

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey Dates: March 20, 21, 22, 25, 26, and 27, 2013.</p> <p>Facility Number: 000475 Provider Number: 155406 AIM Number: 100290540</p> <p>Survey Team: Julie Wagoner, RN, TC Lora Swanson, RN Deb Kammeyer, RN</p> <p>Census Bed Type: SNF/NF: 28 Total: 28</p> <p>Census Payor Type: Medicare: 0 Medicaid: 24 Other: 04 Total: 28</p> <p>These deficiencies also reflects state findings in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on April 5, 2013, by Brenda Meredith, R.N.</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.</p> <p>Hickory Creek at Peru desire this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on April 22, 2013.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013	
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU				STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, record review and interview, the facility failed to notify a family member of a dental exam in 1 of 3 residents reviewed for dental services. (Resident #4)</p>	F000157	<b>F157</b> It is the policy of this facility to notify responsible parties of any need to alter treatment significantly. 1. What corrective action will be accomplished for residents affected? Resident #4	04/26/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU			STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>Finding include:</p> <p>During an interview on 3-21-13 at 9:41 A.M., Resident #4's daughter indicated the resident had been wearing the same dentures for a long time and the lower denture was loose.</p> <p>The Clinical Record for Resident #4 was reviewed on 3-25-13 at 10:00 A.M. The resident's diagnoses, included but were not limited to, hypertension, dementia, weakness, and osteoporosis.</p> <p>Review of a careplan conference, dated 8-30-12, indicated the resident was experiencing a sore on the bottom of her mouth. The resident's daughter was present at the careplan meeting and it was decided to have the dentist check on her dentures and determine if they were fitting loosely.</p> <p>Review of a dental exam provided by an outside dental service, dated 11-6-12, indicated the following recommendation: "new c/c [upper and lower dentures] if willing...good oral health." The exam also indicated the resident had refused the recommendations. Documentation of a previous dental exam, completed on 7-2-12, indicated "adjusted lower"</p>		<p>had a dental fitting for dentures on March 27,2013. On April 11, 2013 the Administrator reeducated the dental provider, Dr. Charles Miller, DDS and his assistant of the importance of notifying the facility when a recommendation for treatment has been made, whether or not the patient refuses the service. Dr. Miller verbally expressed his understanding and exited with appropriate staff at the conclusion of his visit. 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? An audit of the dentistry services provided for the last year of all residents has been conducted. There have been no other residents identified as being affected.No further action needed at this time. 3.What measures will be put into place to ensure this practice does not recur? The SSD or designee will audit the charts of the residents seen by dental services on an ongoing basis after all scheduled visits to make sure that all recommendations have been followed through on and responsible party notification has been completed. If the SSD finds that notification has not occurred, she will notify the resident's responsible party at that time and will document the notification in the resident's chart. 4. How will corrective action be monitored to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013	
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU				STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>(denture plate).</p> <p>Review of the Social Services progress notes, for November and December 2012, indicated there was no documentation of notification of the family regarding the dental exam and the dentist's recommendation incurred on 11-6-12. A social service note, dated 1-24-13, stated "...Res. [resident] had Podiatry + Dental exams this Q [quarter]. Dentist recom [recommended] c/c if willing,... Writer to look into what 'new c/c if willing' meant."</p> <p>During an interview on 3-25-13 at 11:35 A.M., the DON indicated she did not know if the resident's daughter was notified of the dentist's recommendation. Documentation was requested, from the DON, regarding notification of the resident's family regarding the dental exam recommendations from the 11-6-12 dental exam. There was no documentation provided.</p> <p>During an interview on 3-26-13 at 9:10 A.M., the Administrator indicated she was not aware that (name of dental provider) did not contact the resident's family themselves after an exam.</p>		<p>ensure the deficient practice does not recur and what QA will be put into place? Findings from the SSD audits will be reviewed by the Administrator and then forwarded to the QA&amp;A committee for further review at the monthly meeting. After 90 days and when 100% compliance is obtained further monitoring will be completed as recommended by the QA&amp;A committee.</p> <p><b>Addendum:</b> The SSD will complete the audits on an ongoing basis after each dental service visit indefinitely even when the QA&amp;A Committee members no longer require that audits be reported to the committee. If the SSD finds any concerns after that point in time, she will follow through has indicated earlier in this plan.</p> <p><u>Date of compliance:</u> April 26, 2013</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU			STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>On 3-27-13 at 2:40 P.M., the resident indicated her bottom denture was "loose." An observation was made of the resident easily removing the bottom denture. The resident removed the top denture and it required a tug to remove. The resident indicated she had ..."no problems with eating...."</p> <p>3.1-5(a)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU			STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review and interview, the facility failed to assure the recommendations from a dentist were conveyed to the family and/or implemented for 1 of 3 residents reviewed for dental services.</p> <p>Finding include:</p> <p>On 3-21-13 at 9:41 A.M., an interview with Resident #4's daughter indicated the resident had the same dentures for a long time and that the lower denture was loose.</p> <p>The Clinical Record was reviewed on 3-25-13 at 10:00 A.M. A review of a dental exam thru (providers name), dated 11-6-12, indicated the resident refused the recommendations from the dentist."...new c/c [upper and lower dentures] if willing...good oral health." A previous dental exam, on 7-2-12, indicated "adjusted lower."</p> <p>Review of the Social Services Progress Notes for 11-6-12 thru 11-19-12, indicated there was no</p>	F000250	<p><b>F250</b> It is the policy of this facility to provide medically-related social services to attain or maintain the highest practicable physical, mental and psycho social well-being of each resident. 1. What corrective action will be accomplished for residents affected? Resident #4 had a dental fitting for dentures on March 27,2013. On April 11, 2013 the Administrator reeducated the dental provider, Dr. Charles Miller, DDS and his assistant of the importance of notifying the facility when a recommendation for treatment has been made, whether or not the patient refuses the service. Dr. Miller verbally expressed his understanding and exited with appropriate staff at the conclusion of his visit. 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? An audit of the dentistry services provided for the last year of all residents has been conducted. There have been no other residents identified as being affected.No further action needed at this time. <u>3.What measures will be put into place to ensure</u></p>	04/26/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013	
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU				STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>documentation of notification of the family regarding the dental exam and the dentist's recommendation. A social service note, dated 1-24-13, stated "...Res. [resident] had Podiatry + Dental exams this Q [quarter]. Dentist recom [recommended] c/c if willing...." Writer to look into what "new c/c if willing" was with (providers name).</p> <p>During an interview on 3-25-13 at 11:35 A.M., the Director of Nursing (DON) indicated the resident had refused the recommendation of the dentist. She further indicated she did not know if daughter was notified of the dentist's recommendation.</p> <p>During an interview on 3-26-13 at 9:10 A.M., the Administrator indicated she was not aware that (providers name) did not contact the resident's family after an exam.</p> <p>On 3-27-13 at 2:40 P.M. the resident indicated her bottom denture was "loose." An observation was made of the resident easily removing the bottom denture. The resident removed the top denture and it required a tug to remove. The resident said she had no problems with eating.</p>		<p><u>this practice does not recur?</u> The SSD or designee will audit the charts of the residents seen by dental services on an ongoing basis after all scheduled visits to make sure that all recommendations have been followed through on and responsible party notification has been completed. . If the SSD finds that notification has not occurred, she will notify the resident's responsible party at that time and will document the notification in the resident's chart.</p> <p>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? Findings from the SSD audits will be reviewed by the Administrator and then forwarded to the QA&amp;A committee for further review at the monthly meeting. After 90 days and when 100% compliance is obtained further monitoring will be completed as recommended by the QA&amp;A committee.</p> <p><b>Addendum:</b> The SSD will complete the audits on an ongoing basis after each dental service visit indefinitely even when the QA&amp;A Committee members no longer require that audits be reported to the committee. If the SSD finds any concerns after that point in time, she will follow through has indicated earlier in this plan.</p> <p><u>Date of compliance:</u> April 26, 2013</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU			STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	3.1-34(a)(2)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interviews, the facility failed to ensure the mattresses fit the bedframes and were free of gaps for 2 residents who met the criteria. (Residents #40 and #4) In addition, the facility failed to ensure 1 of 1 residents reviewed for falls in a sample of 3 received adequate supervision to prevent falls. (Resident #12)</p> <p>Findings includes:</p> <p>1. During an interview on 03/21/13 at 9:22 A.M., LPN #5 indicated Resident #12 had recently fallen in her room trying to get herself out of bed to go to the bathroom.</p> <p>The clinical record for Resident #12 was reviewed on 03/22/13 at 10:30 A.M. Resident #12 was admitted to the facility on 11/22/04, and readmitted on 02/06/07. The resident had diagnoses, including but not limited to, diabetes, htn, hypothyroidism, cardiovascular</p>	F000323	<p><b>F323</b> It is the policy of this facility to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. 1A. What corrective action will be accomplished for residents affected? Related to mattresses: An environmental tour was conducted. All mattresses that were found not to fit appropriately were replaced. 2A. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? After an environmental tour of the facility it was found that 21 resident mattresses did not fit the bed frames and were not free from gaps. Immediately upon this finding the Administrator called the mattress supplier and placed an order for 27mattresses to replace the 21 resident mattresses as well as the 6 unoccupied facility beds. Because the mattresses could not be shipped for next day delivery, staff was all inserviced and instructed to roll blankets at</p>	04/26/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU			STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>disease, hypokalemia, tardive dyskinesia, hemi balismus, psychosis, delirium, osteoporosis, osteopenia, bipolar disease, dementia, and hypercholesterol.</p> <p>Nursing notes, dated 03/04/13 at 1:55 A.M., indicated the following: " Resident was found on the floor in the bathroom on the far right wall, completely away from the toilet. Said she was trying to "get something," which clearly wasn't in the room. (sic) no skin tears, no lacerations small bump starting to form on left central posterior head.</p> <p>Review of facility fall investigation report for Resident #12 and interview with the Director of Nursing, on 03/26/13 at 2:09 P.M., indicated a nursing staff member had taken the resident into the bathroom on 03/04/13 at 1:55 A.M., and left the resident unattended, left the room and went to go get a brief, and the resident fell while unattended. She indicated the resident should not have been left unattended. She indicated the staff member received a disciplinary note and all nursing staff were reinserviced regarding the issue.</p> <p>A Fall risk assessment, completed on 03/20/13, indicated the resident's</p>		<p>the foot of each of the 21 resident mattresses to create a bolster effect and eliminate gap. An audit tool was created and implemented to audit and ensure placement of bolsters every shift until the arrival of appropriate size mattresses. Mattresses were received March 28, 2013 and replaced the previous mattresses <u>3A. What measures will be put into place to ensure this practice does not recur?</u> Correct size mattresses were received on March 28, 2013 and immediately put in place for those 27 beds that were affected. The Maintenance Director, while completing his quarterly preventative maintenance checklist will assess the mattresses for correct fitting for each of the 36 bed frames in the facility and will document those checks. In addition, the Maintenance Director will assess the mattress fit whenever a mattress or bed is changed, or if an overlay or other type of device has been added to the bed or mattress for preventive or treatment purposes. If there are any findings, he will report this to the Administrator and/or designee immediately 4A. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Maintenance Director will report his quarterly findings to the QA&amp;A meeting the month during which they are completed, This will be done on</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013	
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU				STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>score was 25 which placed the resident in the high risk for falls category.</p> <p>The current care plan, related to falls, for Resident #12, which was revised on 07/20/12, and current through 04/01/13, indicated the resident was at risk for falls, and included the following interventions: " daily monitoring for adverse reactions related to pschotropics [medication], gdr (gradual dose reduction) of psychotropics as per guidelines, toilet plan as scheduled, observe me for changes in my functional abilities, quarterly and prn [as indicated] fall risk assessments, therapy screens quarterly and prn, pharmacy med reviews prn, enabler bars on bed x 2, encourage me to wear nonskid foot wear, alarms on bed and w/c to alert staff of possible self transfers, encourage me to use my assistive devices and not push my w/c [wheelchair], assist me to lock brakes on w/c, w/c at bed side."</p> <p>Interview with the Director of Nursing, on 03/26/13 at 2:09 P.M., indicated the facility policy for residents with wheelchair alarms was not to leave them unattended or alone while toileting them. She indicated staff were reinserviced and the particular</p>		<p>an ongoing basis. 1B What Corrective action will be accomplished for residents affected Related to falls: As stated during the survey, staff was reinserviced and the employee involved received disciplinary action. Since the time of her fall, Resident #12 has also received physical and occupational therapy, in which a self releasing alarming belt was recommended and is currently in place. . 2B. How Will the Facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken No other residents were found to be affected related to falls due to lack of supervision. Staff was reinserviced on April 16, 2013 to reiterate the importance of supervision for those residents with alarms. <b>Addendum:</b> It is the policy of this facility to complete fall risk assessments quarterly and on an as needed basis for all residents. This assessment tool will then be utilized to develop an individualized fall prevention care plan for each resident. Care plans will be reviewed on a quarterly and as needed basis to verify that the preventative measures remain appropriate and in place. Revisions will be made as deemed necessary by the Interdisciplinary Team (IDT). . <u>3B. What Measures will be put into place to ensure this practice</u></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU			STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>staff member who left Resident #12 unattended, on 03/04/13 at 1:55 P.M., received "disciplinary" action.</p> <p>Review of a nursing note, on 03/15/13 at 2:00 P.M. indicated the following: "...resident unable to comprehend danger of transferring self...."</p> <p>2. Observation of the bed for Resident #40, on 03/21/13 at 11:39 A.M., indicated the bed mattress was noted to be too short for the bed frame. There was a gap, greater than 4 1/2 inches noted between the top of the mattress and the head of the bed frame.</p> <p>The clinical record for Resident #40 was reviewed on 03/26/13 at 2:30 P.M. Review of the most recent quarterly MDS (minimum data set) assessment for Resident #40, completed on 12/11/12, indicated the resident alert and oriented, was blind, was totally dependent on staff for bed mobility, required extensive staff assistance for transferring needs, and was not ambulatory.</p> <p>Review of a nursing summary note, completed on 02/18/13, indicated the resident utilized a standing lift for transfers, and a w/c for mobility. Nursing notes, from 01/01/13 -</p>		<p><u>does not recur</u> The DON will continue to complete fall investigations to determine the factors of any falls. She will bring the results of her investigation to the interdisciplinary morning management meeting that occurs at least 5 days a week for review and recommendations made by the team. She will add the recommendations to the 24 hour report for communication to each shift. In addition the CNA assignment sheets will be updated with any new fall interventions. <b>Addendum:</b> Fall risk assessments will be completed quarterly and on an as needed basis for all residents following facility policy. These assessments will be used to assess and plan individual resident preventative measures. The preventative measures will be added to the care plan and the CNA assignment sheets accordingly. <u>4B.How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Staff will be inserviced each month for three months regarding fall prevention and the importance of not leaving residents unattended while alarm is disarmed. Director of Nursing or designee will review or complete fall investigations on an ongoing basis, CNA assignment sheets will be updated with new fall prevention information and results of the investigations will</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU			STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>03/22/13, indicated there was no documented falls from bed or documentation of the resident attempting to get herself out of bed</p> <p>3. During observation of the room for Resident #4, conducted on 03/21/2013 at 8:55 AM, the following was noted for the bed: two, 1/4 length assist rails, were noted to be elevated The mattress was too short for bed frame. A block measuring 4 5/8 inches was noted to fit in space at top of the bed between the mattress and the headboard.</p> <p>The clinical record of Resident #4 was reviewed on 3-22-13 at 1:50 P.M. The resident had diagnoses, included but were not limited to, hypertension, dementia, history of TIA (trans ischemic accident), weakness, history of syncope, and osteoporosis.</p> <p>The most recent Minimum Data Set (MDS) Quarterly Assessment, competed on 1-23-13, indicated the resident scored a moderately cognitively impaired, and was independent with bed mobility.</p> <p>During the survey process, on 03/21/13, during Stage 1 observation, it was noted the mattresses on most of the resident beds were significantly</p>		<p>be forwarded to the Administrator for review. Results will be discussed during daily stand up meeting and falls will then be discussed each month at the QA&amp;A meeting. <b>Addendum:</b> At least quarterly random audits of each resident's fall prevention care plans will be audited by the Director of Nursing and/or designee to assure compliance with preventative measures. In addition, fall prevention care plans will be reviewed by the interdisciplinary team after a fall has occurred, as part of the morning management clinical meeting that occurs at least 5 days a week. <u>Date of compliance:</u> April 26, 2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013	
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU				STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>shorter than the bed frames, leaving a large gap at either the top, bottom, or both ends of the bed.</p> <p>On 03/21/13, the Administrator was notified of the concern and a brief environmental tour was scheduled with the Maintenance Director for the following morning.</p> <p>The mattresses and bedframes were measured, on 03/22/13 at 8:40 A.M., with the Administrator, and the Maintenance Supervisor, Employee #1. The bed mattress for Resident #40, who resided in room 7 was noted to have a gap of 4 1/2 inches from the top of the mattress to the headboard and 2 1/4 inches from the bottom of the mattress to the footboard . The mattress for Resident #4 measured the same as the mattress for Resident #40. Interview with the Administrator, on 03/22/13 at 9:00 A.M., indicated the mattresses in the building had been replaced about 2 years ago and 76 inch mattresses had been ordered. She indicated new furniture had been ordered within the past year and all residents received a new bed. She indicated the new bedframes were 82 inches long. She indicated the corporation would need to order 80 inch mattresses to safely fit the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU			STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>bedframes.</p> <p>Interview with the Administrator, on 03/22/13 at 10:30 A.M., indicated the facility was ordering new mattresses for all of the resident beds that had the 76 inch mattresses on them. She indicated she had attempted to have them overnighted but the manufacturer did not have enough of the 80 inch mattresses in stock to overnight them. She indicated she would have the maintenance staff place rolled blanket bolsters in the gaps until the mattresses were delivered. She also indicated she would inservice all of the staff on the bolsters to ensure they stayed in place and were not removed by staff. She also indicated she would audit the bolsters daily to ensure they remained in place.</p> <p>On 03/22/13 at 11:30 A.M., rolled bolsters were observed in place in all of the affected beds. The bolsters were placed between the bottom of the mattress and the foot of the bed to allow the head of the bed to be raised without dislodging the bolsters.</p> <p>Interview with the Administrator, on 03/27/13 at 10:00 A.M., indicated she had confirmed the mattress delivered and the mattresses were to be</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU			STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	delivered on 03/28/13. There were 27 mattresses scheduled to be delivered on 03/28/13 by (name of delivery service) on the confirmation tracking record.  3.1-45(a)(1)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU			STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review and interviews, the facility failed to ensure 1 of 3 residents who met the criteria for nutrition review in a sample of 23 maintained adequate Body Mass Index (BMI) and was free from significant weight loss. (Resident 12)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #12, completed on 03/22/13 at 8:45 A.M., indicated the resident was not on a weight loss program, did not have a terminal condition, and had a 9.5 % weight loss in the past 30 days, and an 11.4 percent weight loss in the past 6 months.</p> <p>Resident #12 was admitted to the facility on 11/22/04, and readmitted on 02/06/07, with diagnoses, including but not limited to, diabetes, htn (hypertension), hypothyroidism,</p>	F000325	<p><b>F325</b> It is the policy of this facility to ensure that a resident maintains acceptable parameters of nutritional status and receives a therapeutic diet when there is a nutritional problem. 1. What corrective action will be accomplished for residents affected? Resident#12 is currently receiving speech therapy addressing mastication and swallowing. This resident continues on Nutrition at Risk monitoring program and is reviewed weekly by the interdisciplinary team. The resident's weight has increased from 103.5 pounds on March 22, 2013 to 107 pounds on April 14, 2013. As of April 18, 2013, Resident #12 will receive all fortified foods at this time and will be reviewed by Registered Dietitian biweekly. 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? Currently we have 6 residents</p>	04/22/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013	
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU				STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>cardiovascular disease, hypokalemia, tardive dyskinesia, hemi balismus, psychosis, delirium, osteoporosis, steopenia, bipolar disease, dementia, hypercholesterol</p> <p>The resident's weight record indicated the following weights: 03/17/13 - 105 pounds 02/08/13 - 115 pounds 12/07/12 - 115 pounds 09/07/13 - 117 pounds</p> <p>A readmission dietary assessment, completed on 01/24/13, by the Registered Dietician (RD) indicated the resident received a medical soft diet, was on a consistent cho (carbohydrate), nas (no added sugar) diet with 1 houseshake dly (daily), was eating 75 - 100 % of all three meals, has her own teeth which are in poor condition, weighed 114 pounds, and had a BMI score of 19. There were no additional recommendations except to "follow up in 4 weeks. "</p> <p>A dietary note, completed by the RD on 03/22/13, indicated the resident's current weight was 103.5 pounds. The note indicated the resident received double eggs at breakfast , fortified mashed potatoes, and fortified house shakes. The note indicated the RD had spoken with the</p>		<p>who receive nutritional supplements either through houseshakes or magic cups. The certified nursing assistants will document either the amount in "cc" of house shakes consumed or the percentage of magic cup consumed. This information will be contained in the Hickory Creek at Peru food intake book on a monthly basis. <u>3.What measures will be put into place to ensure this practice does not recur?</u> The dietary manager or designee will monitor the food intake book at least 5 days a week to make sure that it is completed thoroughly. This information will be provided in morning meeting. Any follow up that is required will be obtained as needed. In addition, residents considered at risk of weight loss or who have been identified as needing additional nutrition will be reviewed in the NAR meeting monthly until their weight and nutrition is stable. <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? Results of food intake book review completed by the dietary manager will be reviewed by the Administrator and then forwarded to the QA&amp;A committee for further review. After 90 days and when 100% compliance is obtained further monitoring will be completed as recommended by the QA&amp;A committee. <u>Date of compliance:</u></u></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013	
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU				STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>resident and the resident had reported she disliked the house shakes. The note indicated the RD was recommending to discontinue the house shakes and start giving the resident a magic cup (a frozen pudding supplement) twice a day to aid in weight stabilization. The note indicated the resident was to continue to be followed by the NAR (Nutrition at Risk) committee. The resident had reported no problems chewing or swallowing issues with her current modified texture diet. The resident's current BMI had declined and was now 17.27. The resident's estimated nutritional needs were assessed to be protein 50 grams, 1530 - 1785 kcal , and 1530 cc fluid per day.</p> <p>Review of the Nutrition at Risk (NAR) committee minutes for Resident #12 indicated on 01/16/13 the resident was readmitted with a weight of 115 and the recommendation was for her weight to be monitored weekly x 4 weeks. On 01/16/13 , there was no weight obtained but an intervention of a houseshakes at hs (bedtime) was added. On 01/30/13 , the resident's weight was 114 and the comment "cont to encourage at mealtimes" was the only recommendation. On</p>		April 22, 2013				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013	
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU				STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>02/06/13, the resident's weight was 112.5 and the only recommendation was " offer substitutes." On 02/02/13 the resident's weight was 114 and "double eggs at breakfast" was added. On 02/27/13 the resident's weight was 112.5 and the intervention was: "provide hs snack." On 03/04/13, the resident's weight was 110 and there were no interventions added. On 03/13/13, the resident's weight was 108 and the intervention was "alert RD [Registered Dietician]." On 03/20/13, the resident's weight was down to 103.5 pounds, and the only intervention was " need reweight."</p> <p>On 03/26/13 at 2:00 P.M., interview with the FSS (Food Service Supervisor), Employee #4, who was responsible for documenting any nutritional intervention for the NAR meetings, indicated any resident who was hospitalized was put in the NAR list for at least 4 weeks after readmission. She indicated she wrote an NAR interventions implemented if there were recommendations made. She indicated since Resident #12 did not like the health shakes, a magic cup was implemented and given to the resident at 10 am and 2 PM. She indicated the resident loved eggs so</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>an intervention of double eggs portion at breakfast was implemented and/or continued as an intervention She indicated she also got fortified potatoes but did not like cereal so that is why the double portion of eggs was utilized. She indicated the certified nursing assistants were responsible for documenting the supplements on the food and fluid records. She indicated there was no separate place to document how much of a liquid or solid nutritional intervention was consumed as the food and fluid for the whole meal and/or snack time was combined on the charting.</p> <p>Review of the Resident Fluid and Meal Percentage Intake Log for Resident #12 indicated the fluids for meals was totaled but there was no way to determine how much of the fluid documented was the houseshake supplement which was to be given to the resident until 03/22/13, when it was discontinued. There was also no way to ensure the magic cup was given to the resident at 10:00 A.M. as there was no documentation of any AM intake for March 22 - 27. In addition, the HS documentation only indicated the cubic centimeters of fluid was documented from 03/22/13 - 03/27/13.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Review of the March 2013 MAR (Medication Administration Record) with QMA #3, on 03/27/13 at 2:00 P.M., indicated there was no documentation for health shakes or magic cup separately documented for Resident #12.</p> <p>Interview with the Director of Nursing, on 03/27/13 at 2:20 PM., indicated she thought the supplements were documented in the MAR. She was informed there was no documentation regarding supplements given for Resident #12 in the MAR. She indicated maybe medical records had additional documentation but no documentation was ever produced.</p> <p>3.1-46(a)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation and record review, the facility failed ensure the medication error was not greater than 5%. The facility made 2 errors in 27 opportunities for a medication error rate of 7.41%.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 3-22-13 at 8:52 a.m., the Qualified Medication Assistant (QMA) #3 attempted to give poly-iron 150 mg. orally to Resident #28, however the medication was not available. The QMA attempted to have the nurse get the medication out of the emergency drug kit (EDK) . The medication was not available in the EDK.</li> <li>On 3-22-13 at 11:23 A.M., Resident #6 was given Humalog (fast acting insulin) 3 units by sub cutaneous injection at 11:23 A.M by LPN #6. The resident was brought to dining room at 11:35 A.M. The resident received two glasses of water at 11:55 A.M. The noon meal was delivered to the resident and the resident took her first bite of the meal</li> </ol>	F000332	<p><b>F332</b> It is the policy of this facility to ensure that it is free of medication error rates of five percent or greater. 1. What corrective action will be accomplished for residents affected? Residents#6 and #28 did not have negative effects due to the medication errors. On March 22, 2013, a clarification order was received for Resident #28 to hold the poly-iron and resume once daily the following day. On March 22, 2013, a clarification order was received for all residents receiving fast-acting insulin to be given said insulin 5 to 30 minutes prior to meal time. <b>Addendum:</b> Upon further review, orders were obtained by attending physician to modify fast acting insulin administration times to 15 minutes before or after meals, for our residents receiving this type of insulin to help ensure these residents do not have any hypoglycemic effects.</p> <p><b>Addendum 2: F332: Regarding the timing of the administration of insulin, have you consulted with your Consultant Pharmacist for their recommendations? What are the recommendations?</b> After further analysis and consultation with our Consultant Pharmacist,</p>	05/03/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU			STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>at 12:10 P.M.</p> <p>During an interview on 3-26-13 at 9:30 A.M., the DON (Director of Nursing) indicated the resident should receive their meal "15 to 20 minutes after a short acting insulin is given."</p> <p>On 3-26-13 at 9:35 A.M., a Policy &amp; Procedure titled Medications-General Practices was reviewed. A subtitle...For administering insulin was reviewed and had no recommendations as to when a resident should receive their fast-acting insulin in relationship to a meal.</p> <p>Jones &amp; Barlett Learning 2012 Nurse's Drug Handbook, 11th Edition: Rapid-acting insulin Humalog stated "...give Humalog only SubQ up to 15 minutes before a meal...."</p> <p>3.1-48(c)(1) 3.1-25(b)(9)</p>		<p>the facility is altering the plan of correction as follows: Even though manufacturers of fast-acting insulin indicate there is no statistical difference in giving fast-acting insulin within 15 minutes after eating, in order to maintain continuity of care and practice for all brands of fast-acting insulin, the facility has revised its policy stating that fast-acting insulin injections will be given no earlier than 15 minutes before meals. Fast-acting insulin will not be given after meals. <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 were affected by this practice. Physician orders were obtained for all residents receiving fast-acting insulin coverage to ensure insulin is administered by following doctor's orders in relation to meal times for each resident who receives insulin. No other residents were affected by the poly-iron medication error. The facility's contracted pharmacy has been contacted to add poly-iron to Hickory Creek at Peru EDK stock.</p> <p><b>Addendum:</b> Upon further review, orders were obtained by attending physician to modify fast acting insulin administration times to 15minutes before or after meals for all residents receiving this type of insulin.For all new residents or residents who are</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			<p>readmitted on fast acting insulin an order will be obtained for insulin to be given 15 minutes before or after meal. The nursing staff will be re-inserviced on the signs/symptoms of hyperglycemia and hypoglycemia. As they are in the dining room just prior to, during, and after the meals, they will observe residents for any signs of diabetic reaction. If any are noted, the nurse will assess the resident and follow through with the physician as indicated by the resident's condition and the physician's orders. <b>Addendum 2:</b> After further analysis and consultation with our Consultant Pharmacist, the facility is altering the plan of correction as follows: Even though manufacturers of fast-acting insulin indicate there is no statistical difference in giving fast-acting insulin within 15 minutes after eating, in order to maintain continuity of care and practice for all brands of fast-acting insulin, the facility has revised its policy stating that fast-acting insulin injections will be given no earlier than 15 minutes before meals. Fast-acting insulin will not be given after meals. The nursing staff will be inserviced on the new procedure regarding fast-acting insulin administration. <u>3. What measures will be put into place to ensure that this practice does not recur?</u> The DON or designee will observe a medication administration pass one time</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			<p>weekly for 90 days. Each nurse/ QMA has been re-educated on the facility's policy and procedures for medication administration, as well as the policy and procedure for receiving a telephone order. Each nurse or QMA will be observed at least once during this time period. If concerns are identified, the nurse/QMA will receive the necessary re-training and will be observed performing medication pass until he/she can demonstrate 100% compliance.</p> <p><u>4. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Results of the observation of medication administration pass will be brought to the Administrator to review. This information will be forwarded to the QA&amp;A committee and after 90 days, the decision will be made to continue the observation or discontinue if 100% compliance achieved.</p> <p><u>Date of compliance:</u> May 3, 2013</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013	
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU				STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to distribute and serve food under sanitary conditions in regard to hand washing during delivery of meal trays for 26 of 28 residents in the facility. (Employee #2 and Employee #3)</p> <p>Findings include:</p> <p>On 3/25/13 at 12:10 P.M., Employee #2 was observed assisting a resident to the main dining room in her wheelchair. Once the resident was seated at the table Employee #2 locked the wheelchair brakes and removed the leg pedals. Employee #2 then placed a clothing protector around the residents neck. After assisting the resident Employee #2 continued to serve trays to the other residents without washing her hands or using hand sanitizer.</p> <p>On 3/25/13 at 12:15 P.M., Employee #3 was observed adjusting a residents oxygen tubing on her face,</p>	F000371	<p><b>F371</b> It is the policy of this facility to ensure that we store, prepare, distribute and serve food under sanitary conditions. 1. What corrective action will be accomplished for residents affected? All staff was inserviced on April 16, 2013 regarding the practice of distributing food under sanitary conditions, including hand washing and use of alcohol based sanitizer. <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 were identified as being affected by this practice. <u>3. What measures will be put into place to ensure that this practice does not recur?</u> Department Managers will monitor meal tray distribution 3 times a day, 5 days a week for 90 days and record findings. If there are findings during a meal distribution, the Department Manager involved will intervene at that time and counsel the necessary staff member regarding the appropriate practice. <u>4. How will the corrective action be monitored to ensure the deficient practice does</u></p>	04/22/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013	
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU				STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>then placed a clothing protector around the residents neck. Employee #3 continued to serve trays to the other residents in the main dining room without washing her hands or using hand sanitizer.</p> <p>On 3/26/13 at 2:31 P.M., interview with the Dietary Manager indicated the staff should use hand sanitizer after passing every third tray. She further indicated if the staff need to assist a resident with positioning, placing a clothing protector on or touching a residents personal belongings the staff should wash their hands before serving another tray.</p> <p>On 3/27/13 at 3:04 P.M., record review of the current policy titled "Handwashing/Alcohol-Based Hand Rub" received from the Administrator indicated, "...The absolute indications for and the ideal frequency of handwashing are not known. However, in the absence of a true emergency, personnel should always wash their hands...Before and after each resident contact...After touching a resident or handling his/her belongings...."</p> <p>3.1-21(i)(3)</p>		<p><u>not recur and what QA will be put into place?</u> Results of the monitoring of tray distribution will be brought to daily stand up meeting to review. This information will be forwarded to the QA&amp;A committee and after 90 days, the decision will be made to continue the observation or discontinue if 100% compliance is obtained. <b><u>Date of compliance:</u></b> April22, 2013</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU			STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation and record review, the facility failed to accurately document a medication order to the Medication Administration Record in 1 of 7 residents observed receiving medications. (Resident #28)</p> <p>Finding includes:</p> <p>On 3-22-13 at 8:52 A.M. the Qualified Medication Assistant (QMA) #3 attempted to give polyiron 150 mg. orally to Resident #28, however the medication wasn't available. The QMA was asked to read the medication's instructions for use as written on the Medication Administration Record (MAR). The QMA read the order as "... Poly-iron 150 mg. po [by mouth] QD [every day]." The QMA then stated she</p>	F000514	<p><b>F514</b> It is the policy of this facility to ensure accurate clinical records. 1. What corrective action will be accomplished for residents affected? Resident#28 did not have a negative affect due to the medication error. On March 22, 2013 a clarification order was received for Resident #28 to hold the poly-iron and resume once daily the following day. No other residents were affected by the poly-iron medication error. The facility's contracted pharmacy has been contacted to add poly-iron to Hickory Creek at Peru EDK stock.</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></p> <p>No other residents were affected by the poly-iron medication error, and there have been no other</p>	04/22/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/27/2013
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU			STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>needed to check the order because the medication had been given twice a day at 8 A.M. and at 8 P.M., for 16 times in the month of March.</p> <p>A physician order was reviewed on 3-22-13 at 8:45 A.M., and indicated on 2-22-13, an order had been written for Poly-iron 150 mg QD for anemia. The QMA notified LPN # 6 of the error. LPN #6 notified the physician and received new orders to hold the Poly-iron until medication was available from the pharmacy.</p> <p>On 3-26-13 at 10:12 A.M., A Policy &amp; Procedure titled Telephone Orders on line #6 stated "... Write order on medication and/or treatment record exactly as written on the telephone order form...."</p> <p>3.1-50(a)(2)</p>		<p>instances of medication errors identified. <u>3.What measures will be put into place to ensure that this practice does not recur?</u> Upon the receipt of a new physician order the nurse will transcribe the order onto the MAR exactly as written and for the next 24 hours the following nurses will initial on the yellow carbon copy to indicate that they have read the order and that it is correctly written on the Medication Administration Record. Once reviewed, the physician orders will be returned to the DON who will ensure nurses are reviewing as instructed. In addition, copies of physician telephone orders are reviewed at the morning clinical meeting that occurs at least 5 days a week. Any question about the transcription or carry through of a physician's order will be followed up by the DON at that time. Two licensed nurses will be responsible for the notation and review of monthly physician orders which is completed on an ongoing basis each month.</p> <p><u>4.How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The DON or designee will observe a medication pass once a week for 90 days to ensure medication administered as ordered. Each nurse or QMA will be observed at least once during this time period. If concerns are identified, the nurse/QMA will receive the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			necessary re-training and will be observed performing medication pass until he/she can demonstrate 100% compliance. The Director of Nursing will complete a weekly QA audit for 90 days to monitor compliance. The DON or designee will bring the results of their audits and reviews to the monthly QA&A committee for further review. After 90 days and when 100%compliance is obtained, any further monitoring will be completed as recommended by the QA&A committee. <u>Date of compliance:</u> April22, 2013	