

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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F 0000 Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: February 29 and March 1, 2, 3, 4, 2016.</p> <p>Facility number: 000346 Provider number: 155543 AIM number: 100288320</p> <p>Census bed type: SNF/NF: 27 Total: 27</p> <p>Census payor type: Medicaid: 27 Total: 27</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on March 10, 2016.</p>	F 0000		
F 0248 SS=E Bldg. 00	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive</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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	<p>assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to provide cognitively stimulating activities for 3 of 3 cognitively impaired residents who were reviewed for activities (Residents #4, #13 and #18).</p> <p>Findings include:</p> <p>1. During an observation on 02/29/2016 at 10:27 a.m., Resident #18 was observed in bed with his eyes closed. The activity called "news and snack" was observed to be going on in the main dining room.</p> <p>During an observation on 2/29/2016 at 2:30 p.m. Resident #18 was observed in bed. The "Zoo" activity was going on in the main dining room.</p> <p>During an observation on 3/1/2016 at 8:27 a.m., Resident #18 was observed in his wheelchair in his room with the television on.</p> <p>During an observation on 3/1/2016 at 10:14 a.m., Resident #18 was observed in bed. The "snack and music" activity was going on in the main dining room.</p> <p>During an observation on 3/1/2016 at 2:18 p.m., Resident #18 was observed in</p>	F 0248	<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 Huntington respectfully requests that this Plan of Correction be accepted and considered for paper compliance.</p> <p>F 248 It is the policy of this facility that an ongoing program of activities will be designed for each resident, including those who are cognitively impaired.</p> <p>1. What corrective action(s) will be done by the facility? Residents #4, #13 and #18 are to have activities according to their individual needs that provide stimulation and interest according to their cognitive abilities. These residents have been assessed and a schedule for activities has been</p>	04/01/2016

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	<p>his room sitting in his wheelchair with the television on looking at the privacy curtain. The television was behind the privacy curtain. The "hangman" activity was being played in the main dining room.</p> <p>During an observation on 3/3/2016 10:18 a.m., Resident #18 was observed laying in bed. The "current events" activity was going on in the main dining room.</p> <p>During an interview with the Activity Director on 3/3/2016 at 1:11 p.m., she indicated she does one to one activities and sensory group for residents with cognitive impairment. She indicated that Resident #18 liked to go to BINGO, concerts, watch game shows and to go outside. The Activity Director indicated that Resident #18 went to one group activity one time per week and she did one to one activity one time per week with him. She then indicated that her one to one group was called "Blue Birds." The Activity Director indicated that, although Resident #18 could not read, he received a monthly activity calendar and was told each day of the activities by either the Certified Nursing Assistants (CNA) or herself. She also indicated that either she or the CNA's transported Resident #18 to activities each day.</p>		<p>made which meets their assessed strengths,needs and abilities. Each one's care plan has been updated, as well.</p> <p>2. Howwill the facility identify other residents having the potential to be affectedby the same practice and what corrective action will be taken? All residents whorequire cognitively stimulating activities have the potential to be affected. Allresidents will be assessed to identify any activities that do not meet theircognitive level. Any resident found tohave activities not meeting their cognitive status will have an activityprogram developed for them that meets their individual needs. In the case ofgroup activities, they will be added to the activity calendar. In addition, theactivity program will be reflected in the residents' care plans.</p> <p>3. Whatmeasures will be put into place to ensure this practice does not recur? A one on onein-service is to be completed for the Activity Director to educate her on theimportance as well as policy and procedure for assessing and providingactivities tailored to meet individualized goals and needs. The Activity Director is to provide accurate documentationon PCC for every resident that is provided one on ones and the activity thattook place. She will bring that documentation to the morning IDT meeting thatmeets at least 5 days a</p>	

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	<p>During an interview with CNA #9 on 03/04/2016 at 9:50 a.m., she indicated Resident #18 could not propel his own wheel chair.</p> <p>A review of the medical record for Resident #18 began on 2/29/2016 at 2:09 p.m. Diagnoses included, but were not limited, to "Dementia in other disease classified elsewhere with behavioral disturbance, unspecified intellectual disabilities, muscle weakness, Down Syndrome, Epilepsy, Major Depressive Disorder." Resident #18 had a current MDS (Minimum Data Set) assessment that indicated he was moderately cognitively impaired.</p> <p>A review of the activity care plan for Resident #18 began on 03/02/2016 at 8:09 a.m., and indicated the following:</p> <p>"I sometimes don't come to activities I might enjoy such activities such as bingo, ball toss and snack... ...Goal: I will come to activities at least 2 x per week"</p> <p>Interventions included but were not limited to: "I need assistance to activities I might enjoy, I need reminded 5-10 minutes before an activity starts, I will receive a calendar once a month."</p>		<p>week for review by the IDT. The Administrator will complete an audit log for all activities that are completed 5x a week for 4 weeks; 2x a week for 4 weeks; 1x a week for 4 weeks, then; then at least twice a month on an ongoing basis.</p> <p>4. How will corrective action be monitored to ensure the deficient practice does not recur and what Quality Assurance measure will be put into place? The Activity Director will bring monthly calendar to the monthly QA. The calendar will be reviewed at the meeting to ensure compliance is maintained and as well as to identify any areas that may need improvement or revision to meet goals of the residents.</p> <p>Compliance date for completion: April 1, 2016</p>	

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	<p>A review of the one to one activity record on 3/3/2016 at 1:29 p.m., indicated Resident #18 had a recent decline in mobility and activities. It also indicated Resident #18 would have one to one activity with the Activity Director or come to group activity two times per week. The one to one activities for the month of February included but were not limited to "sleeping, lotion and zoo."</p> <p>A review of the activity log for Resident #18 for the month of February, 2016 was provided by the Activity Director on 3/3/2016 at 2:15 p.m. It indicated Resident #18 attended and participated in "fun fitness, Pictionary, current events, ring toss, coffee break and ball toss." The log also indicated Resident #18 attended and participated in the Zoo activity on February 29, 2016.</p> <p>The Activities- Quarterly/ Annual Participation Review for Resident #18 was provided by the DON on 3/4/2016 at 9:53 a.m. It indicated "Res [Resident] comes to snack, movie, concerts, and some concerts. Res also listens to music on his head phones."</p> <p>2. On 3/1/16 at 11:40 a.m., Resident #4 was seated in her wheelchair in the hallway near the nurse's station.</p> <p>On 3/1/16 at 1:28 p.m., Resident #4 was</p>			

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	<p>seated in her wheelchair in the hallway outside of the nurse's station.</p> <p>On 3/1/16 at 2:19 p.m., Resident #4 was seated in her wheelchair at a table in the main dining room, facing the window. She had a coffee cup in front of her. The Activity Director (AD) was leading a game of "Hangman" on a dry-erase board with three other residents. Resident #4 had her back to the board and was not participating in the game.</p> <p>On 3/2/16 at 8:14 a.m., Resident #4 was seated in her wheelchair in the hallway outside of the nurse's station.</p> <p>On 3/2/16 at 9:39 a.m., Resident #4 was seated in her wheelchair, chin to chest, in the hallway outside of the nurse's station.</p> <p>On 3/2/16 at 10:00 a.m., Resident #4 was seated in her wheelchair in the hallway outside of the nurse's station. "Current events and snacks" was taking place in the main dining room.</p> <p>On 3/2/16 at 1:21 p.m., Resident #4 was seated in her wheelchair in the hallway outside of the nurse's station.</p> <p>On 3/3/16 at 8:32 a.m., Resident #4 was seated in her wheelchair in the hallway.</p>			

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	<p>On 3/3/16 at 8:43 a.m., Resident #4 was seated in her wheelchair in the hallway. She was holding a plastic mesh ball in her hands. The Activity Director and MDS Coordinator were on either side of the resident, speaking about how the ball had "freaked out another resident (Resident #5), but Resident #4 seemed to like it. Neither staff member spoke to Resident #4.</p> <p>Review of Resident #4's clinical record began on 2/29/16 at 11:39 a.m. Diagnoses included, but were not limited to, Down's Syndrome, severe intellectual disability, and congestive heart failure.</p> <p>Resident #4 had a 11/25/15 Minimum Data Set assessment (MDS), which indicated her decision making ability was moderately impaired and required extensive assistance for mobility.</p> <p>A "PSYCHOSOCIAL ASSESSMENT", dated 9/1/15, indicated Resident #4 enjoyed pursuing activities of interest such as cutting coupons and coloring. It further indicated she was able to communicate with simple statements.</p> <p>An "ACTIVITIES - QUARTERLY/ANNUAL PARTICIPATION REVIEW", dated 11/17/15, indicated the resident's favorite</p>			

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	<p>activity was coloring on her own and she participated in "eat in", coloring on her own, and came to table-top bowling. It further indicated Resident #4's careplan remained appropriate.</p> <p>An "ACTIVITIES - INITIAL REVIEW", dated 1/14/16, indicated Resident #4 came to activities such as bingo, movies, and snacks. It further indicated she had begun going on outings for PASRR services. It also indicated Resident #4 did not have a cognitive deficit requiring her activity plan to be modified.</p> <p>An "ACTIVITIES - QUARTERLY/ANNUAL PARTICIPATION REVIEW", dated 2/18/16, indicated Resident #4 came to bingo, women's eat in, music concerts, church, and some crafts. It further indicated Resident #4's careplan remained appropriate and she had exceeded her activity goals.</p> <p>There was no activities assessment for Resident #4 for the period of time between her admission date of 8/25/15 and the activity assessment dated 11/17/15 in the resident's clinical record.</p> <p>There was no careplan for Resident #4's activities program in her clinical record.</p>			

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	<p>Review of Resident #4's activity log for February, 2016 indicated Resident #4 attended and participated in, activities including, but not limited to, bingo, cooking club, table-top bowling, ring toss, word search, and fun fitness. The activity log indicated she had attended a football activity on 2/7/16 and bingo on 2/29/16, but had not participated.</p> <p>Review of Resident #4's activity log for March 1 and 2, 2016 indicated Resident #4 had attended and participated in, activities including, but not limited to, hangman, fun fitness and cooking club.</p> <p>During an interview, on 3/3/16 at 11:25 a.m., CNA #9 indicated Resident #4 enjoyed coloring books and looking at magazines. She indicated the resident had a box in her room and staff had to set the items up for her to use. She further indicated Resident #4 usually had to be asked about wanting to color, but would ask to be given her box on occasion. She indicated Resident #4 would go to some activities in the dining room, but her participation depended on the level of the activity.</p> <p>On 3/3/16 at 1:50 p.m., the Social Services Director indicated Resident #4 did not begin going on outings for PASRR services until the end of</p>			

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	<p>February due to Resident #4's health and weather conditions.</p> <p>On 3/3/16 at 2:01 p.m., a caseworker from the developmental services agency indicated Resident #4 did not begin going on outings until the previous week.</p> <p>On 3/3/16 at 1:11 p.m., the AD indicated Resident #4 attended activities such as bingo and some crafting activities. She indicated Resident #4 was not actually able to play bingo, but would flip the plastic covers for the numbers back and forth if she had a bingo card in front of her. She also indicated Resident #4 would attend craft activities if it involved coloring or painting.</p> <p>The AD indicated Resident #4 was given a calendar every month, but the AD was not sure if Resident #4 was able to read or see the calendar. She indicated Resident #4 usually just "hung out" in the dining room during group activities and didn't always participate. She indicated Resident #4 attended outings with an outside developmental service and that kept her busy.</p> <p>She further indicated Resident #4's initial activity assessment was not completed following her admission to the facility in August of 2015 due to the AD being off</p>			

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	<p>of work. She further indicated Resident #4 had never had a careplan developed for activities since her original admission in August 2015. She indicated she had realized this the past Friday, but had not yet had the chance to make a careplan.</p> <p>No further information was received at the time of exit from the facility.3.</p> <p>During an observation of Resident #13 on 3/1/16 at 10:14 a.m., there was a current events and snack activity observed in the large dining room. Resident #13 was in his room, sitting in his wheelchair, facing away from his room's doorway with his head drooped.</p> <p>During an observation of Resident #13 on 3/2/16 at 8:51 a.m., Resident #13 was sitting in his wheelchair by the glass back door and looking out the window. The Activity Director walked down the hallways, carried a bucket of chocolate candy and offered a piece to various residents. She did not offer a piece to Resident #13 .</p> <p>During an observation of Resident #13 on 3/2/16 at 10:42 a.m., there was a current events and snack activity observed in the large dining room. Resident #13 was in his room, sitting in his wheelchair, facing away from his room's doorway with his head drooped. His TV was on, but he</p>			

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	<p>was not watching it.</p> <p>During an observation of Resident #13 on 3/2/16 at 10:56 a.m., Resident #13 was in his room, sitting in his wheelchair, facing away from his room's doorway with his head drooped. His TV was on, but he was not watching it. There was a mesh net that had a red "Stop" sign up and velcroed across his doorway. A fun fitness activity was indicated on the Activities calendar but no group activity was observed at this time.</p> <p>During an observation of Resident #13 on 3/2/16 at 1:56 p.m., Resident #13 was in his room, sitting in his wheelchair, facing away from his room's doorway with his head drooped. His TV was on, but he was not watching it. The activity calendar indicated that "cooking club" began at 2:00 p.m.</p> <p>During a random observation on 3/2/16 at 2:02 p.m., the activity director walked down the hallway and asked several residents to come to the activity in the large dining room, she did not ask Resident #13.</p> <p>During an observation of Resident #13 on 3/2/16 at 2:27 p.m., Resident #13 was in his room, sitting in his wheelchair, facing away from his room's doorway with his</p>			

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	<p>head drooped. His TV was on, but he was not watching it.</p> <p>During an observation of Resident #13 on 3/3/16 at 8:52 a.m., Resident #13 was in his room, sitting in his wheelchair, facing away from his room's doorway with his head drooped. His TV was on, but he was not watching it.</p> <p>During an observation of Resident #13 on 3/3/16 at 9:28 a.m., Resident #13 was at the back door, sitting in his wheelchair. The maintenance supervisor came in from outside and moved Resident #13 away from the back door and faced him so he was facing into the building.</p> <p>During a random observation on 3/3/16 at 9:53 a.m., the Activity Director walked down the hallway and asked some residents if they wanted pop or coffee. She walked past Resident #13's room and did not ask him.</p> <p>During an observation of Resident #13 on 3/3/16 at 10:32 a.m., Resident #13 was in his room, sitting in his wheelchair. There was a mesh net that had a red "Stop" sign up and velcroed across his doorway.</p> <p>During an observation of Resident #13 on 3/3/16 at 2:23 p.m., Resident #13 was in his room, sitting in his wheelchair. A</p>			

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	<p>group activity was observed in the large dining room.</p> <p>During an interview with the Activity Director on 3/3/16 at 1:11 p.m., she indicated Resident #13 used to attend many group activities but then he went to the hospital. She stated that Resident #13 was "mostly on his own" since he came back to the facility. She indicated that she did one on one activities for cognitively impaired residents, but Resident #13 was not on her one on one list and did not receive one on one activities.</p> <p>Resident #13's clinical record was reviewed on 3/2/16 at 8:53 a.m. Resident #13's current diagnoses included, but were not limited to, dementia, hemiplegia and hemiparesis following cerebrovascular disease, expressive language disorder, anxiety, and major depressive disorder.</p> <p>Resident #13 had a current, 1/21/16, quarterly, minimum data set (MDS) assessment which indicated he was severely cognitively impaired and totally dependent on staff for mobility.</p> <p>Resident #13 had a current, 10/29/15, annual, MDS assessment which indicated the following areas were very important</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2016
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750		
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	<p>to him: have things to read, listen to music, be around animals, keep up with the news, do things with groups of people, do favorite activities, go outside when the weather was good and participate in religious services.</p> <p>Review of a document titled "Interdisciplinary Care Plan", dated 2/18/15, provided by the Administrator in training on 3/3/16 at 3:20 p.m., included the following: "...I enjoy activities like bingo, current events and snack, outings and parties. However, sometimes I would rather stay in my room watching tv reading or be at the back door looking outside...Goal: I will come to activities at least 2x week...Interventions: I will be given a calendar [sic] every month. I will be encouraged to attend activities. I will be reminded of activities I like. I will have 1:1 with A.D. [Activities Director] if I don't reach my goal...."</p> <p>Review of a document titled, "Activity Progress Notes", dated 8/10/15, provided by the Administrator in training on 3/3/16 at 3:20 p.m., included the following: "...Res [Resident] comes to snack, movies, and he likes to be outside. Res likes to eat in and will some times come to eat out. He has a care plan that is up to date...." The document was signed by the Activities Director.</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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	<p>Review of a document titled, "Activities - Initial Review", dated 2/12/16, provided by the Administrator in training on 3/3/16 at 3:20 p.m., included the following: "Past Activity Interests... Res [Resident] likes to be outside or sitting in the sun. Res [Resident] comes to bingo, concerts, and menus eat in...Res [Resident] doesn't like the cold but when its nice he likes to go places...Sometimes he needs help weather [sic] it be set up or help with a task...." It also indicated Resident #13's current activity interests included group activities, outings, one on ones with staff, and independent activities.</p> <p>Review of the activity calendars for the months of January, February and March 2016, provided by the Activities Director on 3/3/16 at 2:15 p.m., indicated Resident #13 attended 12 group activities in January. In February, Resident #13 was in the hospital from February 1 - 9. He attended 4 group activities from February 18 - 29. The March calendar indicated Resident #13 did not attend any group activities and had 1 one on one activity with the Activities Director.</p> <p>3.1-33(a)</p>			

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F 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the 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 observation, interview, and record review, the facility failed to develop an individualized activities plan of care for 1 of 3 dependent residents reviewed for activities programs (Resident #4).</p> <p>Findings include:</p>	F 0279	<p>F 279 DEVELOP COMPREHENSIVECARE PLANS 1. What corrective action(s) will be done bythe facility? Resident #4 is to have an Activity Care Plan that is individualized toattain and maintain well-being relative to psychosocial, physical and mentalneeds. 2. How will the</p>	04/01/2016

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	<p>On 3/1/16 at 11:40 a.m., Resident #4 was seated in her wheelchair in the hallway near the nurse's station.</p> <p>On 3/1/16 at 1:28 p.m., Resident #4 was seated in her wheelchair in the hallway outside of the nurse's station.</p> <p>On 3/1/16 at 2:19 p.m., Resident #4 was seated in her wheelchair at a table in the main dining room, facing the window. She had a coffee cup in front of her. The Activity Director (AD) was leading a game of "Hangman" on a dry-erase board with three other residents. Resident #4 had her back to the board and was not participating in the game.</p> <p>On 3/2/16 at 8:14 a.m., Resident #4 was seated in her wheelchair in the hallway outside of the nurse's station.</p> <p>On 3/2/16 at 9:39 a.m., Resident #4 was seated in her wheelchair, chin to chest, in the hallway outside of the nurse's station.</p> <p>On 3/2/16 at 10:00 a.m., Resident #4 was seated in her wheelchair in the hallway outside of the nurse's station. "Current events and snacks" was taking place in the main dining room.</p> <p>On 3/2/16 at 1:21 p.m., Resident #4</p>		<p>facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All dependent residents have the potential to be affected. Audit is to be completed on all residents with the potential to be affected by Social Services Director according to cognition and BIMs scores. Social Services Director will collaborate with Activity Director to establish the resident(s) who meet the need for dependent activities. The Activity and Social Services Director will bring to IDT by March 25, 2016 during morning meeting for collaboration of accuracy of identifying residents with the potential to be affected. DON to audit all Activity Care Plans to ensure they have been completed and notify Activity Director of any incomplete.</p> <p>3. What measures will be put into place to ensure this practice does not recur? One on one in-service is to be completed with Activity Director to educate Care Plan policy and procedure upon admission, readmission and changes. In-service for all involved in Care planning implementation and review per policy and procedure. Director of Nursing will audit all disciplines for completion of Care Plans for activities, medical diagnoses, social services, dietary and other conditions that require care plans. The audit will be</p>	

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	<p>Resident #4 was seated in her wheelchair in the hallway outside of the nurse's station.</p> <p>On 3/3/16 at 8:32 a.m., Resident #4 was seated in her wheelchair in the hallway.</p> <p>On 3/3/16 at 8:43 a.m., Resident #4 was observed seated in her wheelchair in the hallway. She was holding a plastic mesh ball in her hands. The Activity Director and MDS Coordinator were on either side of the resident, speaking about how the ball had "freaked out another resident (Resident #5), but Resident #4 seemed to like it. Neither staff member was observed to speak to Resident #4.</p> <p>Review of Resident #4's clinical record began on 2/29/16 at 11:39 a.m. Diagnoses included, but were not limited to, Down's Syndrome, severe intellectual disability, and congestive heart failure.</p> <p>Resident #4 had a 11/25/15 Minimum Data Set assessment (MDS), which indicated her decision making ability was moderately impaired and required extensive assistance for mobility.</p> <p>A "PSYCHOSOCIAL ASSESSMENT", dated 9/1/15, indicated Resident #4 enjoyed pursuing activities of interest such as cutting coupons and coloring. It</p>		<p>done for all admissions and readmissions for indications or changes. The IDT will audit care plans of admitted and readmitted residents at morning meeting to ensure all appropriate disciplines have completed a careplan which is individualized to meet the resident's needs.</p> <p>4. How will corrective action be monitored to ensure the deficient practice does not recur and what Quality Assurance measure will be put into place? All admissions and readmissions will be documented on an audit tool to identify care plans that are to be implemented along with designation to those disciplines responsible for completing the care plan. The audit tool will be reviewed in QA monthly to ensure that compliance is completed and to identify areas for improvement. The audit tool will be brought to the monthly QA for 3 months. At the end of the three months when 100% compliance has been achieved: the IDT will continue to review admission and readmission care plans at the morning meetings, revise all resident care plans with condition changes, and review care plans of each resident, per the MDS schedule.</p>	

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	<p>further indicated she was able to communicate with simple statements.</p> <p>An "ACTIVITIES - QUARTERLY/ANNUAL PARTICIPATION REVIEW", dated 11/17/15, indicated the resident's favorite activity was coloring on her own and she participated in "eat in", coloring on her own, and came to table-top bowling. It further indicated Resident #4's careplan remained appropriate.</p> <p>An "ACTIVITIES - INITIAL REVIEW", dated 1/14/16, indicated Resident #4 came to activities such as bingo, movies, and snack. It further indicated she had begun going on outings for PASRR services. It also indicated Resident #4 did not have a cognitive deficit requiring her activity plan to be modified.</p> <p>An "ACTIVITIES - QUARTERLY/ANNUAL PARTICIPATION REVIEW", dated 2/18/16, indicated Resident #4 came to bingo, women's eat in, music concerts, church, and some crafts. It further indicated Resident #4's careplan remained appropriate and she had exceeded her activity goals.</p> <p>There was no careplan for Resident #4's activities program in her clinical record.</p>			

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F 0280 SS=D Bldg. 00	<p>The activity Director was interviewed on 3/3/16 at 1:11 p.m. She indicated Resident #4's initial activity assessment was not completed following her admission to the facility in August of 2015 due to the AD being off of work. She further indicated Resident #4 had never had a careplan developed for activities since her original admission in August 2015. She indicated she had realized this the past Friday, but had not yet had the chance to make a careplan.</p> <p>No further information was received at the time of exit from the facility.</p> <p>3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)</p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared</p>			
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	<p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure the resident's activity care plan was revised after returning from a hospitalization for 1 of 3 residents reviewed for activities (Resident #13).</p> <p>Findings included:</p> <p>During an observation of Resident #13 on 3/1/16 at 10:14 a.m., there was a current events and snack activity observed in the large dining room. Resident #13 was in his room, sitting in his wheelchair, facing away from his room's doorway with his head drooped.</p> <p>During an observation of Resident #13 on 3/2/16 at 8:51 a.m., Resident #13 was sitting in his wheelchair by the glass back door and looking out the window. The Activity Director walked down the hallways, carried a bucket of chocolate candy and offered a piece to various residents. She did not offer a piece to Resident #13 .</p>	F 0280	<p>F 280</p> <p>It is the policy of this facility that all residents' careplans are kept current and are revised as the residents' conditions change.</p> <p>1. What corrective action(s) will be done bythe facility?</p> <p>Revision of Care Plan for resident #13 for activities was completed bythe Activity Director March 25th, 2016 to correlate withpsychosocial, mental and physical needs. Resident is to be actively involved with process to identify needs andpreferences. The maintenance directorwill be provided preferences of resident #13.</p> <p>The Nurse Consultant has in-serviced the members of the Interdisciplinaryteam, including the Activity Director, regarding the need for frequent reviewof residents' care plans to make sure that they are updated to accuratelyreflect the current status of each resident.</p> <p>2. How will the facility identify otherresidents having the potential to be affected by</p>	04/01/2016

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	<p>During an observation of Resident #13 on 3/2/16 at 10:42 a.m., there was a current events and snack activity observed in the large dining room. Resident #13 was in his room, sitting in his wheelchair, facing away from his room's doorway with his head drooped. His TV was on, but he was not watching it.</p> <p>During an observation of Resident #13 on 3/2/16 at 10:56 a.m., Resident #13 was in his room, sitting in his wheelchair, facing away from his room's doorway with his head drooped. His TV was on, but he was not watching it. There was a mesh net that had a red "Stop" sign up and velcroed across his doorway. A fun fitness activity was indicated on the Activities calendar but no group activity was observed at this time.</p> <p>During an observation of Resident #13 on 3/2/16 at 1:56 p.m., Resident #13 was in his room, sitting in his wheelchair, facing away from his room's doorway with his head drooped. His TV was on but he was not watching it. The activity calendar indicated that "cooking club" began at 2:00 p.m.</p> <p>During a random observation on 3/2/16 at 2:02 p.m., the activity director walked down the hallway and asked several</p>		<p><i>the same practice and what corrective action will be taken?</i></p> <p>All residents returning to the facility following a hospitalization have the potential to be affected. A complete audit of all admissions and readmissions will be conducted by the Interdisciplinary team, to identify any resident with an incomplete Care Plan or revision. Any discipline that did not complete a revision or care plan will be notified and they will update or revise the care plan to ensure a true reflection of the resident. The Administrator will monitor this review and completion of care plans; he will render written counseling for continued noncompliance.</p> <p><i>3. What measures will be put into place to ensure this practice does not recur?</i></p> <p>All admissions and readmissions will be audited by the IDT at the morning meeting following their admission or readmission, to ensure that all appropriate disciplines have completed necessary care plans. The Social Service Director will give a copy of the list of families and residents who have been notified of upcoming care plan meetings, to ensure all residents and families have the opportunities to be involved with care plan development. All staff will be in-serviced March 30th, 2016 to</p>	

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	<p>residents to come to the activity in the large dining room, she did not ask Resident #13.</p> <p>During an observation of Resident #13 on 3/2/16 at 2:27 p.m., Resident #13 was in his room, sitting in his wheelchair, facing away from his room's doorway with his head drooped. His TV was on, but he was not watching it.</p> <p>During an observation of Resident #13 on 3/3/16 at 8:52 a.m., Resident #13 was in his room, sitting in his wheelchair, facing away from his room's doorway with his head drooped. His TV was on, but he was not watching it.</p> <p>During an observation of Resident #13 on 3/3/16 at 9:28 a.m., Resident #13 was at the back door, sitting in his wheelchair. The maintenance supervisor came in from outside and moved Resident #13 away from the back door and faced him so he was facing into the building.</p> <p>During an random observation on 3/3/16 at 9:53 a.m., the Activity Director walked down the hallway and asked some residents if they wanted pop or coffee. She walked past Resident #13's room and did not ask him.</p> <p>During an observation of Resident #13 on</p>		<p>look in the communication book, which is located at the nurses' station, for changes and preferences of the residents.</p> <p>4. How will corrective action be monitored to ensure the deficient practice does not recur and what Quality Assurance measure will be put into place? The DON will bring the Communication book to the morning meeting which is held at least 5 days a week. Any changes to the care plans will be kept on a log and brought to QA, for 3 months to ensure compliance. The QA committee may decide to stop the review of the log after the 3 months when 100% compliance is achieved; however the DON/IDT will continue to monitor the care plans of newly admitted and readmitted residents, on an on-going basis, to maintain compliance.</p>				

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	<p>3/3/16 at 10:32 a.m., Resident #13 was in his room, sitting in his wheelchair. There was a mesh net that had a red "Stop" sign up and velcroed across his doorway.</p> <p>During an observation of Resident #13 on 3/3/16 at 2:23 p.m., Resident #13 was in his room, sitting in his wheelchair. A group activity was observed in the large dining room.</p> <p>During an interview with the Activity Director on 3/3/16 at 1:11 p.m., she indicated Resident #13 used to attend many group activities but then he went to the hospital. She stated that Resident #13 was "mostly on his own" since he came back to the facility. She indicated that she did one on one activities for cognitively impaired residents but, Resident #13 was not on her one on one list and did not receive one on one activities.</p> <p>Resident #13's clinical record was reviewed on 3/2/16 at 8:53 a.m. Resident #13's current diagnoses included, but were not limited to, dementia, hemiplegia and hemiparesis following cerebrovascular disease, expressive language disorder, anxiety, and major depressive disorder.</p> <p>Resident #13 had a current, 1/21/16,</p>			

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	<p>quarterly, minimum data set (MDS) assessment which indicated he was severely cognitively impaired and totally dependent on staff for mobility.</p> <p>Resident #13 had a current, 10/29/15, annual, MDS assessment which indicated the following areas were very important to him: "have things to read, listen to music, be around animals, keep up with the news, do things with groups of people, do favorite activities, go outside when the weather is good and participate in religious services."</p> <p>Review of a document titled "Interdisciplinary Care Plan", dated 2/18/15, provided by the Administrator in training on 3/3/16 at 3:20 p.m., included the following: "...I enjoy activities like bingo, current events and snack, outings and parties. However, sometimes I would rather stay in my room watching tv reading or be at the back door looking outside...Goal: I will come to activities at least 2x week...Interventions: I will be given a calendar [sic] every month. I will be encouraged to attend activities. I will be reminded of activities I like. I will have 1:1 with A.D. [Activities Director] if I don't reach my goal...."</p> <p>Review of a document titled, "Activity Progress Notes", dated 8/10/15, provided</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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	<p>by the Administrator in training on 3/3/16 at 3:20 p.m., included the following: "...Res [Resident] comes to snack, movies, and he likes to be outside. Res likes to eat in and will some times come to eat out. He has a care plan that is up to date..." The document was signed by the Activities Director.</p> <p>Review of a document titled, "Activities - Initial Review", dated 2/12/16, provided by the Administrator in training on 3/3/16 at 3:20 p.m., and included the following: "Past Activity Interests...Res [Resident] likes to be outside or sitting in the sun. Res comes to bingo, concerts, and menus eat in...Res [Resident] doesn't like the cold but when its nice he likes to go places...Sometimes he needs help weather [sic] it be set up or help with a task..." It also indicated Resident #13's current activity interests included group activities, outings, one on ones with staff, and independent activities.</p> <p>Review of the activity calendars for the months of January, February and March 2016, provided by the Activities Director on 3/3/16 at 2:15 p.m., indicated Resident #13 attended 12 group activities in January. In February, Resident #13 was in the hospital from February 1 - 9. He attended 4 group activities from February 18 - 29. The March calendar indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
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F 0282 SS=E Bldg. 00	<p>Resident #13 did not attend any group activities and had 1 one on one activity with the Activities Director.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure residents with monthly orthostatic blood pressure monitoring received those services as ordered by the physician for 4 of 5 residents reviewed for unnecessary medications. (Residents #10, #17 and #1) Furthermore, the facility failed to follow care plan interventions to ensure resident safety, while consuming food and liquids. (Resident #5)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #10 was reviewed on 3/2/16 at 10:51 a.m. Diagnoses included, but were not limited to, Schizophreniform disorder, anxiety disorder, major depressive disorder, hypertension, specific personality disorders, bipolar disorder and dementia without behavioral disturbance.</p>	F 0282	<p>F 282 It is the policy of this facility to provide services to residents in accordance to their plan of care, including monthly orthostatic blood pressure monitoring, and to follow care plan interventions including those to ensure resident safety while consuming foods and fluids. 1. What corrective action(s) will be done by the facility? All residents with an order for orthostatic blood pressures were placed on a monthly log sheet for documentation tracking. The residents orthostatic blood pressure orders were placed on the ETAR in PCC. The day the blood pressures are to be completed will be reflected on the ETAR, to alert the nurses. The ordered blood pressures for residents #1, #10 and #17 were completed. The licensed nursing staff were re-educated on the topic of obtaining orthostatic blood pressure per physician</p>	04/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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	<p>Record review indicated on 11/30/15, the physician ordered the following: "...Orthostatic blood pressure every month. Call MD [Doctor of Medicine] if abnormal [lying, sitting, standing] d/t [due to] psych [psychotropic] med [medication] use...."</p> <p>A second verbal physician order on 11/30/15 indicated the following: "...Long term use of psych meds [medications] one time a day starting on the 9th and ending on the 10th every month related to OTHER LONG TERM (CURRENT) DRUG THERAPY...."</p> <p>The "Blood Pressure Summary" and medication administration record from 1/1/16 through 2/29/16 was provided by the Director of Nursing (DON) on 3/2/16 at 2:10 p.m. It indicated no orthostatic blood pressures, which would include blood pressures lying, sitting and standing for Resident #10 for the months of January and February, 2016.</p> <p>A review of a current health care plan for Resident #10 indicated the following: "...I take medication for my bipolar type schizophrenia with psychosis...Date Initiated: 01/25/2016...." Interventions included, but were not limited to "...Nurse to take my orthostatic b/p</p>		<p>order and on documentation of the blood pressures. Proper eating utensils were provided forresident #5 according to Care Plan and therapy referral.</p> <p>2. How will the facility identify other residentshaving the potential to be affected by the same practice and what correctiveaction will be taken? Any resident with orthostatic blood pressure orders and orders foradaptive eating equipment have the potential to be affected. The DON/Designee will review all new MD orders, at the morning clinical meeting, to ensure thatorders are transcribed correctly on the EMAR or ETAR. Any orders not properly transcribed will becorrected immediately. Therapy evaluations will be reviewed by the DON. Therapy recommendationswill be discussed at the clinical meeting by the therapist. All recommendationswill be conveyed to the physician and orders obtained. The orders will beplaced in PCC by the licensed nurse. Any adaptive equipment will be obtainedand will be documented on the resident's tray card and indicated on the CNAassignment sheet. 3. What measures will be put into place toensure this practice does not recur? CNAs and nursing staff werein-serviced on March 30th, 2016 on reading meal tray cards when servingresident meals, to</p>	

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
---	--

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	<p>[blood pressure] every month...Date Initiated: 01/25/2016...."</p> <p>During an interview with the Director of Nursing (DON) on 3/2/16 at 2:10 p.m., she indicated Resident #10 was to have orthostatic blood pressures monthly and was to start on the 9th and end on the 10th of every month. The DON further indicated the order date was 11/30/15.</p> <p>During an interview with the DON on 3/2/16 at 3:01 p.m., she indicated no orthostatic blood pressures were completed for January and February, 2016 for Resident #10.</p> <p>2. The clinical record of Resident #17 was reviewed on 3/2/16 at 3:30 p.m. Diagnoses included, but were not limited to, major depressive disorder, vascular dementia without behavioral disturbance, hypertension, anxiety disorder, and cerebrovascular disease.</p> <p>Record review indicated on 10/09/2013, the physician ordered the following: "...Orthostatic blood pressure in the morning every 1 month(s) starting on the 15th for 1 day(s) for psychotropic drug use. Do lying, sitting, standing. Notify MD if abnormal readings...."</p> <p>The "Blood Pressure Summary" and</p>		<p>ensure any needed adaptive equipment is present on mealtray. Licensed nurses were in-serviced on (put date here) on the topic offollowing physician orders, specifically orthostatic blood pressures andadaptive eating utensils. DON/ designee havereviewed the CNA assignment sheets, to ensure adaptive eating utensils arelisted on the sheets. The DON and DSM will review the care plans of thoseresidents who receive orthostatic blood pressures and adaptive eating equipmentto ensure the physician orders are reflected on the care plan. The DON will audit all orders, includingtherapy orders, to ensure they are transcribed correctly on the EMAR and ETAR, atleast 5 days a week, on an ongoing basis. The DSM will audit the trays of thoseresidents who have adaptive eating equipment orders, at one meal daily for 4weeks, 4 x week for 3 weeks, 3 x weekfor 2 weeks, then at least twice a month on an on-going basis to ensurecompliance. 4. How will corrective action be monitored toensure the deficient practice does not recur and what Quality Assurance measurewill be put into place? TheDirector of Nursing and the DSM will bring results of all audits to QA monthlyfor discussion, concerns or improvements for compliance. This will continue onan ongoing</p>	

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
---	--

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	<p>medication administration record from 1/1/16 through 2/29/16 was provided by LPN #5 on 3/2/16 at 2:34 p.m. It indicated no orthostatic blood pressures, which would include blood pressures lying, sitting and standing for Resident #17 for the months of January and February, 2016.</p> <p>During an interview with the DON on 3/2/16 at 3:33 p.m., she indicated no orthostatic blood pressures were completed for January and February, 2016 for Resident #17.</p> <p>During an interview with the Nurse Consultant on 3/2/16 at 2:53 p.m., she indicated the orders for orthostatic blood pressure monitoring were not carried over from the physician orders to the electronic medication and treatment administration records. She further indicated the nurses would not be able to know if orthostatic blood pressures were due for a resident, because it would not trigger them to do so on the electronic medication and treatment administration records.</p> <p>During an interview with the Nurse Consultant on 3/3/16 at 3:43 p.m., she indicated it was a standard in nursing to follow the physician orders.</p>		basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
---	--

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	<p>A review of the policy titled "Vital Signs (Temperature, Pulse, Blood Pressure, Respirations" dated June 2014, was provided by the Nurse Consultant on 3/4/16 at 10:12 a.m. and indicated the following:</p> <p>"...POLICY: Vital signs will be taken as per physician's order...</p> <p>...PURPOSE: ...To measure the amount of pressure the blood exerts against the walls of an artery...."</p> <p>No further information was provided by exit on 3/4/16.</p> <p>3. A review of the medical record for Resident #1 indicated diagnoses included but were not limited to Paranoid Personality Disorder, Major Depressive Disorder and Dementia with behavioral disturbances.</p> <p>A review of the most recent physician orders provided by LPN #5 on 3/2/2016 at 2:11 p.m. indicated a physician order for orthostatic blood pressure to be done every 30 days and to take the blood pressure lying down and sitting. The order start date was listed as 11/01/2015.</p> <p>Medications included but were not limited to: Risperidone (antipsychotic</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
---	--

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	<p>medication) 2.5 mg two times daily for Paranoid Delusional Disorder.</p> <p>A blood pressure summary for Resident #1 was provided by LPN #5 on 3/2/2016 at 2:11 p.m., indicated no orthostatic blood pressure had been taken for January or February.</p> <p>During an interview with DON on 3/2/2016 at 2:00 p.m., she indicated orthostatic blood pressures were done for residents who received antipsychotic medication and then indicated there were no orthostatic blood pressure taken for January or February, 2016.</p> <p>During an interview with the MDS (Minimum Data Set) Coordinator on 3/3/2016 at 2:43 p.m., she indicated there were no orthostatic blood pressures for Resident #1 for January or February, 2016.</p> <p>4. On 3/1/16 at 8:11 a.m., Resident #5 was in the therapeutic dining room, being assisted with breakfast by CNA #8. CNA #8 was using a regular spoon to assist the resident. There were no adaptive utensils at the resident's place setting.</p> <p>On 3/2/16 at 12:20 p.m., Resident #5 was in the therapeutic dining room being assisted with lunch by CNA #8. CNA #8 was using a regular spoon to assist the</p>			

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
---	--

(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. There were no adaptive utensils at the resident's place setting.</p> <p>On 3/3/16 at 8:15 a.m., Resident #5 was in the therapeutic dining room, being assisted with breakfast by CNA #9. CNA #9 was using a regular spoon to assist the resident. There were no adaptive utensils at the resident's place setting.</p> <p>On 3/4/16 at 8:10 a.m., Resident #5 was in the therapeutic dining room, being assisted with breakfast by CNA #9. CNA #9 was using a regular spoon to assist the resident. There was a small plastic adaptive spoon sitting next to Resident #5's plate.</p> <p>Review of Resident #5's clinical record began on 2/29/16 at 11:15 a.m. Diagnoses included, but were not limited to, profound intellectual disability, expressive language disorder, dementia with behaviors, and dysphagia.</p> <p>Resident #5 had a 1/7/16 annual Minimum Data Set assessment (MDS), which indicated the resident was rarely or never understood, had both short term and long term memory problems and her decision making was moderately impaired. It also indicated Resident #5 received restorative nursing services during 7 days of the assessment period.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
---	--

(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
F 0312 SS=D Bldg. 00	<p>Review of a "RESTORATIVE NURSING PROGRAM (FMP)" document, dated 12/16/15, indicated Resident #5's current problem was coughing/choking during meals with an increased risk of aspiration. The instructions included, but were not limited to, "small bites at meals."</p> <p>Resident #5 had a current careplan problem of needing a pureed diet with a divided plate and miniature maroon spoons. Interventions included, but were not limited to, "small bites and needing to be fed by staff."</p> <p>During an interview, on 3/4/16 at 8:10 a.m., the DON indicated Resident #5 was to have small bites and special spoons at meals.</p> <p>During an interview, on 3/4/16 at 8:30 a.m., CNA #9 indicated she was aware Resident #5 was supposed to have two small spoons at meals to prevent choking.</p> <p>3.1-35(g)(2)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2016	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750			
(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>activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a restorative eating program was followed to maintain a resident's ability to safely consume food and drink for 1 of 1 residents reviewed for ADL maintenance (Resident #5).</p> <p>Findings include:</p> <p>On 3/1/16 at 8:11 a.m., Resident #5 was in the therapeutic dining room, being assisted with breakfast by CNA #8. CNA #8 was using a regular spoon to assist the resident. There were no adaptive utensils at the resident's place setting.</p> <p>On 3/2/16 at 12:20 p.m., Resident #5 was in the therapeutic dining room being assisted with lunch by CNA #8. CNA #8 was using a regular spoon to assist the resident. There were no adaptive utensils at the resident's place setting.</p> <p>On 3/3/16 at 8:15 a.m., Resident #5 was in the therapeutic dining room, being assisted with breakfast by CNA #9. CNA #9 was using a regular spoon to assist the resident. There were no adaptive utensils at the resident's place setting.</p>	F 0312	<p>F 312</p> <p>It is the policy of this facility to ensure that a restorative eating program is followed as planned to maintain the residents' ability to safely consume food and drink.</p> <p>1. What corrective action(s) will be done by the facility?</p> <p>Education will be provided to the nursing and dietary staff on March 30th, 2016 focusing on adaptive equipment for resident #5. Dietary to ensure that adaptive equipment is on resident trays prior to leaving kitchen and nursing to ensure the ordered adaptive equipment is present on the trays before eating assistance begins.</p> <p>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?</p> <p>All residents have the ability to be affected by this practice. The DON and DSM will audit all adaptive equipment orders to ensure each is reflected correctly in PCC, on meal tray cards, care plans, and CNA Assignment Sheets.</p> <p>If the DON, DSM, or other members of the IDT observe that</p>	04/01/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2016	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750			
(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 3/4/16 at 8:10 a.m., Resident #5 was in the therapeutic dining room, being assisted with breakfast by CNA #9. CNA #9 was using a regular spoon to assist the resident. There was a small plastic adaptive spoon sitting next to Resident #5's plate.</p> <p>Review of Resident #5's clinical record began on 2/29/16 at 11:15 a.m. Diagnoses included, but were not limited to, profound intellectual disability, expressive language disorder, dementia with behaviors, and dysphagia.</p> <p>Resident #5 had a 1/7/16 annual Minimum Data Set assessment (MDS), which indicated the resident was rarely or never understood, had both short term and long term memory problems and her decision making was moderately impaired. It also indicated Resident #5 received restorative nursing services during 7 days of the assessment period.</p> <p>Review of a "RESTORATIVE NURSING PROGRAM (FMP)" document, dated 12/16/15, indicated Resident #5's current problem was coughing/choking during meals with an increased risk of aspiration. The instructions included, but were not limited to, "small bites at meals."</p>		<p>adaptiveequipment is not being used as ordered and planned, she will notify the DON andDSM (if they are not already aware) of the issue. The DSM or DON will make surethat the equipment is made available to the resident as ordered as quickly aspossible. Once that is done, the DON and/or DSM will review the need for theequipment with the staff involved and re-train them on the need to follow eachresident's plan of care. Written counseling will be rendered for continuednoncompliance.</p> <p>3. What measures will be put into place to ensurethis practice does not recur? All new orders regarding adaptive equipment for eating or other residentassistance orders will be placed on PCC, tray cards, care plans, communicationbook, and CNA assignment sheet. DON willaudit new orders, at least 5 days a week at the morning Clinical Meeting. An audit sheet will verify that order wasplaced on all aspects of staffing communication. Communication will be done daily or as neworders occur. Staff in-service regardingwhere to find new communications will be held on 3-30-2016. If any issues areidentified, they will be addressed as outlined in question #2.</p> <p>4. How will corrective action</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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(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
F 0323 SS=D Bldg. 00	<p>Resident #5 had a current careplan problem of needing a pureed diet with a divided plate and miniature maroon spoons. Interventions included, but were not limited to, "small bites and needing to be fed by staff."</p> <p>During an interview, on 3/4/16 at 8:10 a.m., the DON indicated Resident #5 was to have small bites and special spoons at meals.</p> <p>During an interview, on 3/4/16 at 8:30 a.m., CNA #9 indicated she was aware Resident #5 was supposed to have two small spoons at meals to prevent choking.</p> <p>3.1-38(a) 3.1-38(3)(A) 3.1-38(3)(B) 3.1-38(3)(C) 3.1-38(3)(D) 3.1-38(3)(E)</p> <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</p>		<p>be monitored to ensure the deficient practice does not recur and what Quality Assurance measure will be put into place?</p> <p>Auditsheets will be brought to QA monthly for review of staff practices and to discuss areas for improvement. Once 100% compliance has been obtained the Committee may decide not to continue the audits; however the DON and the DSM will continue to audits the use of adaptive equipment at meals on an ongoing basis.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2016	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750			
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	<p>assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure safe mobility was maintained for 1 of 1 residents reviewed for safe mobility (Resident #5).</p> <p>Findings include:</p> <p>On 3/2/16 at 8:12 a.m., Resident #5 was seated in her wheelchair in her room. Her left arm was down inside the left side of her wheelchair and her feet were on the floor behind the foot pedals of her wheelchair.</p> <p>On 3/2/16 at 9:14 a.m., Resident #5 was seated in her wheelchair at the side entry door. The DON was observed to propel the resident to the hallway with her left foot dragging the floor behind the wheelchair foot pedals. Her right foot was turned in and being held on the foot pedal by the toe of her shoe.</p> <p>On 3/2/16 at 10:43 a.m., Resident #5 was seated in her wheelchair in her room. Her left foot was on the floor behind the foot pedals, with her right foot turned in on the opposite foot pedal.</p> <p>On 3/3/16 at 8:31 a.m., CNA #13 was observed propelling Resident #5 in her wheelchair. Resident #5's right foot was</p>	F 0323	<p>F 323</p> <p>It is the policy of this facility to ensure that theresident environment remains free of accident hazards, including making surethat each resident has safe mobility throughout the facility.</p> <p>1. What corrective action(s) will be done bythe facility? Resident #5 mobility assessment was completed. Adaptive equipment has been ordered for the resident'sfeet. All staff is to ensure thatresident's feet are in a safe position prior to propelling her inwheelchair. A Care Plan has beendeveloped to address proper feet placement while up in wheelchair and the CNA assignment sheethas been updated.</p> <p>2. How will the facility identify otherresidents having the potential to be affected by the same practice and whatcorrective action will be taken? All residents using mobility adaptiveequipment and needing wheelchair positioning have the potential to be affected.The DON/designee will audit all residents for the need of mobility adaptiveequipment and wheelchair positioning. Duringthe audit the DON and the MDSC will ensure that needed adaptive equipment is inplace. Adaptive equipment will be addedto the nursing assistant assignment</p>	04/01/2016			

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	<p>dragging the floor behind the wheelchair foot pedals.</p> <p>A progress note, dated 2/26/16 at 9:21 p.m., indicated Resident #5's right ankle/foot was swollen. The note further indicated an xray was completed and was negative for a fracture.</p> <p>Review of subsequent progress notes indicated Resident #5's ankle continued to be swollen through 3/1/16.</p> <p>A progress note, dated 2/28/16 at 2:42 p.m., indicated staff ensured foot pedals were in place to Resident #5's wheelchair.</p> <p>A progress note, dated 2/28/16 at 9:23 p.m., indicated staff ensured foot pedals were in place to Resident #5's wheelchair.</p> <p>A progress note, dated 3/1/16, indicated staff ensured foot pedals were in place to Resident #5's wheelchair.</p> <p>Review of Resident #5's clinical record began on 2/29/16 at 11:15 a.m. Diagnoses included, but were not limited to, profound intellectual disability, expressive language disorder, dementia with behaviors, and dysphagia.</p>		<p>sheets. A care plan will be written foreach resident who requires adaptive mobility or positioning equipment. Any resident found to be affected will be evaluatedby therapy and any adaptive equipment that needs implemented, will be ordered.</p> <p>3. What measures will be put into place toensure this practice does not recur? An all staff in-service will be held on 3-30-2016. The focus of thetraining will be identifying unsafe mobility and wheelchair positioning, aswell as the use of mobility adaptive equipment A mobility assessment will be completed uponevery resident's admission to the facility. Therapy will screen all residentsupon admission and quarterly. The physician of any resident, who could benefitfrom services, to address mobility or the need of adaptive equipment, will benotified and a request will be made for therapy orders. The DON/designee will observe and audit eachresident, 1 x time weekly x 4 weeks, focusing on potential mobility and positioningrisks. If unsafe mobility or the need for adaptive equipment is noted, thefacility will immediately intervene to address the findings. The audit tool will be brought to morningmeetings and will be included as part of the weekly Standard of Cares.</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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	<p>Resident #5 had a 1/7/16 annual Minimum Data Set assessment (MDS), which indicated the resident was rarely or never understood, had both short term and long term memory problems and her decision making was moderately impaired. It also indicated Resident #5 was totally dependent on staff to propel her wheelchair.</p> <p>Resident #5 had a current careplan problem of needing assistance with ADLs. Interventions included, but were not limited to, needing staff to propel her in her wheelchair. There was no care plan to address the resident not keeping her feet on the foot pedals to prevent falls and accidents.</p> <p>During an interview on 3/3/16 at 10:38 a.m., CNA #13 indicated Resident #5's feet did not stay on the foot pedals of the wheelchair and had to be put back on the pedals frequently. She further indicated the resident could lift her feet, but not well enough to reposition them on the pedals or remove them from the pedals.</p> <p>During an interview, on 3/4/16 at 8:10 a.m., the DON indicated Resident #5's feet often fell from her wheelchair pedals. She further indicated the facility had not identified interventions to prevent her feet from dragging on the floor while the</p>		<p>4. How will corrective action be monitored to ensure the deficient practice does not recur and what Quality Assurance measure will be put into place?</p> <p>The audit log along with any findings will be discussed in monthly QA to improve areas of concern for safe mobility for residents along with other safety concerns. The Committee may decide to stop the weekly audits after the 4 week period of time however; quarterly therapy screens will continue and staff will continue to notify therapy when mobility or positioning needs are identified.</p>	

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750		
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F 0356 SS=C Bldg. 00	<p>resident was being propelled in the wheelchair.</p> <p>During an interview, on 3/4/16 at 8:31 a.m., CNA #9 indicated Resident #5 could not propel her own wheelchair or purposefully reposition her own legs and feet. She further indicated the resident's feet fell from the wheelchair pedals frequently while being propelled in the wheelchair.</p> <p>3.1-45(a)(2)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the</p>				

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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	<p>beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure nurse staffing information was posted for 2 of 5 days of the survey. This practice had the potential to affect 26 of 26 residents residing in the facility.</p> <p>Findings include:</p> <p>On 3/01/16 at 8:13 a.m., the clipboard at the nurse's station displaying the document, "REPORT OF NURSING STAFF DIRECTLY RESPONSIBLE FOR RESIDENT CARE", was dated 3/1/16 and indicated a facility census of 26 residents. The remainder of the document indicating the number of nurses and certified nursing assistants was not filled in.</p> <p>On 3/01/16 at 11:36 a.m., the clipboard at the nurse's station displaying the</p>	F 0356	<p>F 356 POSTEDNURSE STAFFING INFORMATION</p> <p>1. What corrective action will be done by the facility? The daily census sheet was immediately completed with the correct information for direct daily staffing hours.</p> <p>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? All residents have the potential to be affected. While the posting of actual nursing staffing hours did not meet regulations, there were no residents affected by this practice.</p> <p>3. What measures will be put into place to ensure this practice does not recur? The night (3rd) shift charge nurse will post the projected nursing staffing hours for the next day.</p>	04/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2016
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750		
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F 0371 SS=F Bldg. 00	<p>document, "REPORT OF NURSING STAFF DIRECTLY RESPONSIBLE FOR RESIDENT CARE", was dated 3/1/16 and indicated a facility census of 26 residents. The remainder of the document indicating the number of nurses and certified nursing assistants remained blank.</p> <p>On 3/3/16 at 8:25 a.m., the clipboard at the nurse's station displaying the document, "REPORT OF NURSING STAFF DIRECTLY RESPONSIBLE FOR RESIDENT CARE", was dated 3/2/16.</p> <p>During an interview, on 3/1/16 at 11:36 a.m., the DON indicated the night shift nurse was responsible for completing the form for the oncoming day and had not completed them.</p> <p>On 3/03/16 at 8:34 a.m., LPN #3 indicated the staffing information was to have been completed prior to day shift starting.</p> <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</p>		<p>The DON or designated charge nurse will check the projected staffing hours on the next shift (1st) and modify them to show actual hours worked each shift. The Administrator or designated manager will check the posted hours upon arrival to the building each morning to make sure that the hours have been adjusted correctly and the census sheet is complete. The DON will monitor process 5x a week for 4 weeks; 3x a week for 4 weeks; 2x week for 4 weeks; then, randomly to ensure compliance is maintained. Completed nursing staffing forms will be retained for 18 months as per facility policy.</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? Audit sheets will be brought to QA monthly for review to ensure that compliance is continued.</p>		

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750			
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	<p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure food was stored properly in the refrigerator and dry storage area and that vent covers were clean. This deficient practice had the potential to impact 27 of 27 residents who were served food from the facility's kitchen.</p> <p>Findings include:</p> <p>1. A tour of the kitchen with the Dietary Manager began on 2/29/2016 at 7:29 a.m. the following observations were made:</p> <p>In the freezer:</p> <p>a. An unlabeled clear plastic bag containing ten hot dogs with no open date with white frosty crystals throughout the bag and on the hot dogs. The Dietary Manager indicated that she did not know how long the hot dogs had been in the freezer.</p> <p>b. An unsealed and unlabeled clear plastic bag containing eight chicken breasts with no open date. The Dietary Manager indicated she thought the chicken had been delivered the previous week, sealed the bag and placed them on the top shelf of the freezer.</p>	F 0371	<p>F 371</p> <p>It is the policy of this facility to ensure that all food items are properly wrapped, dated, and labeled and/or are stored in sealed containers. All food will be discarded within the appropriate shelf life of the items.</p> <p>1. <u>What corrective action will be accomplished for residents affected?</u></p> <p>Dietary staff members will be in-serviced on 3-28-2016, on proper policy of labeling, dating, and storage of food items, as well as having personal items in refrigerators and freezers used to store resident food items. All air vents in food preparation area have been cleaned and were added to the monthly cleaning schedule and will be monitored by the DSM and Administrator.</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>	04/01/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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	<p>c. An unlabeled clear plastic bag containing two breaded items with no open date. The Dietary Manager indicated they were fish fillets.</p> <p>d. An unlabeled clear plastic bag containing diced chicken with no open date. The Dietary Manager indicated there were approximately three cups of diced chicken in the bag.</p> <p>e. An unlabeled clear plastic bag containing twelve breaded items with no open date. The Dietary Manager indicated they were chicken fingers.</p> <p>In the refrigerator:</p> <p>a. A red tray, that held a cardboard tray of eggs and three containers of liquid eggs, had a clear liquid substance that covered the bottom of the tray.</p> <p>b. An unsealed bag of shredded cheddar cheese with no open date.</p> <p>c. A bottle of "Tuscan Garden" salad dressing tabled with an employee name with no open date. The Dietary manager indicated Cook #7 brought the salad dressing into the facility for the residents to use.</p> <p>d. An unlabeled bag of potato chunks</p>		<p>All residents have the potential to beaffected. If DSM observes staff's fooditems in refrigerator or freezer and/or items that are not labeled, dated, andstored properly, the items will be thrown out and the staff member in questionwill be re-trained. After re-training, theDSM/Administrator will render written counseling as indicated by the situation.</p> <p><u>3. What measures will be putinto place to ensure this practice does not recur?</u></p> <p>The DSM will audit all refrigerators, freezers, anddry food areas for one month, then 2 times a week to ensure food items are properlybeing labeled, dated, stored and resident refrigerators and freezers are freeof employee food items. Any issues noted will be addressed as indicated inquestion #2.</p> <p>Air vents will be placed on a monthly cleaningschedule. If air vents are identified as needing cleaned in between the monthlyschedule, a maintenance work order request will be written and</p>	

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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	<p>and tater tots with no open date. The Dietary Manager indicated there were three servings of potato chunks and tater tots in the bag.</p> <p>e. A bowl containing pureed peaches with no label or date.</p> <p>f. A red tray contained thirteen unlabeled drinks with no date. The Dietary Manager indicated they were made this morning for use throughout the day.</p> <p>In the dry storage:</p> <p>a. An unlabeled and undated large clear plastic tub contained elbow macaroni. The Dietary Manager indicated there were five pounds of elbow macaroni in the clear plastic tub. She also indicated when the dry stock arrived they opened one bag and placed it into the clear plastic tub.</p> <p>b. An unlabeled and undated large clear plastic tub contained rotini noodles. The Dietary Manager indicated there were five pounds of noodles in the container.</p> <p>c. An unsealed box of au gratin potatoes with no open date.</p> <p>d. An unsealed box of Swiss chocolate cake mix with no open date.</p>		<p>given to themaintenance supervisor. The Administrator will follow-up to ensure themaintenance request order was addressed.</p> <p>4. <u>Howcorrective action(s) will be monitored to ensure the deficient practice willnot recur, i.e., what quality assurance program will be put into place:</u> The DSM will report findings of her observations and audits to theQA monthly times 3 months. The QA committee may decide to stop the audits atthe end of the 3 months, when 100% compliance has been achieved; however theDSM will continue to monitor and observe refrigerators, freezers, dry foodstorage areas, and air vents, on an on-going basis.</p>	

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	<p>In the food preparation area:</p> <p>a. An uncovered, large, clear plastic container with a white powdery substance with the scoop submerged inside. Cook #7 indicated the white powdery substance was thickener for use with residents with a modified diet.</p> <p>b. A clear, plastic container of coffee grounds with the scoop submerged inside.</p> <p>c. A vent cover located above the freezer had an accumulation of black dust and debris that hung from the vent cover.</p> <p>During an interview with Cook #7 on 2/29/2016 at 7:32 a.m., she indicated that the unlabeled and undated food would not go bad because the facility usually used all the food that came in the weekly delivery.</p> <p>During an interview with the Maintenance Supervisor on 03/04/2016 at 9:48 a.m., he indicated that he didn't know when the kitchen vent on the wall above the freezer was last cleaned. He also indicated there was no cleaning schedule for the vents. The Maintenance Supervisor further indicated the vent above the freezer in the kitchen was</p>			
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	<p>difficult to get to because of its location and that to clean that vent he had to take it off the wall to clean.</p> <p>A policy titled "RECEIVING AND STORAGE- REFRIGERATION" was provided by the Dietary Manager on 2/29/2016 at 9:14 a.m., indicated the following:</p> <p>"...7. All foods will be properly wrapped, dated, and labeled and/or stored in sealed containers. Food will be discarded within the appropriate shelf life...."</p> <p>A policy titled "RECEIVING AND STORAGE- FROZEN FOODS" was provided by the Dietary Manager on 2/29/2016 at 9:14 a.m., indicated the following:</p> <p>"Frozen Foods:</p> <p>...3. All frozen foods will be properly wrapped, dated and labeled...."</p> <p>A review of the maintenance request form dated 2/25/2016 indicated the Administrator had requested the vent cover behind the freezer be cleaned.</p> <p>No further information was provided prior to the exit of the survey.</p>			

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F 0431 SS=D Bldg. 00	<p>3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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(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>Based on observation, interview and record review, the facility failed to ensure medication patches, packets of " White Petrolatum " and packets of "Dyna Lube" were properly disposed of following expiration dates for 1 of 1 treatment carts observed.</p> <p>Findings include:</p> <p>1. During an observation of medication storage with the Director of Nursing (DON) on 3/1/16 at 1:50 p.m., the treatment cart contained the following:</p> <p>a. Two boxes of "Xeroform Petrolatum" dressing gauze, with a use by date of 07/2014 on the foil wrapper. Box #1 contained three sealed Xeroform dressing gauzes and box #2 contained 11 sealed Xeroform dressing gauzes. Each box initially held 25 Xeroform dressing gauzes and each dressing gauze was 4 inch by 4 inch in size.</p> <p>b. One box contained "White Petrolatum" packets. The box contained 93 individual five gram packets with an expiration date of 10/2011 and two individual five gram packets with an expiration date of 05/2008.</p> <p>2. During an observation of the medication storage with the DON on</p>	F 0431	<p>F 431</p> <p>It is the policy of this facility to ensure that medication, including patches and packets, are properly disposed of when their expiration dates are reached.</p> <p>1. What corrective action will be done by the facility? Medications found to be expired were immediately disposed.</p> <p>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? Complete audit of areas used for storage of supplies, medications, ointments, wound dressings and drops was done and all items were checked for expirations, deterioration, labeling and proper storage. Any affected items were disposed per facility and pharmacy policy and procedure. If the DON finds expired items during any of her audits, she will dispose of them immediately as per policy. She will also re-train the nurses on the facility policy and procedure. If there is recurrent noncompliance, she will render written counseling as indicated by the issue itself.</p> <p>3. What measures will be put into place to ensure this practice does not recur? Nursing in-service regarding policy and procedure for disposal of outdated, contaminated, deteriorated drugs or those in containers that are cracked,</p>	04/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2016	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750			
(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>3/1/16 at 2:38 p.m. the medication room contained the following: One box of "Dyna LUBE Sterile" packets with an expiration date of 03/2013 was noted. There was 69 individual 2.7 gram packets in the box. The box initially held 144 individual packets. The box was located on the bottom shelf of the four door storage cabinet.</p> <p>During an interview with the DON on 3/4/16 at 10:08 a.m., she indicated expired medications and supplies should have been discarded per the facility policy and state regulations.</p> <p>A review of the policy titled "Medications - Storage & Labeling," dated June 2014, was provided by the DON on 3/1/16 at 5:25 p.m., indicated the following:</p> <p>"...MEDICATION ACCESS AND STORAGE:</p> <p>...11. Any outdated, contaminated, or deteriorated drugs, or those in containers that are cracked, soiled, or without secure closures must be removed from stock and destroyed according to the drug destruction policy...."</p> <p>3.1-25(o)</p>		<p>soiled, or without secure closures, was held(put date in here) for all licensed nurses. The night shift nurse is responsible for checking medication and treatment carts and medication room, (three times a week, forexpired medications and treatments. The DON will audit medication cart,treatment cart and med room 5 days a week for 4 weeks; 3 days a week x4 weeks;2 days a week x4 weeks; and then 1 day a week x4 weeks. At the end of thattime, the DON will audit these areas on a random basis, but no less often thantwice a month on an ongoing basis.</p> <p>If the DON identifies any issues with expired medications or otheritems, she will address the situation as indicated in question #2.</p> <p>4. How will corrective actionbe monitored to ensure the deficient practice does not recur and what QA willbe put into place?</p> <p>Audit log will be presented by DON in monthly QA meetings to discussconcerns, compliance and any areas for improvement. The DON will continuethe random medication room, treatmentcart, and medication cart audits on an on-going basis, to ensure compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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(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
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F 0441 SS=F Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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 prevent the spread of infection, the facility must isolate the resident. (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. (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>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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	<p>Based on observation, interview, and record review, the facility failed to ensure proper infection control practices were followed to prevent resident exposure to a possible infectious condition of an employee (CNA #3). Furthermore, the facility failed to ensure sanitary handling of items for resident consumption by direct-care staff. These practices had the potential to affect 27 of 27 residents residing in the facility at start of the survey. (CNA# 3, CNA #6, the Activity Director, CNA #1</p> <p>Findings include:</p> <p>1. During a dining observation, on 2/29/16 beginning at 7:53 a.m., CNA #3 was observed in the assistive dining room, wearing gloves on both hands. Her right eye was visibly swollen, reddened, and watering. Resident #29 asked CNA #3 what was wrong; CNA #3 indicated her eye was bothering her. CNA #3 wiped her right eye with her right lower arm. CNA #3 indicated to CNA #8 she could not serve residents their trays due to her eye. CNA #3 then left the dining room and went to the resident bathroom across from room 1. After she left the bathroom, CNA #3 was observed to apply a pair of gloves she had removed from her pocket. She then returned to the assistive dining room and</p>	F 0441	<p>F 441</p> <p>It is the policy of this facility to establish and maintain an infection control program that ensures proper infection control practices including those to prevent resident exposure to a possible infectious condition of an employee and to ensure sanitary handling of items for resident consumption by direct care staff.</p> <p>1. What corrective action(s) will be done by the facility?</p> <p>CNA #3 is no longer employed at Hickory Creek at Huntington. CNA #1 and CNA #6 were retrained regarding infection control and passing ice water, per Hickory Creek policies and procedures. A return demonstration on the proper way to pass ice water was completed by both nursing assistants. The Activity Director was retrained on infection control during activities and on handwashing. A return demonstration of hand washing was completed by the Activity Director.</p> <p>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?</p> <p>All residents have the potential to be affected by this deficient practice. In the future, if the DON observes staff not handling items for resident consumption in a</p>	04/01/2016
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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(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>began to assist Residents # 3 and #5 to eat their breakfast.</p> <p>2. During an observation of ice pass, beginning on 2/29/16 at 9:39 a.m. the ice cooler was observed outside of room #7. CNA #3 was observed leaving room 7, wearing gloves and holding a water pitcher. She opened the lid to the cooler, reached in and retrieved the scoop, and then filled the pitcher with ice. She replaced the scoop in the cooler, closed the lid and entered room 7 with the water pitcher. While wearing the same gloves, CNA #3 then pushed the cooler to room 8, entered the room, and picked up a water pitcher. She turned the sink faucet on in the room, and carried the water pitcher to the cooler in the hall. She opened the lid to the cooler and retrieved the scoop, filling the pitcher with ice. Upon re-entering the room, she filled the pitcher with water and turned off the faucet. She removed her gloves in the hallway and disposed of them in the trashcan in room 8. She pushed the cart to room 9 and removed a pair of gloves from the room and applied them. She turned the sink faucet on with her hand. She proceeded to fill both water pitchers in the room with the ice from the cooler, leaving the scoop in the ice both times. She turned the faucet off with her hands and discarded the gloves in the trashcan.</p>		<p>manner that assures their cleanliness for the resident, she will stop the employee immediately and will re-train him/her regarding the facility policy for handling these items appropriately. Once that is done, she will observe the staff person in a return demonstration of the practice to make sure that the employee understands the correct way of performing it. The DON will use written counseling as indicated by the situation, as needed.</p> <p>3. What measures will be put into place to ensure this practice does not recur? All staff will be in-serviced by the Director of Nursing on March 30th, 2016 regarding proper hand washing. Return hand washing demonstrations will be completed by all staff. All staff, who have the responsibility to pass ice water, will be in-serviced on March 30th, 2016 on the policy and procedure for passing ice water. All staff will be in-serviced on the signs and symptoms of illness that might be an indication of a condition that is contagious and might expose other staff and residents to the same illness. Any staff member who presents to work with any of these signs and symptoms of possible infection will be assessed by DON or charge nurse at that time. The facility will refer the employee to his/her physician, and he/she will not be scheduled to work until signs and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2016	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750			
(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>She repeated this process for room 10 (B-side only). She entered room 11 and removed gloves from the box in the room. Carrying the gloves in her right hand, she pushed the cart to room 13 and applied the gloves. She repeated the process of turning the sink faucet on and filling the pitchers, with the ice scoop being left in the cooler each time.</p> <p>Wearing the same gloves, she repeated the process for both pitchers in room 15 and room 17, opening and closing the door while touching the doorknob each time. She discarded the gloves in room 17 and removed another pair from the box in the room. Carrying the gloves in her right hand, she pushed the cart to room 18, repeating the process of turning the sink faucet on and filling the pitchers, with the ice scoop being left in the cooler each time.</p> <p>Wearing the same gloves, CNA #3 left room 18, carrying paper towels in her hand. She proceeded to wipe an area of the floor in the hallway and then closed the lid to the cooler while holding the paper towels in her hand. She then discarded the paper towels and gloves in room 18. She did not wash her hands. She then pushed the cart to room 1. Removing gloves from her right pocket, she applied them and carried Resident #1's pitcher to the pantry to fill it with</p>		<p>symptoms of infection are cleared and until they are cleared return to work, by their physician.</p> <p>DON or designee will observe the ice water pass 5 days a week x 4 weeks; 3 days a week x 4 weeks; 2 days a week x 4 weeks; 1 time a week x 4 weeks; then, randomly on an ongoing basis, but no less often than 2 times per month.</p> <p>The DON or designee will observe random staff, from various departments, wash their hands. This will be done daily 5 days a week x 4 weeks; 3 days a week x 4 weeks; 2 days a week x 4 weeks; 1 time a week x 4 weeks; then, randomly ongoing.</p> <p>4. How will corrective action be monitored to ensure the deficient practice does not recur and what Quality Assurance measure will be put into place?</p> <p>DON will bring audit tools for hand washing and ice passing to QA monthly to discuss any concerns or areas for improvement. Once 100% compliance is reached the Committee may decide to stop the reporting of the audits however the DON will observe for compliance each day she works.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2016	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750			
(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>coffee.</p> <p>During an interview, on 2/29/16 beginning at 8:43 a.m., CNA #3 indicated she had woken up that morning with her eye reddened and swollen, but could not get in to the doctor yet for an exam. She further indicated her child had "pink eye" the previous week.</p> <p>On 3/3/16 at 2:37 p.m., the DON indicated she was aware CNA #3 had an infection in her eye. She further indicated CNA #3 had been instructed to wear gloves as a precaution for infection control. She also indicated the ice scoop should not be stored inside the ice cooler.</p> <p>3. During an ice pass observation, beginning on 3/1/16 at 2:18 p.m., the ice cart was observed in the hallway outside of room 13 with the cooler lid open. CNA #6 was standing in the doorway of bathroom #3, speaking with the beautician while the beautician was perming a resident's hair. He was holding a water pitcher with the bottom of the pitcher in his left hand, and his right hand over the top of the pitcher. The lid of the pitcher was being held with the straw between his fingers of his left hand. The Administrator in Training (AIT) approached the cooler and closed the lid, indicating to CNA #6 to keep the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
---	--

(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>cooler lid closed. CNA #6 indicated he was aware of this and he also usually kept the scoop in the cooler, but today he would keep it in the scoop cover. CNA #6 removed the scoop from the cooler, filled the pitcher with ice, placed the scoop in the covered storage, and carried the pitcher to room 13.</p> <p>4. On 3/02/16 beginning at 8:54 a.m., the Activities Director (AD) was observed walking through the facility with a small bucket of candy, offering the candy to staff and residents with the following concerns:</p> <p>The AD unwrapped a chocolate peanut butter cup with her bare hands and placed it in Resident #4's mouth with the fingers of her right hand.</p> <p>The AD unwrapped a chocolate peanut butter egg with her bare hands and placed it in Resident #11's hand.</p> <p>The AD unwrapped a small piece of chocolate with her hands, placed it in the palm of her right hand, and offered it to Resident #25, who picked the candy up and ate it.</p> <p>The AD did not perform hand hygiene during the observation.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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(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>5. During an activities observation of "Cooking Club", on 3/2/16 beginning at 2:21 p.m., in the main dining room, the following was observed:</p> <p>The AD brought a cart containing, but not limited to, a plastic container of peeled hard-boiled eggs, two small covered bowls, a metal mixing bowl, and a plastic container with plastic ware and napkins.</p> <p>The AD placed the container of eggs, disposable plates, napkins, and the mixing bowl onto a table.</p> <p>With her bare hands, she removed the lid to the eggs and placed it face-down onto the table. She began removing eggs from the container, slicing them in half with a plastic fork, scooping the yolks into the mixing bowl with her fingers, and placing the egg halves onto a disposable plate.</p> <p>She passed disposable plates and spoons to Residents #2, #9, #25, #12, #7, and #10. She then placed two egg halves onto each plate using a plastic spoon.</p> <p>The AD returned to the mixing bowl and added the mayonnaise and mustard from the covered bowls into the egg yolks. She began stirring the yolk mixture with</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
---	--

(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>a small disposable knife with her right hand. She then added green food coloring to the mixture and continued to mix the yolks with the small knife with her hand in the bowl. She wiped her hand on a napkin and placed it in the open trash container on the side of the cart. The AD then picked up the bowl, lifted to her chest just under her chin, and walked around the tables with the bowl facing outward to show the residents.</p> <p>The AD then approached each table and began to fill the egg halves with the yolk mixture using a small spoon and the mixing knife.</p> <p>The AD then returned to the table and removed two more eggs, and repeated the above process of slicing the eggs, making the yolk mixture, and filling the egg halves. She placed two halves each onto two napkins and placed the eggs in front of Residents #4 and #30.</p> <p>The residents were eating the eggs as the AD indicated her fingers had been dyed green.</p> <p>On 3/4/16 at 9:44 a.m. the AD indicated she had not received training regarding handling food. She further indicated she had realized during the observation that she probably shouldn't have touched the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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(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>food directly for infection control purposes.</p> <p>Review of a policy titled, "Infection Control", dated October 2004, and obtained from the Administrator on 2/29/16 at 10:23 a.m., indicated the following:</p> <p>"...14. The facility prohibits 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>...15. Staff will wash their hands after each direct resident contact for which handwashing is indicated b accepted professional practice...</p> <p>...STAFF RESPONSIBLE: All staff in all departments...."</p> <p>Review of a policy titled, "Ice Water Pass", dated June 2004, and obtained from the DON on 3/3/16 at 3:14 p.m., indicated the following:</p> <p>"...1. Bring ice to resident rooms in a covered ice chest with the ice scoop covered in a plastic container/bag...</p> <p>...6. Do not leave the ice chest uncovered when it is not in use...</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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	<p>...7. Return the ice scoop to the plastic container/bag after each use. Do not let the ice scoop rest in the ice chest at any time...</p> <p>...8. Wash hands between residents, or use hand sanitizer...</p> <p>...9. If ice is spilled on the floor, pick it up immediately...Wash hands before returning to passing ice..."</p> <p>Review of a policy titled, "Handwashing/Alcohol-Based Hand Rub/Hand Hygiene", dated January 2016, and obtained from the DON on 3/3/16 at 3:14 p.m., indicated the following:</p> <p>"...There are 5 basic moments when staff should make sure that hand hygiene is performed: ...5. After touching resident surroundings..."</p> <p>6. During an interview with Resident #20 on 2/29/16 at 3:15 p.m., CNA #1 was observed in the doorway of Resident #20's room with the ice cart. CNA #1 removed the ice scoop from the cooler with ice and began to fill Resident #20's water pitcher. CNA #1 then placed the ice scoop back into the cooler of ice.</p> <p>7. During an observation on 3/2/16 at 2:35 p.m., CNA #6 used his left index finger and wiped it across the bottom of his nose three times. He then entered</p>			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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F 0465 SS=D Bldg. 00	<p>restroom 2 and got a piece of toilet paper, wiped the bottom of his nose with it and threw the toilet paper in the trashcan. He exited restroom 2 and placed his hands on the handles of Resident #13's wheelchair and began to push it into restroom 2.</p> <p>During an interview with CNA #6 on 3/2/16 at 2:38 p.m., he indicated he did not wash his hands after he wiped his nose and he did not think about it before he touched Resident #13's wheelchair.</p> <p>3.1-18(k) 3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure access covers to the furnace in the ceiling were clean. In addition, the facility failed to ensure wheelchairs were kept clean and in good repair for 9 out of 13</p>	F 0465	F 465 It is the policy of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public, including cleaning of access covers to the furnace in	04/01/2016

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	<p>residents who had wheelchairs (Residents #21, 13, 5, 3, 7, 31, 6, 1, and 9).</p> <p>Findings included:</p> <p>On 3/2/16 at 8:55 a.m., the following observations were made:</p> <ol style="list-style-type: none"> 1. Resident #21's left armrest of his wheelchair had a ripped vinyl-like cover with foam exposed and chunks of the foam missing. 2. Both armrests of Resident #13's wheelchair had worn vinyl-like covers with white threads and foam exposed. 3. Resident #5's wheelchair had foam exposed at the top of the chair in three different spots. The vinyl-like cover was ripped on the right side of the wheelchair near Resident #5's head. 4. Both armrests of Resident #3's wheelchair had ripped armrests with white threads and foam exposed. 5. Resident #7's right armrest of her wheelchair had a cracked vinyl-like cover with blue foam exposed. Dirt and debris were present to the black frame and brakes of her wheelchair. The left wheel had pencil eraser size to nickel size chunks of rubber missing in multiple 		<p>the ceiling and ensuring wheelchairs are kept clean and in good repair.</p> <ol style="list-style-type: none"> 1. <u>What corrective action will be done by the facility?</u> The armrests for residents #21, #13, #3, #7, #31, #6, #9, have been replaced. The facility has ordered a replacement back rest for Resident #5 and it will be installed immediately upon arrival. The Administrator has added wheelchair observation and vent cleaning/observation to the preventative maintenance log sheet. The vent covers in the hallways were cleaned on March 4th 2016. The hallway vent covers have been added to the housekeeping checklist and will be cleaned monthly and/or as often as needed. The Director of Nursing has updated the wheelchair cleaning log sheet and will in-service the nursing staff, on the updated log, on March 30th, 2016. 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 by the deficient practice. The Administrator has placed wheelchairs on the Preventative Maintenance Log Sheet. The Maintenance 	

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	<p>spots.</p> <p>6. Resident #31's left armrest had a cracked vinyl-like cover with foam exposed.</p> <p>7. Both armrests of Resident #6's had a cracked vinyl-like cover with foam exposed.</p> <p>8. Resident #1's wheelchair had a handle with worn and ripped black tape. Dirt and debris were present to both metal brakes and the black metal frame of his wheelchair.</p> <p>9. Both armrests of Resident #9's wheelchair had a worn vinyl-like cover with white threads exposed. The left wheel had pencil eraser size to nickel size chunks of rubber missing in multiple spots.</p> <p>During interviews with the D.O.N. on 3/4/16 at 8:54 a.m. and 10:05 a.m., she indicated wheelchairs were supposed to be cleaned on a weekly basis. She also indicated that she was not aware there was a weekly cleaning schedule form.</p> <p>Review of an untitled document, dated 6/12/15, provided by the MDS coordinator on 3/3/16 at 3:32 p.m., included the handwritten dates of 2/21 -</p>		<p>Director will look at every wheelchair to ensure they are all within good condition and free of rips, tears, or exposed foam. Staff will be in-serviced on March 30th 2016 to continue filling out Maintenance Request forms if there are condition issues with the wheelchairs. The Maintenance Director will in-service the housekeeping staff on the Housekeeping Log Sheet on March 30, 2016. The wheelchairs will be placed on a cleaning schedule by the Director of Nursing and the wheelchairs will be cleaned at least once weekly or sooner if needed. The staff cleaning the wheelchairs will fill out a Maintenance Request Form if they find and condition issues with the wheelchairs while cleaning them. The Maintenance Director has placed vent cleaning and observation on the housekeeping cleaning log sheet. The vents will be cleaned as needed and at least monthly.</p> <p>3. <u>What measures will be put into place to ensure this</u></p>	

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	<p>2/27 and handwritten initials in the columns for 2/22 and 2/24. The MDS coordinator indicated the form was the wheelchair cleaning schedule. She also indicated the handwritten initials indicated wheelchairs had been cleaned in rooms 5 - 8 on 2/22/16 and 13 - 15 on 2/24/16.</p> <p>During an interview with the Administrator in training on 3/4/16 at 10:18 a.m., she indicated if staff noticed wheelchairs in disrepair, they were to fill out a maintenance slip and submit it to the Maintenance Supervisor. She also indicated if the Maintenance Supervisor was unable to repair a wheelchair, the facility would have an outside company come in to repair it.</p> <p>Review of six documents titled, "Maintenance Request", dated 6/15/15, 8/17/15, 2/10/16, 2/12/16, 2/12/16, and 2/16/16, provided by the Administrator in training on 3/4/16 at 10:23 a.m., indicated there were no wheelchair maintenance requests pending.</p> <p>No further documentation was provided at the time of exit on 3/4/16.</p> <p>10. During an environmental observation on 3/3/16 at 9:33 a.m., an accumulation of gray dust and debris hung from a</p>		<p><u>practice does not recur?</u></p> <p>The Administrator has placed wheelchairs on the Preventative Maintenance Log Sheet. The Maintenance Director will look at every wheelchair to ensure they are all within good condition and free of rips, tears, or exposed foam. Staff will be in-serviced on March 30th 2016 to continue filling out Maintenance Request forms if there are condition issues with the wheelchairs. The DON will in-service the nursing staff on the wheelchair cleaning schedule on March 30th, 2016. The wheelchairs will be placed on a cleaning schedule by the Director of Nursing and the wheelchairs will be cleaned at least once weekly or sooner if needed. The staff cleaning the wheelchairs will fill out a Maintenance Request Form if they find and condition issues with the wheelchairs while cleaning them. The Maintenance Director has placed vent cleaning and observation on the</p>	

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	<p>cream-colored access cover in the ceiling above the back door entrance.</p> <p>11. During an environmental observation on 3/3/16 at 9:36 a.m., an accumulation of gray dust and debris hung from a cream-colored access cover in the ceiling above the side door entrance.</p> <p>During an interview on 3/4/16 at 9:10 a.m., the Maintenance Supervisor indicated the access covers gave access to the furnace and they looked very dusty. He also indicated there was no cleaning schedule for the access covers and he had never cleaned them.</p> <p>No further information was provided before exit from the facility on 3/4/16.</p> <p>3.1-19(f)</p>		<p>housekeeping cleaning logsheet. The vents will be cleaned asneeded and at least monthly.</p> <p>4. <u>How will corrective action be monitored to ensurethe deficient practice does not recur and what QA will be put into place?</u></p> <p>The Maintenance Director will bring the Preventative MaintenanceLog Sheet and the Housekeeping Log Sheet to Quality Assurance Meetings monthlyfor three months. The Director of Nursing will bring the wheelchair cleaningcompletion checklist to Quality Assurance Meetings for three months. The QAcommittee may decide to stop the review of all logs at the end of the 3 monthswhen 100% compliance has been achieved; however the DON and the MaintenanceDirector will continue to monitor and observe wheelchairs and air vents on anon-going basis.</p>	