

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155436	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2014
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT WINAMAC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 13TH ST WINAMAC, IN 46996
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 17, 18, 19, 20, and 21, 2014</p> <p>Facility number: 000414 Provider number: 155436 AIM number: 100288550</p> <p>Survey team: Jennifer Redlin, RN-TC Caitlyn Doyle, RN Heather Hite, RN (11/17, 11/18, 11/19) Julie Ferguson, RN</p> <p>Census bed type: SNF/NF: 27 Total: 27</p> <p>Census payor type: Medicare: 1 Medicaid: 19 Other: 7 Total: 27</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on November</p>	F000000	<p>This Plan of Correction constitutes the written allegation of 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 requirements established by state and federal law. Hickory Creek at Winamac desires this Plan of Correction to be considered the facility's allegation of Compliance. Compliance is effective 12/21/14.</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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F000241 SS=D	<p>26, 2014, by Janelyn Kulik, RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to waiting to enter a resident's room after knocking for 2 of 3 residents reviewed for dignity. (Resident #1 and #2)</p> <p>Findings include:</p> <p>1. On 11/17/14 at 2:30 p.m., the Resident Interview was initiated with Resident #1. The interview was conducted in the resident's room. The door was closed to the resident's room to maintain confidentiality.</p> <p>On 11/17/14 at 2:32 p.m., during the Resident Interview, CNA #1 knocked on the resident's closed door. She did not wait for a response from the resident. She entered the resident's room and went to get an item out of the resident's roommate's closet. The CNA then left the room.</p>	F000241	<p><u>F241 1. What corrective action will be done by the facility?</u> All staff will be re-educated by the Administrator and Director of Nursing on the importance of treating all residents with dignity and respect by 12/12/14, including knocking on the doors to their rooms and waiting for a response before entering the room. <u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected and all staff will be educated upon hire and annually thereafter and at any time an issue is identified on the importance of treating residents with dignity and respect. This includes knocking on resident doors and waiting for a response as well as identifying themselves when entering the resident's room. If any member of the interdisciplinary team or Administrator observe that staff is not knocking on doors and waiting for the resident's response before entering, he/she</p>	12/12/2014

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	<p>On 11/17/14 at 2:35 p.m., during the Resident Interview, CNA #1 knocked on the resident's closed door. She did not wait for a response from the resident. She entered the resident's room and went to get an item from the resident's roommate's side of the room. The CNA then left the room</p> <p>On 11/17/14 at 2:40 p.m., during the Resident Interview, CNA #1 knocked on the resident's closed door. She did not wait for a response from the resident. CNA #1, accompanied by CNA #2 and Resident #2, entered the resident's room. CNA #1 and CNA #2 assisted Resident #2 into bed.</p> <p>The record for Resident #1 was reviewed on 11/18/14 at 11:22 a.m. The Admission Minimum Data Set (MDS) assessment, dated 9/14/14, indicated the resident had a Brief Interview of Mental Status (BIMS) score of 15, which indicated she was cognitively intact.</p> <p>Interview with the Director of Nursing (DON), Administrator, and Nursing Consultant on 11/20/14 at 3:05 p.m., indicated staff should wait for the resident to respond before entering the room.</p> <p>2. On 11/17/14 at 3:00 p.m., the</p>		<p>will stop the employee at that time and will re-train them on the need for knocking on the resident's door and waiting for a response before entering. The applicable department manager will be notified of the observation no later than the next scheduled morning meeting, and counseling/progressive disciplinary action will be done as indicated by the situation. 3. <u>What measures will be put into place to ensure that this practice does not recur?</u> Each interdisciplinary team manager and Administrator will monitor for staff compliance with knocking on resident doors, identifying themselves, and entering the room with the resident's permission as they make frequent rounds throughout the building as part of their normal duties during their work hours. In addition, the interdisciplinary team managers complete Guardian Angel rounds on assigned residents at least 5days a week. As part of these rounds, interviews and observations of resident care are done. Observations of staff compliance with knocking on residents' doors and waiting for a response before entering the room will be part of the Guardian Angel rounds. Any identified issues will be addressed as indicated in question #2. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will</u></p>	

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F000279 SS=D	<p>Resident Interview was initiated with Resident #2. The interview was conducted in the resident's room. The door was closed to the resident's room to maintain confidentiality.</p> <p>On 11/17/14 at 3:02 p.m., during the Resident Interview, CNA #1 knocked on the resident's closed door. She did not wait for a response from the resident. She entered the resident's room, approached Resident #2, and asked the resident if she needed anything.</p> <p>The record for Resident #2 was reviewed on 11/18/14 at 11:22 a.m. The Quarterly Minimum Data Set (MDS) assessment, dated 10/7/14, indicated the resident had a Brief Interview of Mental Status (BIMS) score of 15, which indicated she was cognitively intact.</p> <p>Interview with the Director of Nursing (DON), Administrator, and Nursing Consultant on 11/20/14 at 3:05 p.m., indicated staff should wait for the resident to respond before entering the room.</p> <p>3.1-3(t)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the</p>		<p><u>be put into place?</u> The Administrator or DON will bring the results of the Guardian Angel rounds, as well as observations made at other times, to the monthly QA&A Committee meeting for review and recommendation on an ongoing basis. Any recommendations made by the committee will be followed up by the designated department manager who will report the results of those recommendations back to the committee at the next scheduled QA&A meeting. Date of Compliance: 12/12/14</p>		

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	<p>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 record review and interview, the facility failed to develop a resident care plan for the diagnosis of diabetes mellitus, for 1 of 5 residents reviewed for unnecessary medications. (Residents #15)</p> <p>Findings include:</p> <p>Resident #15's record was reviewed on 11/18/14 at 1:51 p.m. The resident's diagnoses included, but were not limited to, dementia and diabetes mellitus.</p> <p>There was a lack of documentation to indicate the resident had a care plan and/or interventions related to the diagnosis diabetes mellitus.</p>	F000279	<p><u>F279</u></p> <p>- <u>What corrective action will bedone by the facility?</u></p> <p>- A care plan for resident #15addressing diabetes was created immediately.</p> <p>On 12/12/14, all nurses willbe inserviced by the Director of Nursing on the development of care plans thatare to be written in response to the residents' changing conditions anddiagnoses.</p>	12/12/2014

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	<p>The Quarterly MDS (Minimum Data Set) assessment dated 9/4/14 indicated a diagnosis of diabetes mellitus.</p> <p>During an interview on 11/18/14 at 2:45 p.m., with the DON (Director of Nursing) and the MDS (Minimum Data Set) Coordinator, they indicated there was no care plan for diabetes mellitus.</p> <p>3.1-35(a)</p>		<p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> No other residents have been identified as being affected. Care plans are in place for each resident addressing their current medical needs.</p> <p>If the DON or other IDT member finds that a resident is lacking a care plan for a current medical need, she will make sure that one is written immediately to reflect all interventions that are in place to meet that resident's needs.</p> <p>Once that is done, she will re-train the nurse(s) involved regarding the facility policy for care plan development. She will also provide counseling as indicated by the noncompliance.</p> <p><u>3. What measures will be put into place to ensure that this practice does</u></p>	

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			<p><u>not recur?</u></p> <p>During the morning interdisciplinary team (IDT) meeting that occurs at least five days a week, new physician orders are routinely reviewed and care plans updated to reflect changes in condition, treatment, and diagnoses obtained from the information reviewed.</p> <p>In addition, the DON or designee will perform random care plan audits 3 days a week for 30 days and then weekly for 60 days. Results of the audits will be forwarded to the Administrator for review. Identified issues will be addressed as indicated in question #2.</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>The DON will bring the results of the audits to the monthly QA&A committee meeting for 90 days. At that time, if 100% compliance has been reached, the</p>	

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow resident's physician orders and care plans, related to blood sugar monitoring and insulin administration for 2 of 5 residents reviewed for unnecessary medications (Resident's #8 and #15)</p> <p>Findings include:</p> <p>1. Record review for Resident #8 was completed on 11/18/14 at 11:24 a.m. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.</p> <p>The Admission Minimum Data Set (MDS) assessment completed on 8/4/14, indicated the resident was cognitively impaired. The resident received insulin administration 7 x in a 7 day assessment</p>	F000282	<p>QA&A Committee may decide to stop the audits. However, the IDT morning management meeting review of new physician orders and development of new/revised care plans will continue on an ongoing basis.</p> <p>Date of Compliance: 12/12/14</p> <p><u>F282</u></p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>All medication administration records related to insulin administration and blood sugar checks were clarified and rewritten immediately for residents #8 and #15.</p> <p>There will be an inservice on 12/12/14 by the Director of Nursing reviewing the insulin administration and blood glucose checks, as well as the documentation of each in</p>	12/12/2014	

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	<p>period.</p> <p>A care plan dated 8/4/14, indicated the resident had diabetes mellitus and was at risk for diabetic distress. Interventions included to administer medications as ordered.</p> <p>The November 2014 Physician Order Summary indicated an order for Novolog (diabetes medication) Flexpen insulin per sliding scale to be given three times daily. To be given at am, lunch, and HS (at bedtime). The units to be given were as followed:</p> <p>Blood sugar of 172-200= 2 units Blood sugar of 201-250= 4 units Blood sugar of 251-300= 6 units Blood sugar of 301-350= 8 units Blood sugar of >350= 10 units</p> <p>Review of the October 2014 Medication Administration Record (MAR) indicated the following:</p> <p>On 10/2/14 at lunch time the residents blood sugar was 325. One box on the MAR indicated the resident received 6 units of insulin, the other box indicated the resident received 8 units of insulin. The resident should have received 8 units of insulin. The Director of Nursing (DON) could not confirm how much</p>		<p>accordance with current physician orders. Following the re-education, nurses will be observed by the Director of Nursing or Designee completing these procedures.</p> <p>2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>All residents with insulin and blood sugar checks have the potential to be affected, however all were checked and none were found to have been affected.</p> <p>3. <u>What measures will be put into place to ensure that this practice does not recur?</u></p> <p>The DON and or Designee will audit the medication administration records 3 x a week for 30 days, then weekly for 60 days to ensure accurate monitoring and</p>	

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	<p>insulin the resident received on this date.</p> <p>On 10/18/14 before breakfast the residents blood sugar was 178. The MAR indicated the resident received 0 units and the resident should have received 2 units of insulin.</p> <p>The October 2014 MAR indicated the resident was receiving insulin injections four times a day on the following dates:</p> <p>10/1, 10/2, 10/3, 10/4, 10/5, 10/6, 10/7, 10/8, 10/9, 10/10, 10/11, 10/12, 10/13, 10/14, 10/15, 10/16, 10/17, 10/19, 10/20, 10/21, 10/22, 10/24, 10/25, 10/26, 10/27, 10/28, 10/29, 10/30, and 10/31/2014</p> <p>Review of the November 2014 MAR indicated the following:</p> <p>On 11/3/14 at HS the residents blood sugar was 351 and the resident received 6 units of insulin. The resident should have received 10 units of insulin.</p> <p>On 11/7/14 at HS the residents blood sugar was 301 and the resident received 6 units of insulin. The resident should have received 8 units of insulin.</p> <p>The November 2014 MAR indicated the resident was receiving insulin injections four times a day on the following dates:</p>		<p>documentation of blood sugars and insulin administration in accordance with physician orders. Any identified errors will be immediately addressed and nurses re-educated with disciplinary action as needed.</p> <p>Errors will also be documented as Medication Errors and will be investigated by the DON and Administrator. Once the root cause is identified, the process will be reviewed and revised, if necessary. Any changes in process will be in-service to all licensed nurses at that time.</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>The DON will bring the results of audits and any medication error investigation to the QA&A Committee at the next scheduled monthly meeting.</p>		

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	<p>11/1, 11/2, 11/3, 11/4, 11/5, 11/6, 11/7, 11/8, 11/9, 11/10, 11/11, 11/13, 11/14, 11/15, 11/16, and 11/17/2014</p> <p>Interview with the DON on 11/19/14 at 11:34 a.m., indicated the residents physician order indicated the resident to receive insulin three times a day but the resident was receiving insulin four times a day.</p> <p>Interview with the DON on 11/20/14 at 11:17 a.m., indicated the resident received the wrong amount of insulin on the days above.</p> <p>Interview with the Administrator on 11/20/14 at 11:30 a.m., indicated blood sugars and insulin administration have been an issue and was an ongoing process to fix.</p> <p>2. Resident #15's record was reviewed on 11/18/14 at 1:51 p.m. The resident's diagnoses included, but were not limited to, dementia and diabetes mellitus.</p> <p>Review of Physician's Order Summary (POS) for October and November 2014, included an order for "accuchecks: check blood sugar twice daily. Notify MD if below 60 or above 400, Humalog (insulin) Kwik inj (pen device for insulin injections) 100/ml (milliliters): use per</p>		<p>Anyfurther recommendations made by the QA&A Committee will be followed up bythe DON, who will bring the results of those recommendations to the followingmonth's Committee meeting. The auditing will continue for 90 days until 100%compliance has been achieved. The QA&A Committee may decide to stop theauditing report; however, any medication error, including those related toinsulin and accucheck administration, will be brought to the QA&A Committeefor review and recommendation on an ongoing basis.</p> <p>Date ofCompliance: 12/12/14</p>				

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	<p>sliding scale: 60-150=0 units; 151-200=4 Units, 201-250=8 Units, 251-300=12 Units, 301-350=16 Units; 351-400=20 Units; over 400= give 20 Units and call MD."</p> <p>A review of October 2014 MAR (Medication Administration Record) indicated a lack of documentation for blood sugar glucose monitoring results at BB (Before Breakfast) on October 2 and October 4, 2014.</p> <p>A review of the resident's October 2014 MAR indicated, on 10/3 the evening blood sugar result was 178, the resident received no insulin and should have received 4 Units of insulin. On 10/5 the evening the blood sugar result was 216, the resident received no insulin and should have received 8 Units of insulin. On 10/9 the evening blood sugar result was 151, the resident received no insulin and should have received 4 Units of insulin. On 10/11 the evening blood sugar result was 183, the resident received no insulin, and should have received 4 Units of insulin. On 10/12 the evening blood sugar result was 185, the resident received no insulin and should have received 4 Units of insulin. On 10/22 the evening blood sugar result was 171, the resident received no insulin and should have received 4 Units of insulin.</p>			

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	<p>On 10/25 the evening blood sugar result was 177, the resident received no insulin and should have received 4 Units of insulin. On 10/26 the evening blood sugar result was 167, the resident received no insulin and should have received 4 Units of insulin.</p> <p>A review of the November MAR 2014 indicated lack of documentation for blood sugar monitoring results at BB on 11/5, 11/10 & 11/18 and evening on 11/4.</p> <p>A review of the resident's November 2014 MAR indicated, on 11/8 the evening blood sugar result was 158, the resident received no insulin and the resident should have received 4 Units of insulin.</p> <p>During an interview on 11/18/14 at 2:35 p.m. with the DON (Director of Nursing) indicated, the October and November MARS had lacked documentation for blood sugar results and missing insulin coverage.</p> <p>On 11/19/14 at 1:30 p.m., the DON provided the policy, titled, "diabetic Testing" and indicated this document was current. This policy indicated the following: "...DOCUMENTATION: ...blood glucose level in mg/dl</p>						

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F000329 SS=D	<p>(Milligrams/deciliter), including time and date of test...."</p> <p>3.1-35 (g)(2)</p> <p>483.25(l)</p> <p>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to follow resident's physician orders and care plans, related to blood sugar monitoring and insulin administration for 2 of 5 residents reviewed for unnecessary medications (Resident's #8 and #15)</p> <p>Findings include:</p>	F000329	<p><u>F329 1. What corrective action will be done by the facility?</u> All medication administration records related to insulin administration and blood sugar checks were clarified and rewritten immediately for residents #8 and # 15. There will be an inservice on 12/12/14 by the Director of Nursing reviewing the insulin administration and blood glucose</p>	12/12/2014			

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	<p>1. Record review for Resident #8 was completed on 11/18/14 at 11:24 a.m. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.</p> <p>The Admission Minimum Data Set (MDS) assessment completed on 8/4/14, indicated the resident was cognitively impaired. The resident received insulin administration 7 x in a 7 day assessment period.</p> <p>A care plan dated 8/4/14, indicated the resident had diabetes mellitus and was at risk for diabetic distress. Interventions included to administer medications as ordered.</p> <p>The November 2014 Physician Order Summary indicated an order for Novolog (diabetes medication) Flexpen insulin per sliding scale to be given three times daily. To be given at am, lunch, and HS (at bedtime). The units to be given were as followed:</p> <p>Blood Sugar of 172-200= 2 units Blood Sugar of 201-250= 4 units Blood Sugar of 251-300= 6 units Blood Sugar of 301-350= 8 units Blood Sugar of >350= 10 units</p> <p>Review of the October 2014 Medication</p>		<p>checks, as well as the documentation of each in accordance with current physician orders. Following the re-education, nurses will be observed by the Director of Nursing or Designee completing these procedures. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents with insulin and blood sugar checks have the potential to be affected, however all were checked and none were found to have been affected. 3. <u>What measures will be put into place to ensure that this practice does not recur?</u> The DON and or Designee will audit the medication administration records 3 x a week for 30 days, then weekly for 60 days to ensure accurate monitoring and documentation of blood sugars and insulin administration in accordance with physician orders. Any identified errors will be immediately addressed and nurses re-educated with disciplinary action as needed. Errors will also be documented as Medication Errors and will be investigated by the DON and Administrator. Once the root cause is identified, the process will be reviewed and revised, if necessary. Any changes in process will be in-serviced to all licensed nurses at that time. 4. <u>How will corrective action be</u></p>				

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	<p>Administration Record (MAR) indicated the following:</p> <p>On 10/2/14 at lunch time the residents blood sugar was 325. One box on the MAR indicated the resident received 6 units of insulin, the other box indicated the resident received 8 units of insulin. The resident should have received 8 units of insulin. The Director of Nursing (DON) could not confirm how much insulin the resident received on this date.</p> <p>On 10/18/14 before breakfast the residents blood sugar was 178. The MAR indicated the resident received 0 units and the resident should have received 2 units of insulin.</p> <p>The October 2014 MAR indicated the resident was receiving insulin injections four times a day on the following dates:</p> <p>10/1, 10/2, 10/3, 10/4, 10/5, 10/6, 10/7, 10/8, 10/9, 10/10, 10/11, 10/12, 10/13, 10/14, 10/15, 10/16, 10/17, 10/19, 10/20, 10/21, 10/22, 10/24, 10/25, 10/26, 10/27, 10/28, 10/29, 10/30, and 10/31/2014.</p> <p>Review of the November 2014 MAR indicated the following:</p> <p>On 11/3/14 at HS the residents blood sugar was 351 and the resident received 6</p>		<p><u>monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON will bring the results of audits and any medication error investigation to the QA&A Committee at the next scheduled monthly meeting. Any further recommendations made by the QA&A Committee will be followed up by the DON, who will bring the results of those recommendations to the following month's Committee meeting. The auditing will continue for 90 days until 100% compliance has been achieved. The QA&A Committee may decide to stop the auditing report; however, any medication error, including those related to insulin and accucheck administration, will be brought to the QA&A Committee for review and recommendation on an ongoing basis. Date of Compliance: 12/12/14</p>	

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	<p>units of insulin. The resident should have received 10 units of insulin.</p> <p>On 11/7/14 at HS the residents blood sugar was 301 and the resident received 6 units of insulin. The resident should have received 8 units of insulin.</p> <p>The November 2014 MAR indicated the resident was receiving insulin injections four times a day on the following dates:</p> <p>11/1, 11/2, 11/3, 11/4, 11/5, 11/6, 11/7, 11/8, 11/9, 11/10, 11/11, 11/13, 11/14, 11/15, 11/16, and 11/17/2014.</p> <p>Interview with the DON on 11/19/14 at 11:34 a.m., indicated the residents physician order indicated the resident to receive insulin three times a day but the resident was receiving insulin four times a day.</p> <p>Interview with the DON on 11/20/14 at 11:17 a.m., indicated the resident received the wrong amount of insulin on the days above.</p> <p>Interview with the Administrator on 11/20/14 at 11:30 a.m., indicated blood sugars and insulin administration have been an issue and was an ongoing process to fix.</p> <p>2. Resident #15's record was reviewed</p>						

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	<p>on 11/18/14 at 1:51 p.m. The resident's diagnoses included, but were not limited to, dementia and diabetes mellitus.</p> <p>Review of Physician's Order Summary (POS) for October and November 2014, included an order for "accuchecks: check blood sugar twice daily. Notify MD if below 60 or above 400, Humalog (insulin) Kwik inj (pen device for insulin injections) 100/ml (milliliters): use per sliding scale: 60-150=0 units; 151-200=4 Units, 201-250=8 Units, 251-300=12 Units, 301-350=16 Units; 351-400=20 Units; over 400= give 20 Units and call MD."</p> <p>A review of October 2014 MAR (Medication Administration Record) indicated a lack of documentation for blood sugar glucose monitoring results at BB (Before Breakfast) on October 2 and October 4, 2014.</p> <p>A review of the resident's October 2014 MAR indicated, on 10/3 the evening blood sugar result was 178, the resident received no insulin and should have received 4 Units of insulin. On 10/5 the evening the blood sugar result was 216, the resident received no insulin and should have received 8 Units of insulin. On 10/9 the evening blood sugar result was 151, the resident received no insulin</p>			

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	<p>and should have received 4 Units of insulin. On 10/11 the evening blood sugar result was 183, the resident received no insulin, and should have received 4 Units of insulin. On 10/12 the evening blood sugar result was 185, the resident received no insulin and should have received 4 Units of insulin. On 10/22 the evening blood sugar result was 171, the resident received no insulin and should have received 4 Units of insulin. On 10/25 the evening blood sugar result was 177, the resident received no insulin and should have received 4 Units of insulin. On 10/26 the evening blood sugar result was 167, the resident received no insulin and should have received 4 Units of insulin.</p> <p>A review of the November MAR 2014 indicated lack of documentation for blood sugar monitoring results at BB on 11/5, 11/10 & 11/18 and evening on 11/4.</p> <p>A review of the resident's November 2014 MAR indicated, on 11/8 the evening blood sugar result was 158, the resident received no insulin and the resident should have received 4 Units of insulin.</p> <p>During an interview on 11/18/14 at 2:35 p.m. with the DON (Director of Nursing) indicated, the October and November</p>			

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F000441 SS=D	<p>MARS had lacked documentation for blood sugar results and missing insulin coverage.</p> <p>On 11/19/14 at 1:30 p.m., the DON provided the policy, titled, "diabetic Testing" and indicated this document was current. This policy indicated the following: "...DOCUMENTATION: ...blood glucose level in mg/dl (Milligrams/deciliter), including time and date of test..."</p> <p>3.1-35 (g)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to</p>			

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	<p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control practices and standards were maintained related to, hand washing while assisting residents with their lunch meal for 1 of 1 dining observations. (Resident's #1 and #20)</p> <p>Findings include:</p> <p>During an observation of the noon meal on 11/17/14 at 12:43 p.m. in the dining room, the following was observed:</p> <p>CNA #3 turned Resident # 20's broda chair around to face the other direction at the dining room table, opened Resident #1's paper for the straw, placed the straw using her unsanitized or washed fingers into the resident's lemonade, then proceeded to assist feeding both</p>	F000441	<p><u>F441 1. What corrective action will be done by the facility?</u> All Nursing staff will be re-educated on hand washing technique, including proper hand washing procedures related to sanitation while assisting residents during meal time by the Director of Nursing on December 12, 2014. This re-training will also include direct observation of individual hand washing technique. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected; however, none have been identified as of this time. If the Administrator, DON or other department manager observes staff with inappropriate handwashing/sanitation techniques while assisting residents during meal service,</p>	12/12/2014

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	<p>residents, using her left hand for Resident #20 and the right hand for Resident #1.</p> <p>During an interview on 11/17/14 at 12:47 p.m. with CNA #3, indicated she should have used hand sanitizer before assisting the residents with the meals.</p> <p>A facility policy on "Hand washing/Alcohol-Based Hand Rub revised 7/10, and received as current from the DON (Director of Nursing), indicated "...GUIDELINES: ... Before and after each resident contact; After touching a resident or handling his/her belongings;...."</p> <p>3.1-21(i)(3)</p>		<p>he/she will stop the staff person at that time and ask that they sanitize their hands before proceeding further. They will be observed throughout that meal by the DON, Administrator, or manager present during the meal to make sure that they perform hand hygiene as per policy. After the meal service, the DON will make sure that the staff member has been retrained in the facility policy regarding hand washing/sanitation that is to be done while assisting residents with meal service. Progressive disciplinary action may be used for continued noncompliance. 3. <u>What measures will be put into place to ensure that this practice does not recur?</u> The Director of Nursing or designee will complete three random hand washing observations weekly for four weeks, two observations weekly for four weeks and then one observation weekly for four weeks until all staff who assist residents with meal service have been observed. Any identified issues will be addressed at the time of observation as indicated in question #2. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Results of the hand washing observations and dining room observations will be reviewed each month by the facility QA&A committee until 100% compliance has been</p>	

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain a functional and safe environment related to marred walls, gouged walls, chipped paint on walls, and loose baseboards throughout the facility.</p> <p>Findings include:</p> <p>During an environmental tour with the Maintenance Director on 11/20/14 at 2:30 p.m. through 2:40 p.m., the following was observed:</p> <p>Room 2B: The wall between the bed and dresser was marred. One resident resided in the room.</p> <p>Room 4A: The paint on the walls by the bed was chipped. One resident resided in the room.</p>	F000465	<p>achieved. Even though the QA&A Committee may decide to stop the hand washing observations, the DON or designee will perform random hand washing audits and dining room observations at least weekly on an ongoing basis. Date of Compliance: 12/12/14</p> <p><u>F465 1. What corrective action will be done by the facility?</u> The Maintenance Supervisor will repair rooms 2B, 4A, 7A, 15B, and 17A as cited on the CMS-2567 by 12/21/14. All staff will be reminded of the facility system for notifying the Maintenance Supervisor when staff finds a need for repair in any of the resident care areas, including their rooms by 12/21/14.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have potential to be affected. The Administrator and Maintenance Supervisor will check all rooms for need of any repair work. Once that is done, they will set a repair schedule for each room. The Maintenance Supervisor will notify the Administrator as each room is finished.</p> <p><u>3. What measures</u></p>	12/21/2014	

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F000520 SS=D	<p>Room 7A: There were gouges in the wall by the baseboard of the door. The baseboard under the sink was loose and pulling away from the wall. The wall in the corner by the closet was gouged. Two residents resided in the room.</p> <p>Room 15B: The paint on the wall next to the bed was peeling. Two residents resided in the room.</p> <p>Room 17A: The paint on the walls by the sink was chipped. One resident resided in the room.</p> <p>Interview with the Maintenance Director at the time of the tour indicated all above areas were in need of repair.</p> <p>3.1-19(f)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee</p>		<p><u>will be put into place to ensure that this practice does not recur?</u> The interdisciplinary managers will check the rooms of the residents that they are assigned to during their Guardian Angel rounds that occur at least 5 days a week. They will report any need for repair to the Administrator and Maintenance Supervisor during the morning management meeting, so that the Maintenance Supervisor can schedule the repair to be done as quickly as possible. Any maintenance repair that has been found and requested by other staff members will also be addressed at the morning meeting and scheduled for correction. The Maintenance Supervisor will notify the Administrator as each repair is completed. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Results of the monitoring done by the Guardian Angel rounds and other staff requests for repairs will be forwarded to the Quality Assurance Committee for further review each month. This will continue on an ongoing basis. Date of Compliance: 12/21/14</p>		

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	<p>consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview, and record review, the facility failed to identify and implement plans of action to correct quality deficiencies related to following physician orders for blood sugar assessment and insulin administration for 2 of 5 residents reviewed for unnecessary medications (Residents #8, #15). This had the potential to affect all residents residing in the facility that received insulin administration.</p> <p>Findings include:</p> <p>The facility failed to ensure physician orders were followed for blood sugar assessment and insulin administration for</p>	F000520	<p><u>F520 1. What corrective action will be done by the facility?</u> The Administrator and the interdisciplinary team will be re-trained by the Nurse Consultant on the facility policy for quality assurance and assessment meetings, including the function and need for continuous assessment, review, planning, and development of action plans to address identified concerns and issues within the facility, including those related to insulin and accucheck administration and documentation of each by 12/21/14. <u>2. How will the facility identify other residents having the potential to be affected by the same practice and what</u></p>	12/12/2014

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT WINAMAC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 13TH ST WINAMAC, IN 46996
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	<p>Residents #8 and#15.</p> <p>Record review for Resident #8 was completed on 11/18/14 at 11:24 a.m. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.</p> <p>The November 2014 Physician Order Summary indicated an order for Novolog (diabetes medication) Flexpen insulin per sliding scale to be given three times daily. To be given at am, lunch, and HS (at bedtime). The units to be given were as followed:</p> <p>Blood Sugar of 172-200= 2 units Blood Sugar of 201-250= 4 units Blood Sugar of 251-300= 6 units Blood Sugar of 301-350= 8 units Blood Sugar of >350= 10 units</p> <p>Review of the October 2014 Medication Administration Record (MAR) indicated the following:</p> <p>On 10/2/14 at lunch time the residents blood sugar was 325. One box on the MAR indicated the resident received 6 units of insulin, the other box indicated the resident received 8 units of insulin. The resident should have received 8 units of insulin. The Director of Nursing (DON) could not confirm how much insulin the resident received on this date.</p>		<p><u>corrective action will be taken?</u> All residents have the potential to be affected by this practice. On an ongoing basis identified concerns or issues in any area, including insulin and accucheck administration and documentation, that affect the residents' care will be brought to the interdisciplinary team meeting at the next scheduled morning meeting which occurs at least 5 days a week. The more severe issues will be immediately addressed by the Administrator or other member of management staff to make sure that the resident is safe and comfortable. Those situations will also be brought to the interdisciplinary team to review and discuss what interventions or other action is needed to make sure that process improvements in place and being monitored so that it continues to occur as planned, or so that the need for more revision is identified as necessary to correct the situation until compliance is in place and the residents' care and services is appropriate. 3. <u>What measures will be put into place to ensure that this practice does not recur?</u> In addition to the review of the 24 hour report, focus charting, incident reports, new physician orders, behavior logs and results of the Guardian Angel rounds which occurs at least 5days a week as part of the interdisciplinary morning</p>	

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	<p>On 10/18/14 before breakfast the residents blood sugar was 178. The MAR indicated the resident received 0 units and the resident should have received 2 units of insulin.</p> <p>The October 2014 MAR indicated the resident was receiving insulin injections four times a day on the following dates:</p> <p>10/1, 10/2, 10/3, 10/4, 10/5, 10/6, 10/7, 10/8, 10/9, 10/10, 10/11, 10/12, 10/13, 10/14, 10/15, 10/16, 10/17, 10/19, 10/20, 10/21, 10/22, 10/24, 10/25, 10/26, 10/27, 10/28, 10/29, 10/30, and 10/31/2014.</p> <p>Resident #15's record was reviewed on 11/18/14 at 1:51 p.m. The resident's diagnoses included, but were not limited to, dementia and diabetes mellitus.</p> <p>Review of Physician's Order Summary (POS) for October and November 2014, included an order for "accuchecks: check blood sugar twice daily. Notify MD if below 60 or above 400, Humalog (insulin) Kwik inj (pen device for insulin injections) 100/ml (milliliters): use per sliding scale: 60-150=0 units; 151-200=4 Units, 201-250=8 Units, 251-300=12 Units, 301-350=16 Units; 351-400=20 Units; over 400= give 20 Units and call MD."</p>		<p>management meeting, the interdisciplinary team meets weekly for Standards of Care which analyzes ongoing trends or patterns within the facility requiring problem-solving or some type of intervention. Any additional needs for process improvement are discussed and approaches are developed for correction. The monthly QA&A Committee meets to review the results of all prior problem identification and the interventions that have been put into place to provide improvement in the services and care of the residents. This Committee will continue the review and oversight of all facility processes until ongoing compliance is demonstrated on a consistent basis. The Nurse Consultant or the Regional Director of Operations will review the minutes of the morning management meetings, weekly Standards of Care, and monthly QA&A Committee at least weekly for the next 90 days. They will indicate their review by their signature and date of review on each committee's minutes. Any identified concerns will be discussed with the Administrator an interdisciplinary team members at the time of the review, with training and direction for improvement provided for the committee members. 4. <u>How will corrective action be monitored to ensure the deficient practice does</u></p>				

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	<p>A review of October 2014 MAR (Medication Administration Record) indicated a lack of documentation for blood sugar glucose monitoring results at BB (Before Breakfast) on October 2 and October 4, 2014.</p> <p>A review of the resident's October 2014 MAR indicated, on 10/3 the evening blood sugar result was 178, the resident received no insulin and should have received 4 Units of insulin. On 10/5 the evening the blood sugar result was 216, the resident received no insulin and should have received 8 Units of insulin. On 10/9 the evening blood sugar result was 151, the resident received no insulin and should have received 4 Units of insulin. On 10/11 the evening blood sugar result was 183, the resident received no insulin, and should have received 4 Units of insulin. On 10/12 the evening blood sugar result was 185, the resident received no insulin and should have received 4 Units of insulin. On 10/22 the evening blood sugar result was 171, the resident received no insulin and should have received 4 Units of insulin. On 10/25 the evening blood sugar result was 177, the resident received no insulin and should have received 4 Units of insulin. On 10/26 the evening blood sugar result was 167, the resident</p>		<p><u>not recur and what QA will be put into place?</u> The QA&A Committee will meet at least monthly to review and provide recommendations as needed for all areas identified as needs improvement, including those identified in the survey and written on the CMS-2567. Action plans for newly identified issues will be developed with interventions and documentation of progress or lack of progress noted on each as the improvement activities are integrated into the facility services. As interventions are added or changed, they will be documented on the action plan. The Administrator and interdisciplinary team will use these as a point of reference as they work on each of the identified areas throughout the month. The action plans for areas already identified as needing improvement will be reviewed at each QA&A Committee meeting to assess progress in the correction efforts. The results will be analyzed by the Committee members and recommendations made as needed to continue the improvement process. After 90 days, the Nurse Consultant and Regional Director of Operations may decide to stop the documentation of their weekly review of the committees' minutes; however, the reviews and related action done by each of the committees including the QA&A Committee will continue on</p>		

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	<p>received no insulin and should have received 4 Units of insulin.</p> <p>Interview with the Administrator on 11/21/14 at 11:06 a.m., indicated the Quality Assessment & Assurance (QA&A) Committee put an action plan in place on 9/24/14 for an area of concern with blood sugar protocol. She indicated they knew they had a problem with blood sugar protocol and brought it to the QA&A committee in September. She further indicated the committee should have caught the medication errors and the issue was ongoing.</p> <p>3.1-52(b)(2)</p>		<p>an ongoing basis. Date of Compliance: 12/21/14</p>		