STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOOSIER VILLAGE	9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268

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F000000	This visit was for a Recertification and State Licensure survey. Survey dates: February 21, 22, 25, 26, 27, 28, 20013 and March 1, 2013 Facility Number: 000548 Provider Number: 155472 AIM Number: N/A Survey team: Lora Brettnacher, RN, TC Heather Lay, RN Census bed type: SNF: 17 NCC: 58 Residential: 88 Total: 163 Census payor type: Medicare: 10 Other: 153 Total: 163 NCC sample: 6 Residential sample: 7 These deficiencies reflect State findings in accordance with 410 IAC 16.2. Quality Review completed on	F000000	This plan of correction constitutes the written compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by the state and federal law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	03/04/2013 by Brenda Nunan, RN.			

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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).			
	Based on record review and interview, the facility failed to develop a coordinated hospice care plan for a resident who received hospice services. This deficient practice affected 1 of 1 hospice resident reviewed [Resident #42]. Findings include: On 2/26/13 at 10:00 A.M., Resident #42's record was reviewed. Diagnoses included, but were not limited to, right hip fracture secondary to fall, aspiration, and dysphagia.	F000279	1. The facility considers the plan of care for the resident receiving hospice services to be coordinated between Hoosier Village and Hospice. On 1/23/13 the facility care plan coordinator and social services designee met with Hospice staff to discuss compliance concerning coordinated plans of care for any resident receiving hospice services. Furthermore, the interdisciplinary team; including the facility care plan coordinator, facility social services designee, hospice social services designee, and hospice nurse reviewed Resident #42 plan of care on	03/11/2013

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	A "Care Plan Review" dated 1/22/13, included, but was not limited to, "Resident has requested not to continue therapy at this time... Hospice referral..." The facility's "Hospice" care plan, dated 1/24/13, included, but was not limited to, "Hospice: Resident is displaying symptoms of end of life and is on hospice care... Will openly discuss feelings regarding end of life as resident wishes in the next 90 days... Offer to have chaplain visit resident as needed... Provide emotional support to resident... Assist resident through various phases of grief process... Observe for changes in mood status... Encourage family to visit/contact resident... Validate [Resident #42's] feelings and listen to her concerns[no discipline listed]..." The hospice agency's care plan, dated 2/13/13, included, but was not limited to, "Team Care Plan" dated 2/13/13, included, but was not limited to, "Patient/Caregiver able to maintain patient's personal hygiene... Aide: Interventions at every visit as patient tolerates... Use gait belt for ambulation/transfers... Tub bath or shower per patient preference... Skin care.. Nail care... Change adult		2/15/13 to ensure that both the facilities care plan and hospice's care plan complimented each other and ensured coordination of care. The coordinated plan of care of resident #42 was reviewed by the facility MDS/Care plan Coordinator with the surveyor and the facility was told that the plan of care must not only be coordinated but integrated into one plan of care. Changes were made to Resident #42 plan of care during the survey process and therefore corrected, according to the surveyor's interpretation of the regulation before surveyors left the building.2. No other residents were affected.3. In an effort to ensure ongoing compliance, any future residents receiving hospice services will have one integrated plan of care that is developed by the facility MDS/Care plan Coordinator with input from Hospice staff.4. As a means of quality assurance, the MDS/Care plan Coordinator will audit quarterly any resident receiving hospice services to ensure that their plan of care is coordinated and integrated with facility and hospice services. Audits will be reviewed with the Quality Assurance Committee for the next 6 months. Ongoing audits will not be necessary if 100% compliance is met for the 6 months.	

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	diaper... Make bed... Feed patient as needed... Skilled [Hospice] Nurse: Instruct on impending death... Reassurance given to patient/family through dying process... Instruct on end stage comfort measures..." On 2/27/13 at 3:00 P.M., the coordinated hospice care plan for Resident #42 was requested from the Administrator. On 2/28/13 at 2:00 P.M., in an interview, the MDS [Minimum Data Set] Coordinator indicated the facility did not have a coordinated care plan; however, the facility had a care plan and the hospice agency had a care plan. She indicated the facility provided daily care to Resident #42 regardless of the days hospice was scheduled to visit. The MDS Coordinator was unable to provide documentation of a coordinated hospice care plan. The hospice agency's "Hospice Services Agreement" dated 12/31/08, included, but was not limited to, "Obligations of Hospice: Hospice Plan of Care: Hospice shall develop, with the advice and input of the facility, a written plan "Hospice Plan of Care" for the management and			

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	palliation of resident's terminal illness... The Hospice Plan of Care shall identify the respective functions of Hospice and facility and whether Hospice or facility is responsible for providing services identified in the Hospice Plan of Care..." 3.1-35(b)(1)			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on record review and interview, the facility failed to follow speech therapy orders for a resident with a diagnosis of dysphagia. This deficient practice affected 1 of 10 residents reviewed for following physician's orders who were observed during medication pass [Resident #60]. Findings include: On 2/25/13 at 2:30 P.M., medication pass was observed with Licensed Practical Nurse [LPN] #11. At that time, Resident #60 received 90 milliliters of Resource [nutritional supplement]. Resident #60 tilted his head back, coughed as he drank the liquid, and proceeded to cough for a brief time after consuming the liquid. LPN #11 did not provide Resident #60 with instruction prior to or during the administration of the liquid. On 2/26/13 at 9:30 A.M., Resident #60's record was reviewed. Diagnoses included, but were not limited to, poly neuropathy,	F000282	1. The intention of the speech therapist's order for the resident to tuck his chin when swallowing was as a recommendation, rather than a plan of care for nursing to provide cues every time the resident took a drink. Furthermore, on 2/27/13 the Speech Therapist discontinued the order recommending chin tuck when swallows due to resident's continued progress and improvement with swallowing. On 3/8/13, Resident #60 was discharged from Speech therapy after meeting all goals, and currently is drinking thin liquids without difficulty. 2. There were no other residents affected. 3. In an effort to ensure ongoing compliance, all orders for liquid consistency diet modifications such as orders for honey thick, nectar thick consistency, or special swallow instructions will be listed on the daily nursing report sheet as well as each residents plan of care. The facility and speech therapist also considers Resource, the nutritional liquid supplement given to resident #60 to be a thicker liquid consistency, therefore not requiring reminders to tuck his	03/15/2013

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	dysphagia, and congestive heart failure. A "Physician's Orders" dated 2/18/13, included, but was not limited to, "Change diet to regular with thin liquids but provide liquids 1 sip at a time with chin tuck position when swallows. Maintain all other dietary restrictions..." On 2/26/13 at 2:15 P.M., in an interview, LPN #10 indicated she was aware that Resident #60 required instruction from nursing to chin tuck with all liquids. She indicated speech therapy instructed all nursing staff on the plan related to his coughing with liquids. 3.1-35(g)(2)		chin when swallowing. 4. As a means of quality assurance, the QA coordinator or designee will audit monthly the nursing report sheets. All audits will be reviewed with the Quality Assurance Committee for the next 6 months. Ongoing audits will not be necessary if 100% compliance is met for the 6 months.	

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R000273	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 maintain safe food handling for 1 of 1 food preparation observations in the memory care kitchen. This deficient practice had the potential to affect 21 of 21 residents who consumed food from the memory care kitchen. Findings: On 3/1/2013, beginning at 10:18 A.M., observations of the noon meal preparation were made. Cook #60 was observed to have a glove on his left hand and no glove on his right hand. He was cutting strawberries. He stopped cutting the strawberries and opened the daily temperature log book. He went back to cutting the strawberries without washing his hands or changing his glove. He then walked to the dish cleaning area and opened the dish dryer. Without washing his hands or changing his glove, he proceeded to cut the strawberries. With his hands, he pulled out his name badge from under his apron, opened a drawer to get a	R000273	1. This occurrence was a rare departure from facility practices in proper hand washing and glove usage in the kitchen. Employee #60 was immediately in-serviced on proper glove usage on 3/1/13.2. There were no residents affected.3. In an effort to ensure ongoing compliance, all dietary staff that work in the affected kitchen were in-serviced on proper glove usage when handling foods on 3/1/13. Furthermore, all dietary staff in the health center, although not affected, were in-serviced on 2/21/13.4. As a means of quality assurance, the dietary supervisor or designee will perform audits for proper glove usage in the kitchen monthly. Audits will be reviewed with the Quality Assurance Committee quarterly for the next 6 months. Ongoing audits will not be necessary if 100% compliance is met for the 6 months.	03/11/2013

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	spoon, gathered the strawberry hulls from the sink, put them in a trash bag, threw away the trash bag, then began to mix the strawberries with other fruit in a bowl. During an interview on 3/1/2013 at 10:30 A.M., Cook #60 indicated he was sick with a sinus infection. He further indicated he did not wash his hands because he did not touch anything with his gloved hand but only with his un-gloved hand which was his cutting hand. On 3/1/2013 at 12:07 P.M., The Administrator provided an un-dated facility policy titled, "Hoosier Village Food Service Department." This document indicated, "...hands were to be washed at the following times: ...after touching hands to the face, hair, or clothing; after working with or cleaning dirty equipment, work surfaces, wash cloths; before preparing or handling food; during food preparation as often as necessary to prevent cross contamination when changing tasks; after handling or removing trash; ...gloves can cause contamination.... Gloves should be changed frequently...."			