

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/19/2012
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NAME OF PROVIDER OR SUPPLIER HEARTH AT STONES CROSSING LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2339 S SR 135 GREENWOOD, IN 46143
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R0000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: January 17, 18, and 19, 2012</p> <p>Facility number: 005722 Provider Number: 005722 AIM number: NA</p> <p>Survey Team: Leia Alley, TC, RN Marcy Smith, RN Patty Allen, BSW Dinah Jones, RN</p> <p>Census bed type: Residential: 118 Total: 118</p> <p>Census payor type: Other: 118 Total: 118</p> <p>Sample: 8</p> <p>These state residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 23, 2012 by Bev Faulkner, RN</p>	R0000		

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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R0092	<p>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:</p> <p>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on, interview and record review, the facility failed to ensure that all three shifts participated in fire drills quarterly. This had the potential to affect 118 residents residing in the facility.</p> <p>Findings include:</p> <p>During review of facility documentation of fire drills on 1/17/12 at 1:15 p.m., documentation of fire drills was lacking for evening shift for April, May, June, the second quarter of 2011. The documentation was lacking for night shift fire drills for July, August, September, the</p>	R0092	<p>1) What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice; The facility has implimented a master schedule for the annual fire drills. This master schedule is kept with the firedrill log book in the mintenance office and the Administrtror also has a copy to use to monitor the accuracy of fire drills and to make sure that they are occuring at the appropriate times and on the appropriate shifts.2) How will the facility identify other residents having the potential t be affected by the same deficient practice</p>	02/13/2012			

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	<p>third quarter of 2011.</p> <p>During interview with the Administrator on 1-17-12 at 2:15 p.m., he indicated they were unable to find the missing documentation for the fire drills.</p> <p>During interview with the Director of Nursing on 1-19-12 at 3:00 p.m., she indicated they were unable to find the missing documentation for the fire drills and this would have the potential to affect 118 residents residing in the facility.</p>		<p>and what corrective actions will be taken; The facility has determined that all residents have the potential to be affected by the deficient practice and have taken the action noted in part 1 of this plan of correction by creating the master fire drill schedule for all of the fire drills for the following year which will be administered by the director of maintenance and monitored by the executive director for the remainder of the year.3) What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not occur; The facility has created the master schedule which will be submitted to the facility leadership team each week at our stand up meeting to ensure that the fire drills are happening on time. Also, the Administrator will monitor the fire drill schedule to ensure that it is being followed and give the maintenance director reminders leading up to the scheduled date of the fire drill.4) How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place and,; The new fire drill master schedule will be submitted to our weekly sit down (QA meeting) to help monitor that the fire drills are being conducted as scheduled, also the administrator will monitor the fire drill master schedule to make sure that the maintenance</p>				

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			director is conducting the fire drills accoring to schedule.5) by what date will the systemic change be completed; The Master fire drill schedule has already been put into place and is effective immediately. It was put into place before State SURvey team exited the building for annual survey. Date completed 2/13/12	

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R0273	<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 and interview, the facility failed to ensure the kitchen staff washed their hands and handled food properly potentially affecting 118 of 118 residents receiving food residing in the facility.</p> <p>Findings include:</p> <p>During observation of the kitchen on 1/17/12, at 10:10 a.m., Dietary Aide #1 poured tea, lemonade, and water into serving pitchers from gallon sized jugs. Without washing her hands, she then picked up lids of pitchers by the bottoms and placed the lids on the pitchers with the bottom edges touching the liquid. Without washing her hands, Dietary Aide #1 placed empty ramekins on serving carts with her bare hands, she then entered the cooler to get plastic gallon size salad dressing container and proceeded to fill the ramekins with salad dressing from the jug. Dietary Aide #1 then pulled a paper towel from a dispenser and wiped a spill from cart. She then lifted the lid of a large trash can with her bare hands and threw the paper towel in the trash can. Without washing her hands, she pushed the cart to the main dining room and placed the</p>	R0273	<p>1) What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice; an inservice on proper hand hygiene and proper food handling has been administered to all dietary staff to ensure that they have been reeducated on the matter. Also, we have been monitoring the staff 5x a week since the survey team exited the building. We will continue to monitor 5x a week throughout February then 2x weekly there after for 2 months. 2) How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken; The facility has determine tht all residents have the potential to be affected because all resident eat foo served from our main dining room. We have inserviced all current dietary employees and have also ensured that all new dietary employees are educated on hand washing and food handling upon hire, which has been our process for new employees of dietary. 3) What measures will be put into place or what systemic changes will the faciity make to ensure that the deficient practice does not occur; we have been monitoring</p>	02/13/2012			

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	<p>ramekins and pitchers on a drink station after which she re-entered the kitchen and did not wash her hands before touching clean plates.</p> <p>During observation in the kitchen on 1/18/12, at 9:30 a.m., Dietary Cook #1 picked up a handful of grated cheese from a bowl with her bare hands and put the cheese on cooked eggs in a skillet on the stove. The remainder of the grated cheese in the bowl was then placed on the food preparation table for later use. Dietary Cook #1 put a prepared omelet on a serving plate and handed the plate to Dietary Aide #1 to take to the dining room and serve to a resident. Dietary Cook #1 put on disposable gloves without washing her hands, picked up a paper towel, picked up a trash can lid and threw the towel into the trash can. Without removing her gloves and washing her hands, she then picked up tongs and transferred cooked bacon to a storage container.</p> <p>During interview with Dietary Manager on 1/18/12 at 10:45 a.m., he indicated 118 residents are offered meals 3 times a day.</p> <p>During interview of DON on 1/19/12 at 2:35 p.m., she indicated that there is no specific policy for hand washing for the kitchen.</p>		<p>the staff 5x a week for hand washing and proper food handling since the survey team exited the building. We will continue to monitor 5x a week throughout February then 2x weekly there after for 2 months.4) How will the corrective actions be monitored to ensure the defecient practice will not recur, i.e, what quality assurance program will be put into place and,; All inservice materil has been submitted to our Quality assurance team at our weekly sit down meetings and we will continue to monitor dietary staff 5x a week through out February and 2x weekly for two months thereafter. 5) By what date will the systemic change be completed; Inservice was completed before state surveyers left the facility for state survey and monitoring will continue through April 2012. The systemic change will be completed by 2/13/12</p>				

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