STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/25/2013

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HICKORY CREEK AT COLUMBUS	5480 E 25TH ST COLUMBUS, IN 47203

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F000000	This visit was for a Recertification and State Licensure survey. Survey dates: January 22, 23, 24, & 25, 2013 Facility Number: 000284 Provider Number: 155424 AIM Number: 100290690 Survey Team: Courtney Hamilton RN TC Gordon Tyree RN Gwen Pumphrey RN Debra Peyton RN Gloria Bond RN Census bed type: SNF/NF: 34 Total: 34 Census payor type: Medicare: 1 Medicaid: 30 Other: 3 Total: 34 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2 Quality review completed on January	F000000	This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of the plan of correction is not an admission that a deficiency exists or that one is cited correctly. This plan of correction is submitted to meet the requirements by state and federal law. Hickory Creek at Columbus desires this plan of correction to be considered the facility's allegation of compliance. Compliance is effective February 6, 2013.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	29, 2013, by Cheryl Fielden, RN			

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on interview and record review the facility failed to ensure that a comprehensive care plan was developed for a resident with chronic pain for 1 of 3 residents reviewed for pain (resident # 9). Findings include: Resident #9's record was reviewed on 1/25/13 at 1:50 P.M., diagnoses included, but not limited to early dementia, morbid obesity, hypertension, and hypothyroidism.	F000279	F279 Comprehensive Care Plans It is the standard of this facility to develop a care plan that includes measurable objectives to meet the resident's medical, nursing, mental and psychosocial needs, including medications that are ordered by the physician. <u>What corrective action will be done by the facility?</u> Resident #9 was care planned for chronic pain on 1/25/13. Although a care plan was missing for Resident #9 regarding her chronic pain a review of her	02/06/2013

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	An interview conducted with Resident #9 on 1/22/13 at 2:47 P.M., indicated the resident was having pain and discomfort in her head and legs. A current physicians order, dated 8/27/12, indicated Resident #9 received "...Hydroco/APAP (pain medication) tab 5mg-325mg po (by mouth) every 6 hours for pain..." An interview with LPN #1 on 1/25/13 at 2:40 P.M., indicated they do attempt non-pharmacological interventions including repositioning for comfort. She indicated that for this resident the best interventions have been medication. The record lacked a care plan relating to the resident's pain management. An interview with the MDS coordinator on 1/25/13 at 1:50 P.M., indicated there was no care plan for Resident #9's pain management. The MDS Coordinator indicated there would not be a care plan because the pain had been resolved with current medications. 3.1-35(a) 3.1-35(b)(1)		nurse's notes for the past two months does not indicate she has any signs or symptoms of pain. Resident #9's pain assessment indicates Resident #9 does not have any complaints of pain. 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 was completed on 1/25/13 on all residents who have chronic pain to ensure he or she had a current pain care plan in place. All residents have a current care plan to address his or her chronic pain. What measures will be put into place to ensure this practice does not recur? All resident orders will be reviewed at least 5 times a week by the Director of Nursing or designee. If an order for a pain medication is received the resident's pain assessment will be updated and a care plan will be initiated. The interdisciplinary team will continue to monitor care plans during the weekly care plan team meeting and as physician orders for pain medication are received. How will the corrective action be monitored to ensure the deficient practice does not recur and what	

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			QA will be put into place? - The DON or designee will monitor all new orders for residents at least 5 days a week. New medication orders, including pain medications will be discussed with the interdisciplinary teams as indicated above. A care plan will be put into place if a new order for pain medication is received. The MDSC will complete a monthly audit of new orders to ensure care plans are in place. She will bring those audits to the QA Committee for review for the next 60 days. After 60 days the QA Committee may decide to stop the requirement for reporting results if 100% compliance has been reported.	

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F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, interview, and record review the facility failed to revise a care plan for a resident with a history of falls for 1 of 3 residents reviewed for falls. (Resident #37) Findings include: Resident #37's record was reviewed on 1/24/13 at 10:49 A.M. Diagnoses included but were not limited to vascular dementia, HTN (Hypertension), progressive supranuclear palsy, OA (Osteoarthritis), anemia, GERD (Gastroesophageal reflux disease),	F000280	F280 Right to Participate Planning Care – Revise CP It is the policy and standard of this facility that residents have the right to partipate in planning care and treatment or changes in care and treatment. The facility would like noted that Resident #37 participates in her care planning and treatment. What corrective action will be done by the facility? Resident #37 did sustain a fall on 1/13/13. Her care plan was updated with a new approach on that day. Resident #37 has not	02/06/2013

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	dementia with behavior disturbance, and diarrhea. A staff interview conducted on 1/22/13 at 3:52 P.M., with the DON (Director of Nursing) indicated Resident #37 sustained a fall without fracture within the previous 30 days. An observation of Resident #37's room on 1/24/13 at 10:10 A.M., indicated resident #37 was sitting up in her wheelchair with a pressure alarm in place. Resident #37's bed was in the regular position with a mat on the floor next to the bed. There was a rolling walker with a brake system on the other side of the room. A care plan dated 11/29/12 indicated Resident #37 was a fall risk. Interventions included "...ambulate with staff assist to dining room chair and sit in stationary dining room chair, not wheelchair..." The care plan indicated these interventions were discontinued on 1/15/13. A restorative care plan dated 11/29/12 indicated resident was unsteady on her feet and had a recent history of falls. The care plan indicated Resident #37 required assistance with ambulation. The care plan indicated these interventions		had a fall since this date. Her care plan is current. 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 all residents with a history of falls was completed on 2/1/13. All residents care plans for falls are up to date with current interventions. What measures will be put into place to ensure this practice does not recur? Resident falls will continue to be discussed during the daily management stand up meeting. During this time the interdisciplinary team will update a resident's care plan if a fall has occurred. The interdisciplinary team will continue to review fall care plans during the weekly care plan meeting. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The interdisciplinary team will monitor all care plans for updates when falls occur. New interventions will be discussed with the interdisciplinary team as indicated above. A care plan and/or new intervention will be put	

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	were discontinued on 1/15/13. A current care plan dated 1/17/13 indicated the resident "...is unsteady on feet - requires extensive assist for transfers..." Approaches included assist to stand and pivot transfer to wheelchair or bed. An interview with LPN #1 conducted on 1/25/13 at 1:40 P.M., indicated the walker was kept in Resident #37's room because she no longer attempted to get up on her own. LPN#1 indicated that sometimes the staff will assist the resident to the dining room using the walker. It would depend on how the resident was doing that day. LPN #1 indicated there was no "...real plan for the resident to ambulate to the dining room due to her falls..." The LPN #1 indicated if the resident was able to use the walker that day, then staff assisted her to the dining room. A current facility policy dated June 2004, titled "Care Planning" provided by the Administrator on 1/25/13 at 4:40 P.M., indicated " Policy: A care plan is initiated upon the admission/readmission of each resident to facility, revised, and updated at intervals throughout the resident's length of stay...Purpose: to		into place if a fall occurs. The MDSC will complete a monthly audit of falls to ensure care plans are in place with an updated intervention. The MDSC will bring this audit to the QA Committee for review for the next 60 days. After 60 days the QA Committee may decide to stop the requirement for reporting the results if 100% compliance has been reported.	

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	identify problems and developmental solutions for the coordination of resident care...Procedure:...#9 Resolved problems are yellowed out, date of resolution noted and rationale documented..." 3.1-35(d)(2)(B)			

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F000371 SS=F	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 that facility failed to ensure opened frozen foods were properly dated when received and opened in 2 of 2 freezers observed in the kitchen. This practice had the potential to affect 34 of 34 residents in the facility. Findings include: An initial tour of the kitchen was conducted on 1/22/13 at 10:10 A.M. The initial tour indicated there were open frozen vegetable bags in a white freezer with no dates or labels on them. An interview with the Dietary Manager on 1/22/13 at 10:10 A.M., indicated there were not any dates on the bags because the date runs off the bags when written with marker and the tape falls off the bag. A followup tour of the kitchen was	F000371	F371 Food Procure Store/Prepare/Service – Sanitary *The facility disagrees with the survey findings regarding this alleged deficiency and respectfully requests the face-to-face Informal Dispute Resolution process.* It is the policy and standard of this facility that food is stored, prepared, distributed and served under sanitary conditions. What corrective action will be done by the facility? All freezer items were dated on 1/24/13. The items in the freezers including the vegetables were not left open. Everything was properly closed. The vegetable bags were closed with twist ties. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be	02/06/2013

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	conducted on 1/24/13 at 11:24 A.M. The followup tour indicated there were open bags of vegetables and potatoes with dates on them in the large freezer. The Dietary Manager indicated at that time the dates were the open dates of the products. The Dietary Manager then indicated the dates on the products were the dates they were received. She indicated if the dates were the dates the products were received then she would have no idea when the products were open. There was also unlabeled corned beef wrapped in foil with many holes and with the meat exposed. The large freezer also contained a pork roast and a turkey without dates on them. The Dietary Manager indicated she knew when the products arrived because she was working that day. She then indicated if she was not working that day, then she would not have any way of knowing when the turkey and pork roast was placed in the freezer. During the followup tour of the kitchen, the small white freezer contained several bags of fruits and vegetables, including bags of cauliflower, peas, carrots, and berries. There was a bag of carrots and a bag of peas open in the door of the freezer. Neither one of the bags		taken? - - No resident has been affected by this alleged deficient practice. An inventory of freezer items was completed on 1/24/13. All items were properly marked and sealed. - What measures will be put into place to ensure this practice does not recur? The dietary staff will be inserviced on 2/6/13 on the facility's policy and procedure regarding proper food storage. The Dietary Manager will monitor the two freezers 5 days a week to ensure all items are properly marked and sealed. The Registered Dietician will monitor the two freezers once a month during her routine visits. Any issues noted will be brought to the Dietary Manager and Administrator's attention immediately. How will the correct action be monitored to ensure the deficient practice does not recur and what QA will put be into place? - The Dietary Manager will monitor the two freezers 5 days a week to ensure all items are properly marked and sealed. The Administrator will monitor the two freezers once weekly to ensure all items are properly sealed for 8 weeks. These audits will be	

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	were sealed closed and had a large amount of frost inside the bags. In the back of the freezer was a large bag of cauliflower that was misshaped and appeared to have indentations in the bag. Upon visual inspection of the outside of the bag, the cauliflower was noted to be covered in a thick layer of frost within the bag. The Dietary Manager at that time indicated there were no dates placed on any of the items in the freezer because there was no way to label them. The Dietary Manager indicated her process was to place the bags of vegetables in the door of the freezer to need to be used first. She indicated the staff would use those first. An undated current facility policy titled, "Receiving and Storage - Frozen Foods" provided by the Administrator on 1/24/13 at 1:35 P.M., indicated "...2. Store supplies in a manner that will allow cold air to circulate around the products...3. All frozen food will be properly wrapped, dated, and labeled. 3.1-21(i)(2)		brought to the monthly QA meetings. After 8 weeks the QA Committee may decide to stop the requirement for reportings results if 100% compliance has been reported.	

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F000456 SS=B	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview and record review the facility failed to ensure 1 of 2 freezers were properly maintained and defrosted. This had the potential to affect 34 of 34 residents in the facility. Findings include: During a kitchen tour conducted on 1/24/13 at 11:24 A.M., the small white freezer was noted to contain a large amount of frost buildup. The top of the freezer was covered with 1/4 inch of frost, all the shelves in the freezer were covered with frost. An interview with the Dietary Manager on 1/24/13 at 11:24 A.M., indicated the facility obtained the freezer last summer and that it had never been defrosted. She indicated the other freezer and refrigerator were cleaned and defrosted weekly, but the staff had not thought about defrosting the white freezer. An undated current facility policy titled, "Receiving and Storage -	F000456	F456 – Essential Equipment, Safe Operating Condition *The facility disagrees with the survey findings regarding this alleged deficiency and respectfully requests the face-to-face Informal Dispute Resolution process.* It is the standard and policy of this facility that all essential mechanical, electrical and patient care equipment is in safe operating condition. What corrective action will be done by the facility? The small white freezer was defrosted on 1/24/13. According to the manufacturers guidelines for this freezer the freezer should be defrosted "when ¼ to ½ inch of frost has accumulated". The ¼ inch of frost in the freezer was not outside the manufacturer's guidelines and was not causing the freezer to operating in an unsafe condition. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?	02/06/2013

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	Frozen Foods" provided by the Administrator on 1/24/13 at 1:35 P.M., indicated "...2. store supplies in a manner that will allow cold air to circulate around the products..." 3.1-19(bb)		No resident has the potential to be affected by this alleged deficient practice. The ¼ inch of frost on the freezer did not cause the freezer to operate unsafely. What measures will be put into place to ensure this practice does not recur? The Dietary Manger will check the small white freezer on a weekly basis for frost build up. When she notices the frost accumulating between ¼ inch to ½ inch she will defrost the freezer. The Administrator will monitor the small white freezer weekly to ensure defrosting is taken place as needed. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Dietary Manager will monitor the small white freezer on a weekly basis for frost build up. If the freezer at this time needs defrosted the Dietary Manager will do so. The Administrator will monitor the small white freezer on a weekly basis to ensure defrosting is taking place as needed. The Administrator will bring her audit to the monthly QA meeting. If 100% compliance is met within 60 days, the QA committee may	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT COLUMBUS	5480 E 25TH ST COLUMBUS, IN 47203

(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
			decide to stop the requirement for reporting results. -	