

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155680	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
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NAME OF PROVIDER OR SUPPLIER HOMEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2494 N LEBANON ST LEBANON, IN 46052
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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: October 22, 23, 24, 27, 28, 29, & 30, 2014</p> <p>Facility number: 002703 Provider number: 155680 AIM number: 200309250</p> <p>Survey team: Lora Brettnacher, RN-TC Kewanna Gordon, RN (October 27, 28, 29, & 30, 2014) Tracina Moody, RN Megan Burgess, RN</p> <p>Census bed type: SNF: 37 SNF/NF: 19 Residential: 38 Total: 94</p> <p>Census Payor type: Medicare: 20 Medicaid: 24 Other: 12 Total: 56</p> <p>Sample: 7</p>	F000000	<p>The facility requests the plan of correction be granted a "desk review" by the Department due to the scope and severity levels of the alleged deficiencies. The submission of this Plan of Correction does not indicate an admission by Homewood Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Homewood Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for residential health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.</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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F000153 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 11/3/14 by Brenda Marshall, RN</p> <p>483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.</p> <p>Based on interview and record review, the facility failed to provide requested medical records to the resident within the required time period. This deficient practice affected 1 of 1 resident reviewed for resident rights regarding medical record access (Resident #40).</p> <p>Findings include:</p> <p>During an interview with Resident #40 on,10/29/14 at 11:20 p.m., she indicated she had requested a copy of her entire medical record over a week ago, and had</p>	F000153	The facility requests IDR for the deficiency based upon the fact that the resident was offered a copy of the record to be provided once fee for copy was secured and paid. To date, the resident has not agreed to allow the facility to begin making the copy. Corrective Action: This resident was offered a copy of entire medical record on 10-30-14. A cost for copying was presented to the resident. The resident has yet to confirm whether they want the record copied or not. Identifying others: The facility contends that any resident requesting medical	10/30/2014

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	<p>not received it.</p> <p>During an interview on, 10/30/14 at 1:20 p.m., the Director of Nursing (DoN), indicated she had given the resident a copy of her falls, but not provided her the entire medical record as requested.</p> <p>A document entitled, "Request for Access to Protected Health Information," received from the Environmental Services Director, on 10/30/14 at 10:20 a.m., indicated Resident #40 had requested a copy of her, "Entire Chart," on 10/14/14.</p> <p>A document entitled, "Bill of Resident Rights," received from the Social Services Director (SSD), on 10/30/14 at 12:19 p.m., indicated, "You have the right, upon oral or written request and 24 hour notice (excluding weekends and holidays), to have access to all records pertaining to you, and upon request and two working days advance notice, to purchase photocopies of all such records."</p> <p>3.1-4(b)(2)</p>		<p>records would be identified as having potential to be affected by the action alleged. Measures: medical records will receive any and all such requests and immediately present them to facility nurse and executive administration who, in turn will provide resident with the fee associated with copying and proceed with ensuring the copy is provided with residents agreement and payment of fees. Monitoring: Medical Records staff will monitor requests placed in writing and ensure that requests are immediately provided for follow through. Medical records will receive a signed copy of initial request in return acknowledging resident has received requested document(s).</p>				

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F000279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure a care plan was developed for nutrition and/or failed to ensure care plans included the correct supervision level/assistance for transfers for 3 of 19 residents reviewed for care plans. (Resident #54, #37, and #58).</p> <p>Findings include:</p> <p>1. On 10/28/2014 at 11:15 a.m., Resident #54's record was reviewed. The physician's order summary, dated 9/25/14, indicated Resident #54 had a</p>	F000279	Corrective Action: The care plans of the residents identified were reviewed and updated as indicated. Identifying others: The facility has determined that all residents have the potential to be affected. Measures/Systems: All interdisciplinary care plan team members responsible for writing care plans will be re-educated on the facility's policy and procedure for developing Comprehensive Care Plans. Monitoring: Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS coordinator. All care plans will be updated as indicated. The	11/29/2014	

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	<p>diagnosis of right hemiparesis.</p> <p>The quarterly minimum data set (MDS) assessment, dated 7/10/14, indicated Resident #54 had functional limitation in range of motion on one side. The MDS indicated the resident required a two person physical assist for bed mobility, transfer, and toilet use. The MDS indicated the resident required a one person physical assist for personal hygiene, bathing, and dressing.</p> <p>The care plan, updated on 9/6/14, indicated Resident #54 required assistance of one person with transfers, toileting, mobility, showers/bathing, washing/drying his back, and applying lotion due to his right sided hemiparesis.</p> <p>The occupational therapy plan of care, dated 9/17/14, indicated Resident #54 had severely impaired motor control and fine motor coordination of the right upper extremity. The plan of care indicated the resident had a flaccid right upper extremity.</p> <p>The monthly nursing assessment, dated 9/20/14, indicated the resident had a partial contracture in the right upper extremity.</p> <p>During an interview on 10/29/2014 at</p>		<p>Director of Health Services (DHS), or designee, will complete random weekly audits consisting of 10% of resident care plans per week for six (6) consecutive weeks. Random audits will be completed to ensure that comprehensive care plans are developed for residents. Audit records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. **The facility will review at each MDS/CarePlan review period quarterly on an ongoing basis, or upon significant condition change, to ensure ongoing compliance.</p>		

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F000280 SS=D	<p>10:46 a.m., the minimum data set (MDS) coordinator indicated the quarterly MDS for Resident #54 was correct and the resident required a two person assist not a one person assist for bed mobility, transfers, and toileting. She indicated the care plan was not accurate.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident was afforded the opportunity to make choices regarding health care for 1 of 1 resident reviewed for participation in care and treatment.(Resident #40).</p>	F000280	<p>Corrective: The facility removed safety intervention items at resident request. Discussed risks versus benefits with resident up to and including death. Resident understands. Identifying others: No other resident(s) were identified as being affected by this deficiency. Measures/Systemic Changes: Complete an audit of all alert and oriented residents</p>	10/30/2014			

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	<p>Findings include:</p> <p>During an observation on, 10/29/14 at 11:20 a.m., Resident #40 was observed seated in a wheel chair in her room. She was observed to have a seat belt around her waist, and a chair alarm on her wheel chair. Her bed was observed to have a bed alarm and an alarmed floor mat at the bedside.</p> <p>During an interview on, 10/29/14 at 11:20 a.m., Resident #40 indicated she was not given an opportunity to make choices about her daily care in regards to the alarms the facility placed on her to prevent falls.</p> <p>A quarterly Minimum Data Set (MDS) dated 10/15/14, indicated Resident #40 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15.</p> <p>A care plan dated 8/24/14, indicated Resident #40 was at risk for falls. Interventions included but were not limited to wheel chair alarm, bed alarm, and seat belt.</p> <p>A care plan dated 10/12/14, indicated, "I am to have psych. (psychiatric) eval (evaluation) for continued falls at to reduce my risk of injury of falls."</p>		that currently have safety interventions to ensure they are in agreement to continue to utilize the safety equipment. For all new admissions, the facility will ensure preferences are honored before any safety interventions are placed. Monitoring: The facility will monitor 10% of all alert and oriented residents with safety interventions on a weekly basis for six consecutive weeks and audit findings will be reviewed by the Quality Assurance Committee until such time as consistent substantial compliance is achieved **The facility will review at each MDS/CarePlan review period quarterly on an ongoing basis, or upon significant condition change, to ensure ongoing compliance.		

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	<p>A care plan dated 10/24/14, indicated Resident #40 was to have an alarmed floor mat as an added intervention to prevent falls.</p> <p>During an interview on, 10/29/14 at 12:22 p.m., the Staffing Coordinator, indicated, Resident 40 had reported that the use of the alarms and other interventions had, "embarrassed her."</p> <p>During an interview on, 10/29/14, at 2:10 p.m., the Social Service Director (SSD), indicated she had set in meetings in which the resident had gotten, "teary" and indicated the alarms were, "embarrassing" to her. The SSD stated the resident "was not thrilled with the alarms." She indicated the resident shuts off her alarms because she does not want to wait for staff to respond to call lights and wants to do things on her own. The SSD indicated she had set up a psych (psychiatric) evaluation as an intervention in response to the residents' falls, and the resident was found to be, "completely aware and cognitively intact." She indicated, she had explained to the resident that she did have "rights but we still have to keep her safe, I have offered her alternate placement, she has declined."</p>			

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	<p>During an interview with the Director of Nursing (DoN), on 10/30/14 at 9:34 a.m., she stated, "I know she does not like the alarms but we continue to educate her to use the call light. I said if you could use the bed alarm and the mat if you don't have a fall for 30 days we can start lifting alarms and interventions off of you." She indicated she had asked the resident if she wanted her to look for her another place to live that could keep her safe.</p> <p>An "Initial Psychosocial Assessment," received from the SSD on 10/29/14 at 2:28 p.m., indicated, Resident #40, "is still very non-compliant with her fall interventions although she is aware of the risks of her non-compliance...." The document indicated the resident had stated, "I just shut them off and do what I want anyways," in regard to the alarms. The document indicated, "Writer also spoke with her about reports of shutting her alarms off and reminded her of the commitment she made in May of 2014 to follow all safety recommendations. Resident #40 stated she did recall the contract she signed. Writer also explained that if Homewood Health Care (HWHC) is unable to keep her safe, we are not meeting her needs and writer, again, offered to find alternate placement."</p>			
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F000323 SS=D	<p>A document entitled, "Bill of Resident Rights," received from the SSD on 10/30/14, at 1:20 p.m., indicated, " You have the right to exercise your rights as a resident of the facility and as a citizen or resident of the United States....you have the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising your rights....You have the right to refuse treatment..."</p> <p>3.1-35(2)(B)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure staff provided the correct amount of assistance to residents to prevent falls for 1 of 4 residents reviewed for falls (Resident #37). This deficient practice resulted in an assisted fall to the floor when Resident #37 was transferred from his bed to his wheelchair.</p> <p>Findings include: Resident #37's record was reviewed on 10/27/14 at 10:00 a.m. A quarterly</p>	F000323	<p>Corrective Action: The care plans of the residents identified were reviewed and updated as indicated. Identifying others: The facility has determined that all residents have the potential to be affected. Measures/Systems: All interdisciplinary care plan team members responsible for writing care plans will be re-educated on the facility's policy and procedure for developing Comprehensive Care Plans. Monitoring: Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS coordinator. All care plans will be</p>	11/29/2014

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	<p>Minimum Data Set assessment tool (MDS), dated 8/29/14, indicated Resident #37 required extensive assistance, with two or more persons providing physical assistance, with transferring (how the resident moves between surfaces including to or from: bed, chair, wheelchair, standing position). Resident was not steady, and only able to stabilize with human assistance when moving from a seated to standing position. Resident was cognitively intact with a Brief Interview Mental Status score (BIMS) of 15 out of 15.</p> <p>A "Fall Circumstance, Assessment, and Intervention", dated 10/3/14, indicated Resident #37 had experienced left and right lower extremity weakness during a transfer from the bed to the wheel chair with assistance of one person, and was assisted to the floor during this transfer in the resident's room.</p> <p>Review of an ADL (Activities of Daily Living) current care plan, dated 12/26/13, indicated Resident #37 required assist of one staff for all ADL care.</p> <p>Review of Resident #37's profile within the CNA (Certified Nursing Assistant) Assignment Kiosk, identified as current by the DON (Director of Nursing), ADON (Assistant Director of Nursing)</p>		<p>updated as indicated. The Director of Health Services (DHS), or designee, will complete random weekly audits consisting of 10% of resident care plans per week for six (6) consecutive weeks. Random audits will be completed to ensure that comprehensive care plans are developed for residents. Audit records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. **The facility will review indicated assistance levels for each resident at MDS/Care Plan reviews quarterly, or upon significant change of condition, to monitor needed assistance levels are accurate and maintain continued compliance.</p>		

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	<p>and CNA #1, on 10/28/14 at 12:24 p.m., indicated the resident required assistance of one for all ADL care.</p> <p>During an interview on 10/28/14 at 11:20 a.m., Resident #37 indicated he had experienced a fall in his room during a transfer from his bed to his wheelchair with assistance from one CNA. The resident indicated that one staff member provided him with assistance during his past transfers.</p> <p>During an interview on 10/28/14 at 12:10 p.m., CNA #1 indicated she was unaware Resident #37 required assistance of two staff for transfers.</p> <p>During an interview on 10/28/14 at 12:40 p.m., the MDS Coordinator indicated the resident's care plan was derived from his MDS information. She indicated the Annual MDS, dated 5/29/14, provided the correct functional status information for the resident and the care plan failed to include the correct assistance amount required for the Resident #37's transfers.</p> <p>An undated policy titled "Guidelines for Circumstance and Reassessment Forms", identified as current by the Corporate Nursing Consultant on 10/30/14 at 1:01 p.m., indicated, "Purpose: To provide a</p>			

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F000372 SS=F	<p>mechanism for investigation, assessment, care plan update, interdisciplinary team review and follow up for specific episodes ... The interdisciplinary team should review the completed form in the daily stand up meeting. Review should include the thoroughness of the investigation, circumstance of the incident, reassessment accuracy, and approach/intervention response"</p> <p>3.1-45(a)(2)</p> <p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to ensure garbage waste was properly contained in compactors with closed lids for 3 of 3 kitchen observations. Findings include: During initial tour of the kitchen on 10/22/14 at 9:40 a.m., with the Dietary Manager, a trash receptacle stationed next to the deep fryer and oven was covered with a lid containing a manually cut hole in the center of it. During an observation of the kitchen on</p>	F000372	<p>Corrective Action: The facility purchased new lids for 3 of 3 garbage containers identified during the survey with holes cut in center. All cans now have a solid, secured garbage lid in place when not in use. Identifying others: The facility contends that any resident served from the kitchen would have had potential to be affected by the deficiency. Measures: The facility has purchased new garbage covers and discarded lids being used prior. Monitoring: The Director of Food Services (DFS), or designee will montitor daily to ensure the garbage cans are</p>	10/30/2014

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NAME OF PROVIDER OR SUPPLIER HOMEWOOD HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2494 N LEBANON ST LEBANON, IN 46052			
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	<p>10/22/14 at 11:36 a.m., the trash receptacle stationed near the food prep area was covered with a lid containing a manually cut hole in the center. The trash receptacle sat two inches from the deep fryer, where food was being prepared in the fryer cages.</p> <p>During an observation of the kitchen on 10/29/14 at 11:35 a.m., a cover was absent for the trash receptacle stationed next to the fryer.</p> <p>During an interview on 10/30/14 at 9:45 a.m., the Dietary Manager indicated that he had cut holes in the trash receptacle lids to ensure his staff would not have to take the lids off with their hands as they prepared food.</p> <p>A facility policy titled " Garbage and Refuse ", dated 4/2009 and identified as current by the Dietary Manager, indicated, " Guideline: All garbage and refuse will be stored and disposed of daily in a sanitary manner according to defined procedures ... Procedure: Garbage receptacles will be lined with sturdy garbage bags and covered at all times, except during active use, and when being transported to the dumpster area "</p>		<p>securely covered when not in use. The Executive Director (ED) will observe the garbage cans for compliance during daily rounding.</p>				

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F000508 SS=D	<p>3.1-21(i)(5)</p> <p>483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on interview and record review, the facility failed to ensure timely radiology services for 1 of 2 residents reviewed for injuries/accidents who required radiology services (Resident #7).</p> <p>Findings include:</p> <p>Resident #7's record was reviewed on 10/27/2014 at 10:05 a.m. A quarterly Minimum Data Set assessment tool (MDS), dated 9/20/2014, indicated Resident #7 was severely cognitively impaired and was totally dependent on staff to meet her needs.</p> <p>An untimed "late entry" nurse's note, dated 10/26/14, indicated on 10/25/14, Registered Nurse (RN) #40 was "told in report" Resident #7 had complained of "pain" and was medicated. This note indicated RN #40 assessed Resident #7 at the beginning of the "2p-10p" shift. RN #40 noted Resident #7's leg "swollen</p>	F000508	<p>Corrective Action: Xray was obtained for the resident. Further, the Executive Director (ED) and the Director of Health Services (DHS) both had phone conference with the lead area Representative for the Xray provider vendor. Guidelines for stat service were reviewed and agreed upon. Identifying Others: No other residents were identified as being affected by this deficient practice. Measures/Changes: Protocol for time frames for service were reviewed between Xray Provider and Facility Administration. If provider is unable to meet the terms of time frame, provider will notify facility and the facility will make alternate arrangements to have residents served by the hospital directly across the street from the facility. Monitoring: The Director of Health Services (DHS) or designee will monitor time frame from call for service to ensure within timeline, or make decision to send to nearby hospital for service.</p>	10/30/2014			

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	<p>with a bruise and small bump beginning to form over the shin. Edema extended from knee to toes...pain a nonverbal 8 to 10." This note indicated RN #40 contacted a physician and obtained an order for an X-ray to be obtained via the facility's contracted mobile radiology provider. This note indicated as of 10/25/14 at at 11:15 p.m., the facility's contracted X-ray provider had not arrived so RN #40 called them back and changed the order to stat (immediate). This note indicated as of 10/26/14 at 9:30 a.m., the facility's contracted X-ray provider had not arrived so RN #40 contacted them and informed them "This is for an acute injury/severe pain and needs to be done ASAP." This note indicated the facility's contracted X-ray provider arrived at the facility on 10/26/14 at 11:35 a.m. (Twelve hours and twenty minutes after the stat order was obtained), an X-ray was obtained, and the results indicated a spiral fracture to Resident #7's mid distal tibia (leg bone). This note indicated the physician was notified and stated, "We need to get her transferred to ER (emergency room), we can't wait to get her an ortho (orthopedic) appt. (appointment)."</p> <p>A physician's order, dated 10/25/14 at 3:22 p.m., indicated an order for a X-Ray to Resident #7's left lower extremity.</p>			

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	<p>A physical's order, dated 10/25/14 at 10:55 p.m., indicated an order for a "stat" X-ray to Resident #7's left lower extremity.</p> <p>A physician's order, dated 10/26/14 at 9:30 a.m., indicated an order for a "stat" X-ray to Resident #7's left lower extremity.</p> <p>During an interview on 10/28/2014 at 10:34 a.m., the facility's Medical Director stated, "...Normally a stat order is 4-6 hours..."</p> <p>During an interview on 10/27/2014 at 2:08 p.m., the Director of Nursing (DON) indicated the original X-ray order on 10/25/14 at 3:22 p.m., was not ordered "stat" but because of Resident #7's "pain" on 10/25/14 at 10:55 p.m., RN #40 called the X-ray provider back and changed the order to "stat." The DON indicated a stat order should have a "four hour turn around." She indicated if a stat order could not be obtained within four hours from when it was ordered she would have expected the resident to be sent out to the emergency room to obtain X-ray services.</p> <p>A document titled "Agreement to Provide X-Ray Services" identified as current on 10/28/14, by the facility's</p>			

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R000000	<p>corporate nurse consultant, indicated, "...Each Imaging Center shall provide its Designated Center (s) with complete, accurate and timely Services upon the request of the Designated Center(s) in accordance with the orders of a resident's attending physician..."</p> <p>3.1-49(g)</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-5.</p>	R000000	The facility requests the plan of correction be granted a "desk review" by the Department due to the scope and severity levels of the alleged deficiencies. The submission of this Plan of Correction does not indicate an admission by Homewood Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Homewood Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for residential health care		

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R000273	<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 maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure garbage waste was properly contained in compactors with closed lids for 3 of 3 kitchen observations. Findings include: During initial tour of the kitchen on 10/22/14 at 9:40 a.m., with the Dietary Manager, a trash receptacle stationed next to the deep fryer and oven was covered with a lid containing a manually cut hole in the center of it. During an observation of the kitchen on 10/22/14 at 11:36 a.m., the trash receptacle stationed near the food prep area was covered with a lid containing a manually cut hole in the center. The trash receptacle sat two inches from the</p>	R000273	<p>facilities. To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.</p> <p>Corrective Action: The facility purchased new lids for 3 of 3 garbage containers identified during the survey with holes cut in center. All cans now have a solid, secured garbage lid in place when not in use. Identifying others: The facility contends that any resident served from the kitchen would have had potential to be affected by the deficiency. Measures: The facility has purchased new garbage covers and discarded lids being used prior. Monitoring: The Director of Food Services (DFS), or designee will montitor daily to ensure the garbage cans are securely covered when not in use. The Executive Director (ED) will observe the garbage cans for compliance during daily rounding.</p>	10/31/2014

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	<p>deep fryer, where food was being prepared in the fryer cages.</p> <p>During an observation of the kitchen on 10/29/14 at 11:35 a.m., a cover was absent for the trash receptacle stationed next to the fryer.</p> <p>During an interview on 10/30/14 at 9:45 a.m., the Dietary Manager indicated that he had cut holes in the trash receptacle lids to ensure his staff would not have to take the lids off with their hands as they prepared food.</p> <p>A facility policy titled "Garbage and Refuse," dated 4/2009, and identified as current by the Dietary Manager, indicated, " Guideline: All garbage and refuse will be stored and disposed of daily in a sanitary manner according to defined procedures ... Procedure: Garbage receptacles will be lined with sturdy garbage bags and covered at all times, except during active use, and when being transported to the dumpster area "</p>				