

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2015
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NAME OF PROVIDER OR SUPPLIER HEARTH AT JUDAY CREEK LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6330 N FIR RD GRANGER, IN 46530
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: August 24 and 25, 2015</p> <p>Facility number: 012229 Provider number: 012229 AIM number: N/A</p> <p>Residential census: 130</p> <p>Residential sample: 7</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000		
R 0029 Bldg. 00	<p>410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, interview and record review, the facility failed to converse with the residents during dining experience for 1 of 3 dining rooms observed. (South dementia unit)</p> <p>Finding includes: On 8-24-2015 from 11:30 A.M. to 11:55</p>	R 0029	The statements made in this plan of correction are not an admission to, nor does it constitute an agreement with the alleged deficiencies herein. To remain in compliance with all state regulations, the community has taken or is planning to take the actions set forth in the following plan of correction. All alleged deficiencies cited have	09/25/2015

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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R 0273 Bldg. 00	<p>A.M., an observation of the dining service for the noon meal was conducted. The dining room is located on the South dementia unit and included all 16 residents, one family member, two CNA's (Certified Nursing Assistants) #6 and #7 and one LPN (Licensed Practical Nurse) #8.</p> <p>CNA #6 and CNA #7 were dishing up and serving food to the residents and LPN #8 was sitting at a table with one resident for the whole observation period. LPN #8's chair was turned away from the table and the resident. LPN #8 conversed with the CNA #6 and CNA #7 about things non-related to care, such as the drive home the day before, and did not talk with the resident at the table.</p> <p>On 8 25-2015 at 11:10 A.M., the Executive Director indicated, "...in the dementia units, the staff should talk with the residents and not each other about things unrelated to the care of the residents...."</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents' units) are</p>		<p>been or are to be corrected by the date or dates indicated. There was no resident identified and no other residents were affected by the alleged deficient practice. All residents on our secured dementia unit have the potential to be affected by this alleged deficient practice. All residents have the right to a pleasant and dignified meal service. The Executive Director will conduct training to nursing and food services staff regarding maintaining resident rights during meal service through staff conversation and engagement. Resident and or family feedback regarding the dining experience will be solicited through ongoing Food Committee Meetings The Executive Director/Keepsake Wellness Director and/or designee will conduct observations of the meal service process to ensure resident rights are being maintained. Observations will be conducted three times per week for 4 consecutive weeks. The weekly for the next 4 weeks, and monthly thereafter. Results of these meal observations will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly.</p>				

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	<p>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 serve food under sanitary conditions in 2 of 3 dining rooms. (Main Dining, Dementia Unit)</p> <p>Findings include:</p> <p>1. On 8-24-2015, a dining service was observed from 11:30 A.M. to 11:55 A.M. on the Keepsake Unit (locked dementia unit) on the south side. CNA (Certified Nursing Assistant) #7 was observed to have a pair of gloves on when the observation began. CNA #7 dished up soup into small green bowls and then picked up 2 bowls with her gloved hands, transporting them to tables for residents. The gloves that CNA #7 was wearing extended past her fingertips and the tip of the gloves touched the soup in the bowls. After sitting the bowls on a table, CNA #7 then touched one resident's chair as she pushed her closer to the table. CNA #7 went back to the serving area and CNA #7 picked up 2 more bowls to serve, the tips of the gloves again touched the soup in the bowls. CNA #7's gloves were dripping with soup as she went back to the serving area. CNA #7 then plated up the Baked Mostaccioli, putting the</p>	R 0273	<p>The statements made in this plan of correction are not an admission to, nor does it constitute an agreement with the alleged deficiencies herein. To remain in compliance with all state regulations, the community has taken or is planning to take the actions set forth in the following plan of correction. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated. There was no resident identified and no other residents were affected by the alleged deficient practice. All residents have the potential to be affected by this alleged deficient practice. The Food Services Director will conduct training to nursing and food services staff regarding sanitation and food safety during meal service. This training will cover topics including facility hand washing policy about when and how to wash hands; proper hand washing procedure with return demonstration; proper use of disposable gloves and the difference between contaminated and uncontaminated gloves; and proper ways to handle dishware/utensils while serving. The Food Services Director and or designee will conduct observations of the meal service process to ensure food is being served under sanitary conditions. Observations will be conducted</p>	09/25/2015			

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	<p>Mostaccioli onto the plate, putting the serving spoon back into the Mostaccioli and using her gloved hands, grabbed the cheese that was hanging over the side of the plate and placing it onto the plate of food. CNA #7's gloved thumb was on every plate that she dished up. CNA #7 grabbed 3 green bowls with her gloved hand, placing her thumb in the top bowl of the stack of 3 and then filled them with pureed food. CNA #7 went to a drawer in the serving area and removed 2 small packets of butter and a knife. CNA #7 put the butter onto the food in the small green bowls. CNA #7 went to a cart with 3 shelves on it and removed the 2 large gray bins from the bottom shelf, sitting them onto the floor. CNA #7 separated the bins placing them onto the shelves of the cart used for clearing dirty dishes. CNA #7 went back to the serving area and dished up 4 more plates of food. CNA #7 was not observed to change her gloves during the observation period.</p> <p>CNA #6 was observed to be serving plates of food to the 16 residents during the observation period. At 11: 44 A.M., CNA #6 washed her hands for 3 seconds, tapping her wet hands on the inside of the sink after washing them and then dried her hands. CNA #6 went back to serving plates of food to the residents.</p>		<p>three time per week for 4 weeks; once a week for the next 4 weeks; and monthly thereafter. Results of these meal service observations will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly.</p>	

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	<p>On 8-25-2015 at 11:10 A.M., during an interview with the ED (Executive Director), the ED indicated, "...hand washing should occur after resident contact, gloves should be changed often if and when they become contaminated and hand washing should occur before putting on new gloves...hand washing should be for 30 seconds during meal service...."</p> <p>On 8-24-2015 at 3:43 P.M., the ED provided the policy titled "Hand Washing," dated 9/27/11, and indicated it was the policy currently used by the facility. The policy indicated "...wash the hands for 15-30 seconds...."</p> <p>2. During the dining observation in the main dining room on 8/24/15 from 11:30 A.M. to 12:40 P.M., the following was observed:</p> <p>Server #2 was observed serving 4 residents lunch plates with thumb in inside edge of plates.</p> <p>Server #3 was observed serving drinks to residents, rubbed her forehead with her hand then continued to serving drinks with out washing her hands.</p> <p>Server #5 was observed to wash her</p>			

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	<p>hands for 12 seconds, turned off faucet with her hands, dried them, then continued to serve drinks to residents.</p> <p>Server #2 was observed serving 3 residents lunch plates with thumb in inside edge of plates.</p> <p>Server #4 was observed to wash her hands for 5 seconds then continued to serve drinks to residents.</p> <p>Server #5 was observed to wash her hands for 12 seconds, turned off faucet with her hands, dried them, then continued to serve drinks to residents.</p> <p>Server #4 was observed to wash her hands for 4 seconds then continued to serve drinks to residents.</p> <p>Server #3 was observed to wash her hands for 10 seconds, dried her hands, then wiped her hands on her pants and then served soup to a resident.</p> <p>Server #5 was observed to wash her hands for 13 seconds, turned off faucet with her hands, dried them, then continued to serve drinks to residents.</p> <p>Server #3 was observed washing her hands for 11 seconds then continued to serve resident lunch plates.</p>			

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	<p>Server #2 was observed serving 2 residents lunch plates with thumb on inside edge of plates.</p> <p>Server #2 was observed serving 2 residents lunch plates with thumb on inside edge of plates.</p> <p>Server #2 was observed serving a resident a lunch plate with thumb on inside edge of plate.</p> <p>Server #4 was observed to wash her hands for 4 seconds then served a resident a cup of coffee.</p> <p>Server #2 was observed serving 2 residents lunch plates with thumb on inside edge of plates.</p> <p>Server #2 was observed serving a resident a lunch plate, wiped face with his hands, then went on to serve 3 more lunch plates to residents.</p> <p>Server #3 was observed serving 2 residents dessert with fingers on the top rim of the bowl.</p> <p>During an interview on 8/25/15 at 11:13 A.M., the ED indicated " ... plates should be handled underneath with thumb on the outer edge...servers should do a 30 second hand wash... washing after touching a resident or</p>			

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	<p>themselves...following proper procedures...."</p> <p>On 8-24-2015 at 3:43 P.M., the ED provided the policy titled "Hand Washing," dated 9/27/11, and indicated it was the policy currently used by the facility. The policy indicated " ...2...wash hands for 15-30 seconds...6. Using paper towel, turn off the faucet. [Don't use your hands to turn off the water as they are clean and the faucet is contaminated]...."</p> <p>On 8/25/15 at 10:33 A.M., review of the current, undated policy titled "Pre Meal Hot Topics" provided by the ED indicated "...Handle plates by the rims. Never let your thumb go onto the plate...."</p>						