STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155851	A. BUILDING 00 B. WING	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ORCHARD POINTE HEALTH CAMPUS	702 SAWYER ROAD KENDALLVILLE, IN 46755

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00450607 and a Residential State Licensure survey. Complaint IN00450607: Findings are cited at F600 and F609. Survey dates: January 6, 7, 8, 9, and 10, 2025. Facility number: 013704 Provider number: 155851 AIM number: 300017697 Census Bed Type: SNF: 27 SNF/NF: 30 Residential: 30 Total: 87 Census Payor Type: Medicare: 12 Medicaid: 28 Other: 17 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality reivew completed January 14, 2025	F 0000	The submission of this plan of correction does not indicate an admission by Orchard Pointe Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents. This facility recognizes its obligation to provide legally and medically necessary care and service 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 and health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance with all state requirements governing the management of this facility. It is thus submitted as a matter of statue only. Orchard Pointe Health Campus respectfully request from the Department a desk review for paper compliance.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect Based on interview and record review the facility failed to ensure freedom from verbal and physical	F 0600	1 1. Resident A and Resident B had no known negative psychosocial effects from the	01/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Megan Nickles	DHS	01/30/2025

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	abuse for 2 of 24 residents reviewed (Resident A, and Resident B). Findings include: In a review of a written complaint on 1/6/25 at 9:24 AM, a Complainant indicated Qualified Medicine Aide (QMA) 7 had been verbally abusive to Resident A in Complaint IN00450607. The Complainant indicated a facility vendor had witnessed and reported the abuse to the Administrator. The Complainant indicated the Administrator and Assistant Director of Nursing (ADON) were aware of the abuse and did not report it to Resident A's family or the State Department of Health. The Complainant indicated QMA 7 had previous occurrences of witnessed abuse and was eligible to be rehired. During an interview on 1/7/25 at 11:27 AM, Facility Vendor 6 indicated they were present in the assisted dining room on 11/15/24 during breakfast. Vendor 6 indicated QMA 7 came into the assisted dining room with an agitated demeanor, verbally indicating displeasure about being assigned to assist in feeding residents. Vendor 6 indicated Resident A made a statement she was unable to hear to QMA 7, who was seated next to Resident A assisting him with his meal. Vendor 6 indicated QMA 7 became upset and raised her voice to Resident A. She told the resident she only disrespected him because he had disrespected her. QMA 7 then abruptly stood up, grabbed Resident A's meal tray and slammed it on the tray cart. Vendor 6 indicated QMA 7's body language appeared angry and escalated as she went over to Resident B. Resident B had been seated at a table with her clothing protector in her mouth. QMA 7 forcibly pulled the clothing protector out of Resident B's mouth verbally		incident. The alleged employee no longer is employed by Trilogy Health Services. 2 2. All residents in the restorative dining had the potential to be affected. Education was provided to all staff on the abuse policy and reporting guidelines along with return demonstrations. 3 3. As a measure of ongoing compliance, the DHS or designee, will audit staff in all departments at random by presenting abuse scenarios 2 times weekly x 8 weeks, 1 time weekly x 8 weeks, 1 time every other week x 8 weeks. 4 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is January 31, 2025.	

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	indicating she should not be eating laundry detergent. Vendor 6 indicated an unidentified employee came in the room and asked QMA 7 to leave the dining room and finish her medication pass. Vendor 6 indicated they had emailed the Administrator requesting a phone call since she was not present in the building at the time. Vendor 6 indicated they verbally reported the incident as described to the Administrator over the phone on 11/19/24. 1. During an interview on 1/7/25 at 3:52 PM, Resident A's Power of Attorney (POA) indicated they were not aware of any occurrences of disrespectful, rude or abusive conduct toward Resident A. The POA indicated Resident A would not have the ability to recall any abusive event that may have occurred. Resident A's record was reviewed on 1/8/24 at 11:52 AM. Diagnoses included diffuse traumatic brain injury with loss of consciousness, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and depression. Progress notes between 11/15/24 and 11/19/24 did not include any assessments or interviews with Resident A pertaining to recollection or psychosocial effects from verbal abuse. 2. Resident B's record was reviewed on 1/8/25 at 12:59 PM. Diagnoses included dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, personal history of traumatic brain injury, and mild intellectual disabilities. Resident B was unable to be interviewed about abuse.			

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Progress notes between 11/15/24 and 11/19/24 did not include any assessments or interviews with Resident B pertaining to recollection or psychosocial effects from abuse.

In an interview, on 1/8/25 at 1:51PM, Certified Nurse Aide (CNA) 11 indicated rude or inappropriate speech toward a resident should be reported to the person in charge of the shift, or the nurse management.

In an interview, on 1/8/24 at 1:53 PM, Licensed Practical Nurse (LPN)12 indicated verbal abuse could include derogatory or disrespectful speech and physical abuse could include rough physical touch during care. She indicated a nurse's first action upon witnessing abuse was to call the corporate compliance hotline posted on the wall near the front office. LPN 12 walked to the sign and pointed at the phone number.

In an interview, on 1/8/24 at 1:56 PM, Life Enrichment Aide (LEA) 13 indicated rough handling of a resident during care, yelling and using downgrading or derogatory speech toward residents were examples of abuse. LEA 13 indicated any witnessed abuse should be reported to the ADON or the Administrator.

In an interview, on 1/8/24 at 2:01 PM, CNA 14 indicated any staff member witnessing abuse should make sure the resident was safe and then immediately report the abuse directly to the Administrator. If the Administrator was not available, staff should report to the nurse manager in charge.

In a confidential interview, on 1/9/24 at 9:58 AM, Employee 18 indicated QMA 7 had contacted

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	them and indicated she had been terminated for being verbally inappropriate with a resident and roughly pulling a clothing protector out of a resident's mouth. Employee 18 indicated they were on duty the day of the incident and no person from management had requested a statement from them about any knowledge of the incident. In an interview, on 1/9/25 at 2:49 PM, The Administrator indicated QMA 7 was disciplined on 11/19/24 because she had reportedly slammed a breakfast tray down in front of a student. She indicated this incident had been the final incident for this employee concerning conduct. She indicated she had received a report over the phone from the instructor of the CNA class, who performed clinical work in the building, QMA 7 had slammed a tray down in front of a student. She indicated the instructor did not mention anything to indicate any verbal or physical abuse had occurred. She indicated she had no reason to suspect abuse, so she did not conduct an abuse investigation. She indicated she had no statements or notes describing the incident or behavior regarding rough treatment of residents. A witness statement given by the Administrator, dated 11/19/24, presented by the ADON on 1/10/25 at 8:53 AM, indicated the CNA instructor had reported QMA 7 having negative interactions in front of residents in the dining room. The note further indicated she would have jumped in if the situation had gotten physical or abusive. A witness statement given by the ADON, dated 11/19/24, presented by the ADON on 1/10/25 at 8:53 AM indicated she interviewed QMA 7 had asked Resident A to show her respect because she showed him respect. She indicated QMA 7			

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	denied slamming a tray down. During an interview, on 1/10/25 at 11:30 AM, Registered Nurse (RN) 19 indicated she was not aware of any inappropriate behavior at any time in the assisted dining room by any staff member. She indicated when a student or instructor noticed any inappropriate behavior, they should report it to her or an administrative staff member immediately. A current policy dated 7/2/24, titled Abuse and Neglect Procedural Guidelines, provided by the Administrator on 1/6/24 at 9:29 AM indicated physical abuse can include corporal punishment, involving physical punishment to control behavior. Mental abuse involves the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. The policy indicated occurrences of suspected abuse should be reported to the Administrator or the Administrator's designee immediately after resident safety was secured. The policy indicated physicians, consultants, volunteers and other contracted employees and providers should be provided with the Abuse and Neglect Procedural Guidelines for awareness of protocols. The policy indicated the Administrator should identify and interview all involved persons including the alleged victim, perpetrator, witnesses and all others who may have knowledge of the allegation. The Administrator should provide complete, thorough documentation of the investigations. This citation is related to complaint IN00450607. 3.1-27(b)			

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F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on interview and record review the facility failed to ensure an allegation of abuse was reported to the Department of Health for 2 of 24 residents reviewed (Resident A, and Resident B). Findings include: In a complaint review, on 1/6/25 at 9:24 AM, a Complainant indicated Qualified Medicine Aide (QMA) 7 had been verbally abusive to Resident A in Complaint IN00450607. The Complainant indicated a facility vendor had witnessed and reported the abuse to the Administrator. The Complainant indicated the Administrator and Assistant Director of Nursing (ADON) were aware of the abuse and did not report it to Resident A's family or the State Department of Health. During an interview, on 1/7/25 at 11:27 AM, Facility Vendor 6 indicated they were present in the assisted dining room on 11/15/24 during breakfast. Vendor 6 indicated QMA 7 came into the assisted dining room with an agitated demeanor, verbally indicating displeasure about being assigned to assist in feeding residents. Vendor 6 indicated Resident A made a statement she was unable to hear to QMA 7, seated next to Resident A assisting him with his meal. Vendor 6 indicated QMA 7 became upset and raised her voice to Resident A. She told Resident A she only disrespected him because he had disrespected her. QMA 7 then abruptly stood up, grabbed Resident A's meal tray and slammed it on the tray cart. Vendor 6 indicated QMA 7's body language appeared angry and escalated as she went over to Resident B. Resident B had been seated at a table	F 0609	1 1. Resident A and Resident B had no known negative psychosocial effects from the incident. The alleged employee no longer is employed by Trilogy Health Services. 2 2. All residents in the restorative dining had the potential to be affected. Home office support provided education to all members of the leadership team, including ED and DHS, on the abuse policy and reporting guidelines. 3 3. As a measure of ongoing compliance, Social Services or designee, will review grievance logs for potential abuse 2 times weekly x 8 weeks, 1 time weekly x 8 weeks, every other week x 8 weeks. 4 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is January 31, 2025.	01/31/2025

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	with her clothing protector in her mouth. QMA 7 forcibly pulled the clothing protector out of Resident B's mouth. She told Resident B she should not be eating laundry detergent. Vendor 6 indicated an unidentified employee came in the room and asked QMA 7 to leave the dining room and finish her medication pass. Vendor 6 indicated they had emailed the Administrator requesting a phone call since she was not present in the building at the time. Vendor 6 indicated they verbally reported the incident to the Administrator over the phone on 11/19/24. 1. During an interview on 1/7/25 at 3:52 PM, Resident A's Power of Attorney (POA) indicated they were not aware of any occurrences of disrespectful, rude or abusive conduct toward Resident A. The POA indicated Resident A would not have the ability to recall any abusive event that may have occurred. Resident A's record was reviewed on 1/8/24 at 11:52 AM. Diagnoses included diffuse traumatic brain injury with loss of consciousness, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and depression. 2. Resident B's record was reviewed on 1/8/25 at 12:59 PM. Diagnoses included dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, personal history of traumatic brain injury, and mild intellectual disabilities. Resident B was unable to be interviewed about abuse. In an interview, on 1/9/25 at 2:49 PM, The Administrator indicated QMA 7 was disciplined			

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	on 11/19/24 because she had reportedly slammed a breakfast tray down in front of a student. She indicated this incident had been the final incident for this employee concerning conduct. She indicated she had received a report over the phone from the instructor of the CNA class, who performed clinical work in the building, QMA 7 had slammed a tray down in front of a student. She indicated the instructor did not mention anything to indicate any verbal or physical abuse. She indicated she had no reason to suspect abuse, so she did not conduct an abuse investigation, or report the incident. She indicated she had no statements or notes describing the incident or QMA 7's behavior. A current policy dated 7/2/24, titled Abuse and Neglect Procedural Guidelines, provided by the Administrator on 1/6/24 at 9:29 AM indicated the Administrator was accountable for investigating and reporting. The policy indicated the Administrator should identify and interview all involved persons including the alleged victim, perpetrator, witnesses and all others who may have knowledge of the allegation. The Administrator should provide complete, thorough documentation of the investigations. All alleged violations should be reported to the Department of Health within 24 hours of the report. This citation is related to complaint IN00450607. 3.1-28 (c)			
F 0804 SS=F Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview, and record review, the facility failed to ensure food that was	F 0804	1 1. No residents had negative outcomes related to deficient practice.	01/31/2025

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	at proper temperature in 2 of 2 observations. Food prepared in the kitchen was consumed by 57 of 57 residents who resided in the facility. Findings include: During a continuous observation on 1/6/25 from 09:24 AM to 10:00 AM the following observation was made: The temperature of the alcohol cooler was 62 deg. Several bottles of various types of alcohol, one case of bottled water, and a cheese tray were found to be inside. Employee 2, indicated the cheese tray would be thrown away. In an interview on 01/06/25 at 02:17 PM, a resident's family member indicated the resident had complained her food was served cold sometimes. During an observation on 1/8/25 from 10:47 AM - 11:00 AM, the following observation was made: Two of three plates of pureed food, sitting on a shelf above steam table under warming lights, had a temperature measurement of 89 degrees. Resident Counsel minutes, dated 10/28/24, indicated menu changes hadn't improved much since the before month. Food was coming out cold during meal services. Dietary Aids were reaching across other plates to drop off other resident food. Resident Counsel minutes, dated 11/25/24, indicated food was coming out cold during meal services. Dietary Aides were continuing to reach across other plates to drop off resident food. Resident Counsel minutes, dated 12/30/24,		2 2. All residents had the potential to be affected by this practice. Education provided to all culinary staff on regulations regarding food and drink that is palatable, attractive, and at a safe temperature, along with a posttest regarding temperature of food, and implemented digital food temp and cleaning list that reports accountability. 3 3. As a measure of ongoing compliance, the DFS or designee, will complete audits on food and drink that is palatable, attractive, and is served at a safe and appetizing temperature 1 x per day for 5 days x 8 weeks, 1 x per day for 4 days x 8 weeks, 1 x per day for 3 days x 8 weeks. 4 4. As a quality measure, the DFS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is January 31, 2025.	

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	indicated cold food was being served and vegetables were not being cooked all the way. A current policy, dated 1/2024, titled "Hot and Cold Food Temperature Holding Guideline" was provided by an administrator on 1/8/15 at 1:28 PM. The policy indicated "hot food in the steam table should be at least 135 or higher degrees Fahrenheit and arrive approximately at greater than or equal to 120 degrees Fahrenheit when the resident is served." 3.1-21 (a)(1)(2)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and serving practices for 3 of 3 observations. Food prepared in the kitchen was consumed by 57 of 57 residents who resided in the facility. Findings include: During a continuous observation on 1/6/25 from 09:24 AM - 10:00 AM the following observations were made: The drying rack had clear, round, lids stacked with moisture in between lids. The floor in the dishwashing area and dry pantry had dry, brown, particles in sizes from grains of sand to grains of rice. , Observations of the dry pantry included the following: An opened bottle of molasses had must a use by date of 3/11/24.	F 0812	1 1. All items found to be without dates or labels were discarded and the kitchen was disinfected per policy at time of alleged deficient practice. 2 2. All residents had the potential to be affected by this practice. Education provided to all culinary staff with return demonstrations on regulations regarding expired foods, storage of foods, labeling and dating of foods, sanitation of the kitchen, and implemented digital food temp and cleaning list that reports accountability. 3 3. As a measure of ongoing compliance, the DFS or designee, will complete audits on safe storage, foods are dated, labeled, and resealed when opened, expired foods have been discarded, cleanliness of	01/31/2025

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	There were 2 onions sprouting green leaves, one with 4 inches of green growth. One onion was brown, black, and was soft. A yellow cake mix had an expired date of 12/22/24. Observations in the walk-in refrigerator included the following: Six bowls of cottage cheese were uncovered and undated. There were quarter-sized areas of a white, fuzzy substance, on top of 2 strawberries. The received on date was 1/2/25. There was a broken eggshell, whites, and yolk spread to a softball sized area on the floor. Observations in the walk-in freezer included the following: A frozen leftover turkey with a use by date of 12/21/24, was not sealed. A bag with 2 pork patties was not labeled or sealed. In an interview on 1/6/25 at 09:40 AM, the Director of Food Service indicated a deep floor clean was completed at the end of each day, the egg was broken during the delivery. In an interview, on 01/07/25 02:53 PM, the facility administrator indicated 57 residents of 57 residents residing in the facility consumed food that was prepared in the kitchen. A current policy, dated 1/2024, titled "Food Labeling and Dating Policy" was provided by an administrator on 1/7/15 at 3:24 PM. The policy indicated any product removed from its original container, has a broken seal, has been processed in any way must have a label ... that contains the following: ... Date and Time the food was labeled ... Use by date ...Securely cover the food item.		equipment, and proper storage of dishes 1 x per day for 5 days x 8 weeks, 1 x per day for 4 days x 8 weeks, 1 x per day for 3 days x 8 weeks. 4 4. As a quality measure, the DFS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is January 31, 2025.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A current policy, dated 1/2024, titled "Storage Procedures" was provided by an administrator on 1/7/15 at 3:24 PM. The policy indicated open packages are labeled, dated, and stored in closed containers. Refrigerated storage temperature will be at 41 degrees F or below. Prepared perishables such as salads, puddings, milk, etc., are stored in a refrigerator and covered, labeled, and dated until used. All foods in the freezer are wrapped in a moisture proof wrapping or placed in suitable containers, to prevent freezer burn. Items are labeled and dated. 3.1-21(i)(3)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review the facility failed to ensure sanitary handling of personal protective gowns for 2 of 8 residents reviewed (Resident 34 and Resident 45) and proper hand hygiene in meal service in the assisted dining room. This practice affected 7 of 10 residents who ate their meals in the assisted dining room. Findings include: 1. During an observation, on 1/7/24 at 10:32 AM, upon opening the door to Resident 45's room a yellow, disposable gown drifted into the doorway of Resident 45's door touching the doorframe, handle and door. The gown was hanging on the wall on Resident 45's roommate's side of the room near his belongings. Resident 45's bed was empty. Water was heard running in the shower of the attached bathroom. Certified Nurse Aide (CNA) 19 opened the bathroom door, and indicated Resident 45 was in the shower. CNA 19	F 0880	1 1. Resident 45, Resident 34, and all residents in the restorative dining room were not affected negatively by deficient practices. 2 2. All residents have the potential to be affected by deficient practice. All licensed nursing staff completed return demonstrations on proper hand hygiene and education on proper use and storage of PPE with post competency test. 3 3. As a measure of ongoing compliance, the infection preventionist or designee will complete random observations of handwashing and random observations of proper use and disposal of PPE 2 times weekly x 8 weeks, 1 time weekly x 8 weeks, every other week x 8 weeks.	01/31/2025

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	155851	A. BUILDING 00 B. WING	01/10/2025

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	was not wearing a gown. Resident 45s record was reviewed on 1/7/24 at 1:50 PM. Diagnoses included presence of urogenital implants, and neuromuscular dysfunction of the bladder. Resident 45's current quarterly Minimum Data Set (MDS) indicated their Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). The MDS indicated Resident 45 used an indwelling catheter. A physician's order dated 1/7/25 indicated Resident 45 should receive levofloxacin (an antibiotic) 750 mg daily for 7 days for a urinary tract infection. Resident 45's current care plan titled: Resident requires enhanced barrier precautions, indicated the resident had a problem of suprapubic catheter use, with a goal date of 4/2/25. Interventions included don/doff and dispose of PPE systematically and appropriately utilize gown and gloves per EPB policy during high contact ADL care. In an interview, on 1/7/25 at 10:32 AM, Licensed Practical Nurse (LPN) 20 indicated used gowns should not hang in the doorway of the room due to contamination risk. During an interview, on 1/7/25 at 10:35 AM, the Assistant Director of Nursing (ADON) indicated staff should be wearing gloves and a gown when performing showers for Resident 45. She indicated disposable gowns are stored in a closet in the hallway and should not be stored hanging in the doorway after use.		4 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is January 31, 2025.	

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	2. During an observation, on 1/7/24 at 10:33 AM, upon opening the door to Resident 34's room a yellow, disposable gown was observed wadded up and stuffed into the inside door handle. Resident 34's record was reviewed on 1/7/24 at 1:50 PM. Diagnoses included neuromuscular dysfunction of the bladder and gastrostomy status. Resident 34's current annual Minimum Data Set (MDS) dated 12/12/24 indicated their Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). The MDS indicated Resident 34 used an indwelling catheter and a gastric tube. Resident 34's current care plan titled, Resident requires enhanced barrier precautions, indicated the resident had a problem of feeding tube and indwelling catheter use, with a goal date of 4/1/25. Interventions included don/doff and dispose of PPE systematically and utilize gown and gloves during high contact ADL care. A physician's order dated 1/7/25 indicated Resident 34 should receive cephalexin (an antibiotic) 500 mg three times daily for 7 days for a urinary tract infection. In an interview, on 1/7/25 at 10:33 AM, LPN 20 indicated used gowns should not be placed on the inside of the door handle due to contamination risk. During an interview, on 1/7/25 at 10:35 AM, the ADON indicated disposable gowns are stored in a closet in the hallway and should not be stored after use in the door handle. She indicated disposable gowns should be discarded after use.			

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	A current policy, titled Standard Precautions Guidelines, dated 5/11/16 provided by the Administrator on 1/8/24 at 12:07 PM indicated equipment or items in the resident's environment likely to have been contaminated with potentially infectious matter should be handled in such a manner to prevent transmission of infectious agents. 3. During an observation, on 1/9/25 at 9:06 AM, Qualified Medicine Aide (QMA) 21 passed trays to 6 residents seated in the assisted dining room. As she passed the trays she touched each resident's silverware, cut up and prepared residents' food and handed utensils to the residents, frequently contacting their hands, clothing and belongings. No hand hygiene was performed. Certified Nurse Aide (CNA) 22 assisted an unidentified male resident to apply a sweater and then washed her hands with 12 seconds of scrubbing. QMA 21 washed her hands with a 5- second hand scrub and returned to resident care. QMA 21 washed her hands two additional times during observation with durations of 5 and 7 seconds of scrubbing. During an interview, on 1/9/25 at 9:47 AM, CNA 22 indicated staff should sanitize their hands between each tray and perform handwashing after every third tray or when they touch a resident or contaminate their hands. She indicated scrubbing should last 20 seconds. She indicated she was in a hurry and should have washed her hands correctly. During an interview, on 1/9/25 at 9:48, QMA 21 indicated staff should scrub their hands for 60 seconds each time they washed their hands. She indicated she should have washed her hands while passing the trays but was in a hurry to get			

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	all the food out and forgot. A current policy titled Guidelines for Handwashing/Hand Hygiene, dated 5/11/16, provided by the ADON on 1/9/25 at 11:07 AM indicated hand hygiene should be performed before and after serving meals and before and after having direct contact with residents. The policy indicated handwashing should include 20 seconds of friction. 3.1-18(l)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This survey included a Recertification and State Licensure Survey. This visit also included healthcare Complaint IN00450607. Survey dates: January 6, 7, 8, 9, and 10, 2025. Facility number: 013704 Residential Census: 30 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 14, 2025.	R 0000	The submission of this plan of correction does not indicate an admission by Orchard Pointe Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents. This facility recognizes its obligation to provide legally and medically necessary care and service 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 and health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance with all state requirements governing the management of this facility. It is thus submitted as a matter of statue only. Orchard	

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			Pointe Health Campus respectfully request from the Department a desk review for paper compliance.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and serving practices for 3 of 3 observations. Food prepared in the kitchen was consumed by 30 of 30 residents who who resided in the facility. During a continuous observation on 1/6/25 from 09:24 AM - 10:00 AM the following observations were made: The drying rack had clear, round, lids stacked with moisture in between lids. The floor in the dishwashing area and dry pantry had dry, brown, particles in sizes from grains of sand to grains of rice. , Observations of the dry pantry included the following: An opened bottle of molasses had must a use by date of 3/11/24. There were 2 onions sprouting green leaves, one with 4 inches of green growth. One onion was brown, black, and was soft. A yellow cake mix had an expired date of 12/22/24. Observations in the walk-in refrigerator included the following: Six bowls of cottage cheese were uncovered and undated. There were quarter-sized areas of a white, fuzzy substance, on top of 2 strawberries. The received on date was 1/2/25. There was a broken eggshell, whites, and yolk	R 0273	1 1. All items found to be without dates or labels were discarded and the kitchen was disinfected per policy at time of alleged deficient practice. 2 2. All residents had the potential to be affected by this practice. Education provided to all culinary staff with return demonstrations on regulations regarding expired foods, storage of foods, labeling and dating of foods, sanitation of the kitchen, and implemented digital food temp and cleaning list that reports accountability. 3 3. As a measure of ongoing compliance, the DFS or designee, will complete audits on safe storage, foods are dated, labeled, and resealed when opened, expired foods have been discarded, cleanliness of equipment, and proper storage of dishes 1 x per day for 5 days x 8 weeks, 1 x per day for 4 days x 8 weeks, 1 x per day for 3 days x 8 weeks. 4 4. As a quality measure, the DFS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred	01/31/2025

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	spread to a softball sized area on the floor. Observations in the walk-in freezer included the following: A frozen leftover turkey with a use by date of 12/21/24, was not sealed. A bag with 2 pork patties was not labeled or sealed. In an interview on 1/6/25 at 09:40 AM, the Director of Food Service indicated a deep floor clean was completed at the end of each day, the egg was broken during the delivery. In an interview, on 01/07/25 02:53 PM, the facility administrator indicated 57 residents of 57 residents residing in the facility consumed food that was prepared in the kitchen. A current policy, dated 1/2024, titled "Food Labeling and Dating Policy" was provided by an administrator on 1/7/15 at 3:24 PM. The policy indicated any product removed from its original container, has a broken seal, has been processed in any way must have a label ... that contains the following: ... Date and Time the food was labeled ... Use by date ...Securely cover the food item. A current policy, dated 1/2024, titled "Storage Procedures" was provided by an administrator on 1/7/15 at 3:24 PM. The policy indicated open packages are labeled, dated, and stored in closed containers. Refrigerated storage temperature will be at 41 degrees F or below. Prepared perishables such as salads, puddings, milk, etc., are stored in a refrigerator and covered, labeled, and dated until used. All foods in the freezer are wrapped in a moisture proof wrapping or placed in suitable containers, to prevent freezer burn. Items are labeled and dated.		percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is January 31, 2025.	