...because we know his history and his manipulation... and when he was saying that, I did not</p>		<p>did not return to the facility until 4/17/14. When ISDH surveyor reported that resident #8 witnessed his roommate having sex, the facility reported the incident at that time, an investigation was initiated, and resident #58 was placed on fifteen minute checks. Both residents were interviewed by Social Services and Psych on Site Services. The facility policy is that all staff is in-serviced on Resident Mistreatment, Neglect, Abuse (including verbal, sexual, and mental) and Misappropriation of Property policy as well as Reporting a Reasonable Suspicion of a Crime Against a Resident, the Elder Justice Act and all complete affirmation statements upon hire, annually and as appropriate. The annual in-service was completed in March of 2014. Re- in-servicing was initiated 7/3/14 and continued until all staff had attended and completed the affirmation statements. Neither the facility nor the ISDH surveyors could substantiate the alleged non event of sexual abuse made on 7/2/14. Describe how the facility reviewed all the clients in the facility that could be affected by the same deficient practice and state what action the facility took to correct the deficient practice for any client the facility identified as being affected. All residents in the facility had the</p>				

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	<p>see it as abuse. if he is seeking sex with a staff." The Administrator indicated if it really happened it will still be "iffy" whether he would have considered it an allegation of abuse or an ethical issue. The Administrator stated, "It is not abuse. It wasn't a believable story. When he was saying it, it was reported as (Resident #58 named) was being a sexual predictor." The Administrator indicated he was informed of the allegation on April 14, 2014. He indicated Resident #8 did not give a date of when the allegation occurred. The Administrator stated, " I don't see it as abuse even if it happened if it was willing..."</p> <p>During an interview on 7/3/14 at 2:19 P.M., the Social Service Director indicated she and the DoN talked to Resident #8 on April 14, 2014 and he reported to her he had seen Resident #58 going outside with a staff member who "wore a skirt" and having sex with her. She indicated it was not investigated and she did not interview any other staff or residents because the facility did not have a staff who "wore skirts." The Social Service Director indicated all allegations should have been investigated.</p> <p>During an interview on 7/3/14 at 2:19 P.M., the Social Service Director indicated she talked to Resident #8 on</p>		<p>potential to be affected, but no other residents were identified as being affected. All residents were interviewed and no other allegations of sexual abuse were identified. If any future allegations are made, as per facility policy and practice, the Administrator will be notified immediately and any resident(s) involved will be examined and /or interviewed to ensure they are secure and are having their needs met appropriately. A thorough investigation will be initiated immediately. The Administrator will notify all appropriate authorities including ISDH, local law enforcement, Ombudsman, and APS. If any staff member is identified as being involved in the allegation, he/she will be immediately suspended pending the outcome of the investigation. Once the allegation is completed, the Administrator and the management team follow up as needed with training or monitoring activities as deemed necessary by the investigation findings. Annual in-serving on Resident Mistreatment, Neglect, Abuse (including verbal, sexual, and mental) and Misappropriation of Property policy as well as Reporting a Reasonable Suspicion of a Crime Against a Resident, and the Elder Justice Act upon hire, annually and as appropriate will continue.</p>	

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	<p>April 14, 2014 and he reported he saw Resident #58 going outside with a staff member who "wore a skirt" and having sex with her. She indicated it was not investigated because the facility did not have a staff who "wore skirts."</p> <p>During an interview on 7/3/14 at 2:30 p.m., Resident #58 was seated in a recliner in his room with a blanket over his head. Resident #58 was queried regarding whether he had concerns related to care/relationships with staff and/or staff treatment. The resident did not provide a verbal response.</p> <p>Resident #58's record was reviewed on 7/3/2014 at 2:30 p.m. Resident #58 had diagnoses which included, but were not limited to, acute renal failure, failed total hip arthroplasty with dislocation, diabetes, cognitive deficit, anxiety, and schizophrenia. A quarterly minimum data set assessment tool (MDS), dated 4/24/14, indicated Resident #58 was cognitively intact with a Brief Interview Mental Status score of 14.</p> <p>Resident #8's record was reviewed on 7/3/14 at 2:40 p.m. Resident #8 had diagnoses which included, but were not limited to, hyperlipdemia, diabetes, hypertension, depression, and constipation. A quarterly minimum data</p>		<p>Describe the steps or systematic changes the facility made or will make to ensure the deficient practice does not recur, including any in services, but this should also include any system changes you have made. The facility will continue Guardian Angel rounds which are done at least five times a week by the interdisciplinary management team. These rounds are documented and even though the document already contains questions designed to identify any questions or concerns that the residents may have with their care or safety, the wording has been revised to contain questions that are the same as used by the survey agency for the resident interviews: "Has staff, a resident or anyone else here abused you-this includes verbal, physical or sexual abuse?" "Did you tell staff?" "Have you seen any resident here being abused?" "Did you tell staff?" The results of these rounds and interviews are brought to the next scheduled morning management team meeting for review; however, if there are any indications of resident abuse or neglect, the Administrator will be notified immediately and the facility will follow through with reporting and investigating incident as indicated in question #2. In addition, a new form has been created for all</p>	

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	<p>set assessment tool (MDS), dated 4/10/14, indicated Resident #8 was cognitively intact with a Brief Interview Mental Status score of 12.</p> <p>A policy titled, "Resident Mistreatment, Neglect, Abuse and Misappropriation of Property" dated 12/1999, identified as current by the Assistant Director of Nursing on 7/3/14 at 2:40 P.M., indicated, "...Residents will be free from mistreatment, neglect, abuse...All reported incidents of alleged violations involving... abuse...are reported to the Administrator immediately, investigated and reported per state and federal law (typically within 24 hours of allegations of mistreatment, neglect, abuse...The designated employee will communicate all investigation information to the administrator, who will determine further action. All allegations will be thoroughly investigated and measures will be taken to prevent further potential abuse while the investigation is in process..."</p> <p>This Federal tag relates to Complaint # IN00150819.</p> <p>3.1-28(c)</p>		<p>investigations. Any concern that may warrant an investigation is to be placed on these investigation forms and Administrator notified immediately. This form will be reviewed by the Administrator multiple times throughout investigation so he can provide guidance to ensure a thorough investigation and conclusion have been met before signing off on any incident. SSD, DON, or appropriate representative will retain a copy of investigation for a minimum of fifteen months. Annual in-serving on Resident Mistreatment, Neglect, Abuse (including verbal, sexual, and mental) and Misappropriation of Property policy as well as Reporting a Reasonable Suspicion of a Crime Against a Resident, and the Elder Justice Act upon hire, annually and as appropriate will continue. How will the corrective actions be monitored to ensure the deficient practice will not recur? The Administrator, DON, and/or SSD will bring the results of resident concerns including allegations of abuse and neglect to the monthly QAA committee meetings for further review and recommendations for process and improvement. If any recommendations are made, the DON or other designated IDT member will follow through and report the results of those recommendations at the</p>	

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F000226 SS=J	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to implement its policy and procedure to ensure an allegation of staff sexual abuse to a resident was reported to State officials and/or investigated and further potential abuse was prevented for 1 of 1 sampled resident reviewed for abuse related to a staff allegedly having a sexual relationship with a resident (Resident #58). This deficient practice had the potential to affect all 47 residents in the facility.</p> <p>The immediate jeopardy that began on 4/14/14 was removed on 7/4/14 when the facility initiated 15 minute checks on Resident #58, revised its abuse policy to more specifically address recognition and reporting of allegations of sexual abuse, initiated and completed a thorough investigation of the alleged abuse, and in-serviced all staff regarding the aforementioned interventions and policy</p>	F000226	<p>next scheduled QAA meeting. This will continue on an ongoing basis. Date of Compliance: 7/18/2014</p> <p>F_226 It is the policy and standard of care for this facility that all allegations of abuse including sexual abuse are thoroughly investigated and prevention of further potential abuse ensured. The Federal Regulations in question are F225 and F226. Hickory Creek at Sunset believes that it has met the intent of these regulations regarding the actions taken by the facility staff in response to specific residents' activities and statements, with the resulting validation by both facility management and the surveyors that no episode of sexual abuse occurred. We request Face to Face IDR. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. On 4/14/14 a statement was made by resident #8 against resident #58 who was not in the facility at the time the statement was made. Resident #58 was discharged on 4/10/14 and did not return to the</p>	07/18/2014

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	<p>revisions. The noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>During an interview on 7/2/14 at 10:57 A.M. Resident #8 indicated he felt staff did not treat him with dignity because he reported to staff he witnessed his roommate having sex with a female staff in a chair in his room. He stated, "They "wrote me off as a liar."</p> <p>During an interview on 7/2/14 at 12:08 P.M., the Administrator was queried regarding knowledge of Resident #8's allegations regarding his roommate having had sex with a female staff. The Administrator indicated he was aware and he would have the Director of Nursing (DoN) provide the details.</p> <p>During an interview on 7/2/14 at 12:09 P.M., the Director of Nursing indicated Resident #8 reported he saw his roommate having sex with a female staff. The DoN indicated she did not report or investigate the allegations of Resident #58 having sex with a female staff because Resident #8 had a history of making false accusations. The DoN</p>		<p>facilityuntil 4/17/14. Resident #8, a vision impaired resident with a history of makingfalse statements, after speaking with a visitor to the facility, whom hadinstructed him that his roommate was a sexual predator, stated he thought hisroommate was going out the side door to have sex with a staff member. The facilitydid not report this alleged non event due to the fact that the door is not anexit. It has a keypad and once outside, it cannot be reentered. The staffmember as described would have been in violation of dress code. He could nottell why he thought they were having sex other than to state the visitor saidResident #58 was a sexual predator. Resident #58, #8's roommate, was not in thefacility at the time the statement of the alleged non event took place.Resident #58 was discharged on 4/10/14 and did not return to the facility until4/17/14. When ISDH surveyor reported that resident #8 witnessed his roommatehaving sex, the facility reported the incident at that time, an investigationwas initiated, and resident #58 was placed on fifteen minute checks. Bothresidents were interviewed by Social Services and Psych on Site Services. Thefacility policy is that all staff is in-serviced on Resident Mistreatment,Neglect, Abuse (including verbal, sexual,</p>	

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	<p>indicated Resident #58 was ambulatory at the time of the allegation.</p> <p>During an interview on 7/3/14 at 9:41 A.M. with the Administrator and DoN present, the Administrator indicated he was aware of Resident #8's allegation of a female staff and Resident #58 having sex. The Administrator indicated nothing was done about the allegation because Resident #8 was unable to describe a staff member who worked at the facility and because the allegation was Resident #58 had been the "perpetrator" by taking the staff member out of the building to have sex. The Administrator indicated he was not aware of Resident #8's allegation regarding the staff member having sex with Resident #58 in a chair in a room. The Administrator stated, "...because we know his history and his manipulation... and when he was saying that, I did not see it as abuse. if he is seeking sex with a staff." The Administrator indicated if it really happened it will still be "iffy" whether he would have considered it an allegation of abuse or an ethical issue. The Administrator stated, "It is not abuse. It wasn't a believable story. When he was saying it, it was reported as (Resident #58 named) was being a sexual predictor." The Administrator indicated he was informed of the allegation on April 14, 2014. He indicated Resident #8 did not</p>		<p>and mental) and Misappropriation ofProperty policy as well as Reporting a Reasonable Suspicion of a Crime Againsta Resident, the Elder Justice Act andall complete affirmation statements upon hire, annually and as appropriate. Theannual in service was completed in March of 2014. Re- inservicing was initiated7/3/14 and continued until all staff had attended and completed the affirmationstatements. Neither the facility nor theSDH surveyors could substantiate the alleged non event of sexual abuse made on7/2/14. Describehow the facility reviewed all the clients in the facility that could beaffected by the same deficient practice and state what action the facility tookto correct the deficient practice for any client the facility identified asbeing affected. All residents inthe facility had the potential to be affected, but no other residents wereidentified as being affected. All residents were interviewed and no otherallegations of sexual abuse were identified. If any future allegations aremade, as per facility policy and practice, the Administrator will be notifiedimmediately and any resident(s) involved will be examined and /or interviewedto ensure they are secure and are having their needs met appropriately. Athorough</p>				

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	<p>give a date of when the allegation occurred. The Administrator stated, " I don't see it as abuse even if it happened if it was willing..."</p> <p>During an interview on 7/3/14 at 2:19 P.M., the Social Service Director indicated she and the DoN talked to Resident #8 on April 14, 2014 and he reported to her he had seen Resident #58 going outside with a staff member who "wore a skirt" and having sex with her. She indicated it was not investigated and she did not interview any other staff or residents because the facility did not have a staff who "wore skirts." The Social Service Director indicated all allegations should have been investigated.</p> <p>During an interview on 7/3/14 at 2:19 P.M., the Social Service Director indicated she talked to Resident #8 on April 14, 2014 and he reported he saw Resident #58 going outside with a staff member who "wore a skirt" and having sex with her. She indicated it was not investigated because the facility did not have a staff who "wore skirts."</p> <p>During an interview on 7/3/14 at 2:30 p.m., Resident #58 was seated in a recliner in his room with a blanket over his head. Resident #58 was queried regarding whether he had concerns</p>		<p>investigation will be initiated immediately. The Administrator will notify all appropriate authorities including ISDH, local law enforcement, Ombudsman, and APS. If any staff member is identified as being involved in the allegation, he/she will be immediately suspended pending the outcome of the investigation. Once the allegation is completed, the Administrator and the management team follow up as needed with training or monitoring activities as deemed necessary by the investigation findings. Annual in-serving on Resident Mistreatment, Neglect, Abuse (including verbal, sexual, and mental) and Misappropriation of Property policy as well as Reporting a Reasonable Suspicion of a Crime Against a Resident, and the Elder Justice Act upon hire, annually and as appropriate will continue.</p> <p>Describe the steps or systematic changes the facility made or will make to ensure the deficient practice does not recur, including any in services, but this should also include any system changes you have made. The facility will continue Guardian Angel rounds which are done at least five times a week by the interdisciplinary management team. These rounds are documented and even though the document already contains questions designed to</p>	

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	<p>related to relationships with staff and/or staff treatment. The resident did not provide a verbal response.</p> <p>Resident #58's record was reviewed on 7/3/2014 at 2:30 p.m. Resident #58 had diagnoses which included, but were not limited to, acute renal failure, failed total hip arthroplasty with dislocation, diabetes, cognitive deficit, anxiety, and schizophrenia. A quarterly minimum data set assessment tool (MDS), dated 4/24/14, indicated Resident #58 was cognitively intact with a Brief Interview Mental Status score of 14.</p> <p>Resident #8's record was reviewed on 7/3/14 at 2:40 p.m. Resident #8 had diagnoses which included, but were not limited to, hyperlipdemia, diabetes, hypertension, depression, and constipation. A quarterly minimum data set assessment tool (MDS), dated 4/10/14, indicated Resident #8 was cognitively intact with a Brief Interview Mental Status score of 12.</p> <p>A policy titled, "Resident Mistreatment, Neglect, Abuse and Misappropriation of Property" dated 12/1999, identified as current by the Assistant Director of Nursing on 7/3/14 at 2:40 P.M., indicated, "...Residents will be free from mistreatment, neglect, abuse...All</p>		<p>identify any questions or concerns that the residents may have with their care or safety, the wording has been revised to contain questions that are the same as used by the survey agency for the resident interviews: "Has staff, a resident or anyone else here abused you-this includes verbal, physical or sexual abuse?" "Did you tell staff?" "Have you seen any resident here being abused?" "Did you tell staff?" The results of these rounds and interviews are brought to the next scheduled morning management team meeting for review; however, if there are any indications of resident abuse or neglect, the Administrator will be notified immediately and the facility will follow through with reporting and investigating incident as indicated in question #2. In addition, a new form has been created for all investigations. Any concern that may warrant an investigation is to be placed on these investigation forms and Administrator notified immediately. This form will be reviewed by the Administrator multiple times throughout investigation so he can provide guidance to ensure a thorough investigation and conclusion have been met before signing off on any incident. SSD, DON, or appropriate representative will retain a copy of investigation for a minimum of</p>		

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F000371 SS=F	<p>reported incidents of alleged violations involving... abuse...are reported to the Administrator immediately, investigated and reported per state and federal law (typically within 24 hours of allegations of mistreatment, neglect, abuse...The designated employee will communicate all investigation information to the administrator, who will determine further action. All allegations will be thoroughly investigated and measures will be taken to prevent further potential abuse while the investigation is in process..."</p> <p>This Federal tag relates to Complaint # IN00150819.</p> <p>3.1-28(a)</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</p>	F000371	<p>fifteen months. Annualin-serving on Resident Mistreatment, Neglect, Abuse (including verbal, sexual,and mental) and Misappropriation of Property policy as well as Reporting aReasonable Suspicion of a Crime Against a Resident, and the Elder Justice Actupon hire, annually and as appropriate will continue. Howwill the corrective actions be monitored to ensure the deficient practice willnot recur? The Administrator, DON, and/or SSD will bring theresults of resident concerns including allegations of abuse and neglect to themonthly QAA committee meetings for further review and recommendations forprocess and improvement. If any recommendations are made, the DON or otherdesignated IDT member will follow through and report the results of thoserecommendations at the next scheduled QAA meeting. This will continue on anongoing basis. Date of Compliance: 7/18/2014</p> <p>F_371 It is the policy and</p>	07/18/2014			

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	<p>record review, the facility failed to ensure food was stored and distributed under sanitary conditions for 1 of 1 kitchen observation in that food temperatures were not consistently monitored and thermometer was not sanitized between checking food items, refrigeration units were not maintained in a sanitary manner, and opened food items lacked use by or dates opened. This deficient practice had the potential to affect 47 of 47 residents of the facility.</p> <p>Findings include:</p> <p>On 7/2/14 during the kitchen observation which began at 10:48 a.m. with the Dietary Manager (DM) the following was observed:</p> <p>a. A reach in refrigerator had spilled, dried milk on the floor, with a foul odor. The Dietary Manager (DM) indicated she told staff repeatedly to clean it up but did not have a cleaning schedule for the refrigerator. The DM indicated she had not implemented a system for this and intended to get a cleaning schedule at some point.</p> <p>b. A gallon of skim milk, cottage cheese, half gallon of buttermilk, doughnuts (not tightly covered) and tomato juice in the portable refrigerator lacked opened or use</p>		<p>standard of practice for this facility that this facility stores prepares and serves food under sanitary conditions in accordance with Federal, State and local authorities. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. It is the desire of this facility to ensure food stored and distributed under sanitary conditions and that temperatures are consistently monitored and that thermometer is sanitized correctly between checking food items and temperature logs are kept up to date ensuring completion. Alcohol swabs have been placed on a shelf above the steam table and all staff has been educated on the policy and procedure to ensure thermometers are clean, rinsed and sanitized before, after, and in between use.</p> <p>Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice and state what action the facility took to correct the deficient practice for any client the facility identified as being affected. Cross contamination can cause food borne illness and has the potential to affect all residents and staff who consume meals from dietary. No residents or staff members were affected from the deficient practice. Describe the steps or systematic changes</p>	

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	<p>by dates.</p> <p>c. At 11:10 a.m., Dietary Aide #1 checked food temperatures on the steam table. The Aide took the temperature of steak, gravy, potatoes, pureed and mechanical soft items. The same thermometer was used for each food item and was not sanitized between items. The Aide indicated to the DM she needed a sani wipe and the DM indicated she did not have one available. The aide rinsed the thermometer under running water only.</p> <p>On 7/2/14 at 11:10 a.m., the DM was interviewed. The manager indicated food temperatures for breakfast had not been done. A log for the current date had not been initiated. The Manager indicated she tried to get staff to maintain logs but had difficulty. The manager attempted to retrieve food logs from the last several weeks and was only able to find a couple of days worth of tracking. She indicated it had not been documented on a regular basis. On 7/9/14 at 1:40 p.m. the DM provided a temperature checklist for May 26-June 30, with temperatures recorded for three meals daily. The DM did not provide a record of temperatures recorded for July, 2014.</p> <p>On 7/9/14 at 1:30 p.m., the DM was</p>		<p>the facility made or will make to ensure the deficient practice does not recur, including any in services, but this should also include any system changes you have made. Alcohol swabs have been placed on a shelf above the steam table and all staff has been educated on the policy and procedure to ensure thermometers are clean, rinsed and sanitized before, after, and in between use. Describe how the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e. what quality assurance program will be put into place. Dietary Manager and/or Assistant Dietary Manager will monitor practice for temperature checks, including cleaning thermometer between foods and logging correct temperatures, at least two meals daily five times a week for the next two months documenting results on Thermometer Sanitation PI Log. Dietary Manager will review results with Administrator or Director of Nursing weekly and bring report results to Monthly Quality Assurance Meeting. F_371 It is the policy and standard of practice for this facility that this facility stores prepares and serves food under sanitary conditions in accordance with Federal, State and local authorities. Describe what the facility did to correct the</p>		

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	<p>interviewed regarding sanitation of the thermometer between testing multiple food items. The DM indicated the thermometer was to be sanitized between testing of food items and produced a tablet product for sanitizing with directions to dissolve one or two tablets in a gallon of water. The DM indicated the thermometer should have been dipped in the solution and wiped with a clean towel.</p> <p>During the same interview, the DM provided a facility policy titled, "Section 2 Food Temperatures-Serving Line dated 2009. POLICY: The temperatures of all foods on the serving line will be measured and recorded at every meal. PROCEDURE: 1. Hot foods in the steam table are maintained at or greater than 135 degrees Fahrenheit [F] so that items arrive at approximately or greater than 120 degrees F when the resident is served. 2. Cold foods are maintained and served at 41 degrees F or less. 3. Temperatures are taken prior to service to ensure hot foods and cold foods are maintained at the above temperatures. 4. Temperatures are recorded on the Steam table Temperature form and kept on file for 1 year. 5. Proper procedures are used so that measured temperatures are accurate and contamination is prevented: b. Thermometers are clean, rinsed, and</p>		<p>deficient practice for each client cited in the deficiency. It is the desire of this facility to ensure food stored and distributed under sanitary conditions and that refrigerators and floors are free of spills maintaining sanitary conditions. Fresh spills pose a fall hazard to staff but dried spills pose sanitation concerns and risk of food borne illness to all residents and staff. The spilled milk was immediately cleaned up.</p> <p>Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice and state what action the facility took to correct the deficient practice for any client the facility identified as being affected. It is the desire of this facility to ensure food stored and distributed under sanitary conditions and that refrigerators and floors are free of spills maintaining sanitary conditions. Fresh spills pose a fall hazard to staff but dried spills pose sanitation concerns and risk of food borne illness to all residents and staff. No residents were affected by this deficient practice. The spilled milk was immediately cleaned up.</p> <p>Describe the steps or systematic changes the facility made or will make to ensure the deficient practice does not recur, including any in services, but this should also</p>	

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	<p>sanitized before, after, and in between use. An alcohol swab may be used to sanitize the thermometer between uses at one meal...."</p> <p>The facility policy titled, "Section 2 Storage Procedures POLICY: Food and supplies shall be properly stored to keep foods safe and preserve flavor, nutritive value, and appearance. REFRIGERATED STORAGE 3. Refrigeration equipment is routinely cleaned and defrosted and free from garbage and other waste. 5. Food is covered, dated, and stored loosely to permit air circulation. 7. Prepared perishables such as ...milk, etc., are stored in a refrigerator and covered, labeled, and dated until used. Section 2 Storage Procedures-Refrigerator & [and] Freezer Storage Chart Milk Cartons or Gallons 5-7 days after container date."</p> <p>The facility policy titled, "Section 7 Cleaning Instructions: Reach-in Refrigerators and Freezers POLICY; 1. As Needed-A. Wipe down outside of equipment with a clean cloth dipped in sanitizing solution. B. Clean up spills...."</p> <p>3,1-31(i)(3)</p>		<p>include any system changes you have made. All dietary staff has been in serviced on the importance of cleaning up spills immediately and following cleaning schedules as assigned. Assigned cleaning schedule was revised to include the inside of the new reach in coolers instead of stating walk-ins holding the Dietary Cook accountable for proper storage of food and clean up of interior portion of the new reach ins. Describe how the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e. what quality assurance program will be put into place. Dietary Manager and/or Assistant Dietary Manager will monitor cleaning logs daily at least five times a week for the next two months to ensure jobs have been completed correctly and staff held accountable. Dietary Manager will review check off sheets and /or any dietary concerns weekly with Administrator or Director of Nursing. Dietary Manager will bring report results to Monthly Quality Assurance Meeting. F_371 It is the policy and standard of practice for this facility that this facility stores prepares and serves food under sanitary conditions in accordance with Federal, State and local authorities. Describe what the facility did to correct the deficient practice for each</p>	

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			<p>client cited in the deficiency. It is the desire of this facility to ensure food is stored and distributed under sanitary conditions and that all items are properly sealed and stored in accordance with policy and procedure, Federal, State and local authorities. All unlabeled items were immediately discarded. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice and state what action the facility took to correct the deficient practice for any client the facility identified as being affected. All residents and staff are at risk of food borne illness when items are not correctly labeled. However, no residents or staff were affected by this deficient practice. Describe the steps or systematic changes the facility made or will make to ensure the deficient practice does not recur, including any in services, but this should also include any system changes you have made. All dietary staff has been in serviced on storage policy and procedure. Cleaning schedule has been revised to include inspection of reach ins to insure proper labeling/ storage of items. Dietary Manager and/or Assistant Dietary Manager will monitor cleaning logs daily at least five times a</p>	

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			week for the next two months to ensure jobs have been completed correctly and staff held accountable. Describe how the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e. what quality assurance program will be put into place. Dietary Manager and/or Assistant Dietary Manager will monitor cleaning logs daily at least five times a week to ensure jobs have been completed correctly and staff held accountable. Dietary Manager will review check off sheets and /or any dietary concerns weekly with Administrator or Director of Nursing. Dietary Manager will bring report results to Monthly Quality Assurance Meeting.		