

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/22/2014
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
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F 000 Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: December 15, 16,17,18,19, and 22, 2014</p> <p>Facility number: 000284 Provider number: 155424 AIM number: 100290690</p> <p>Survey team: Rita Bittner, RN - TC Tammy Forthofer, RN Julie Dover, RN</p> <p>Census bed type: SNF/NF: 35 Total: 35</p> <p>Census payor type: Medicare: 1 Medicaid: 30 Other: 4 Total: 35</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December 28, 2014, by Janelyn Kulik, RN.</p>	F 000	<p>This Plan of Correction consitutes the written allegation of compliance for the deficiencies cited. However, the submission of the Plan of Correction is not an admission that a deficiency exists or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by the state and federal law. Hickory Creek at Columbus desires this Plan of Correction to be considered the facility's allegation of compliance. Hickory Creek at Columbuys is requesting paper compliance. Compliance is effective 1/14/15.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to maintain the residents' dignity and respect in reference to smoking privileges and internal feedings for 2 of 2 residents reviewed who met the criteria for dignity. (Residents #23, and #28)</p> <p>Findings include:</p> <p>1. During an interview, on 12/16/2014 at 1:44 PM, Resident #23 was asked, "Does staff treat you with respect and dignity?" Resident #23 stated, "The Administrator does not respect me as an individual." He further indicated he was unhappy with the rules the Administrator put in place. He indicated she discontinued the morning smoke break at 6:30 AM. This created a long span of time, from 7:00 PM to the next day at 10:00 AM, with no smoking breaks.</p> <p>During an interview, on 12/19/2014 at 2:57 PM, RN #5 indicated the facility will offer a nicotine patch if the resident</p>	F 241	<p>F241 Dignity and Respect of Individuality The facility respectfully requests a face to face IDR for F241. The facility believes it has meet the requirements for F241.It is the standard of this facility that care for residents is provided in an environment that maintains and enhances resident's dignity and individuality. <u>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</u> The facility will continue with the current smoking policy and procedure. A meeting was held with the residents who currently smoke including resident #23 on 1/9/15 to review the current smoking policy with them again and ask any questions. No concerns were expressed at that time. The clear liquid bag and bag containing brown liquid will be covered when resident #28 is in a common area of the facility. <u>How are other residents having the potential to be affected by the deficient practice will be identified and what corrective action will be</u></p>	01/09/2015

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	<p>cannot wait the 15 hours between smoking times for 7:00 PM to 10:00 AM the next day.</p> <p>An interview was conducted, on 12/19/2014 at 3:02 PM, with the Social Services Director (SSD). She indicated the residents need to be supervised while smoking and when it was cold, the residents had to understand why they could not smoke. When the wind chill gets below 15 degrees, the residents were restricted from smoking. The SSD indicated the facility offers other activities to distract the resident's smoking urges. The SSD indicated residents were restricted from smoking when it had been raining or snowing.</p> <p>During an interview with the Administrator, on 12/19/2014 at 3:12 PM, she provided the current facility smoking policy with a final revision date of September 27, 2013. The Administrator indicated the residents were notified at a meeting of the smoking policy changes. The Administrator indicated, "This is not a group discussion, it is a notification". The Administrator indicated the Interdisciplinary Team (IDT) decided to alter the Smoking Policy.</p> <p>During an interview, on 12/22/2014 at</p>		<p><u>taken?</u> _No other residents have been affected by this deficient practice. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u> _The facility will continue to review the current smoking policy and procedure during the admission process. If changes are made to the smoking policy then a meeting will be held with the residents to discuss the changes to the policy. Resident feeding tube bags will be covered when residents with a feeding tube are in a common area. Nursing staff will be inserviced regarding this procedure by January 10, 2015. Department managers will observe feeding tube bags are covered during their daily rounds. If they should find that one is not, they will intervene immediately to make sure that the bag is covered and the resident's dignity is ensured. <u>How will the corrective action be monitored to ensure the deficient practice will not recur?</u> _Social Services will bring any concerns expressed by any of the smoking residents regarding the smoking policy and procedure or any identified concerns regarding resident dignity to the QA Committee at the next monthly scheduled meeting. Any recommendations made by the committee will be followed up by the designated department and the results of</p>	

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	<p>2:22 PM, the Administrator indicated the policy provided, with a revision date of July 1, 2012, was the smoking policy Resident #23 signed, upon admission to the facility. The Administrator indicated the specific policy, at that time, listed smoking times at 6:30 AM, 10:00 AM, 1:00 PM, 3:30 PM and 7:00 PM.</p> <p>The " Hickory Creek at Columbus Smoking Policy " provided by the Administrator, on 12/19/2014, with the Effective date of October 8, 2011, and with the revision dates of January 1, 2007, and June 15, 2012, indicated the smoking times were as follows:</p> <p style="padding-left: 40px;">6:30 AM 10:00 AM 1:00 PM 3:30 PM 7:00 PM</p> <p>The " Hickory Creek at Columbus Smoking Policy " provided by the Administrator on 12/19/2014 with the Effective date of October 8,2011, and with the revision dates of January 1, 2007, June 15, 2012, and September 27, 2013 indicated the smoking times were as follows:</p> <p style="padding-left: 40px;">10:00 AM 1:00 PM 4:00 PM 7:00 PM</p>		<p>those recommendations will be brought back to the next month's QA Committee for review. The specific concerns regarding smoking and dignity will be reviewed by the QA Committee for the next 60 days. After 60 days the QA committee may decide to stop the requirement for the reporting results if 100% compliance has been achieved. However, the Administrator, DON, or Social Worker will bring any concerns identified or expressed regarding resident dignity and respect to the QA Committee for review and recommendations on an ongoing basis.Addendum to F241:How will the facility meet the individualized needs of the residents? The facility currently has a smoking policy with 4 smoking times per day. Resident #23 was interviewed by the Administrator and Social Service Director on 1/23/15 regarding the smoking times. Resident #23 requested that the 10:00am smoking time be moved to 9:00am. The smoking policy will be changed to reflect the earlier time of 9:00AM and all smoking residents will be notified of that change which will be documented in each resident's medical record. It has been a long standing policy for all of the Hickory Creek Healthcare Foundation facilities that no resident may smoke on the facility property without at least one staff</p>				

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	<p>The " Hickory Creek Healthcare Foundation, Inc Smoking Policy" had an issued date of March 1, 2002, and a revision date of June 14, 2012 and July 1, 2012. It indicated under item #1. The resident and/or legal representative will be notified of this policy and the nursing home specific policy regarding smoking at the time of admission.</p> <p>Record for Resident #23, indicated the Quarterly MDS (Minimum Data Set) Assessment, dated 09/19/2014, listed a BIMS (Brief Interview of Mental Status) score of 15, indicating the resident was alert and oriented.</p> <p>3.1-3(t)</p>		<p>member in attendance with him/her. Smoking is supervised by a staff member for all residents who smoke. It is the company's considered opinion that even alert residents who normally handle their own smoking supplies can accidentally drop the cigarette or ashes onto his/her clothing and thus, start a fire. Smoking aprons are used, but having a staff member in attendance who can monitor for impending accidents while cigarettes are in use and who can use a fire extinguisher if needed to keep serious injury from occurring is paramount for all residents' safety and overrides any individual resident's desire to smoke independently without staff supervision, as recently suggested by an ISDH surveyor. The facility will continue to make all inquiries for admission and newly admitted residents aware of the smoking policy and the times that smoking occurs. Will each resident be assessed as to how to best meet those needs? A smoking assessment is completed upon admission, quarterly and upon significant change. (Attachment #1) Any resident who smokes has a care plan in place that reflects the results of that assessment. What structure has the facility provided for residents (who desire to smoke outside) to shield them from the elements? There is no regulation</p>	

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			<p>or indication in the "Guidance to Surveyors" for F241 which specifically relates to any smoking issues. Even under F242 (which was not cited) which does speak to a facility's smoking policy, there is nothing in the "Guidance to Surveyors" which indicates a requirement for an outdoor shelter for residents who smoke. If a resident chooses to sit outside at any time, even during inclement weather that resident may sit on the facility's covered front porch. The facility also has a back patio that residents can sit on when the weather is appropriate. Resident's are not allowed to smoke in either of these areas at any time because they do not meet the 8 foot clearance from the door for smoking as required by Indiana state law. The facility does provide a separate patio area for the residents to smoke. <u>How will the facility protect the resident's form the weather?</u></p> <p>The facility's smoking policy pertaining to weather is as follows (see attached):</p> <p>-WEATHER: If the temperature during the winter months is a wind chill of 15 degrees or below and during the summer months is a heat index of 95 or above smoking times will be cancelled until the temperature has reached an appropriate degree. Residents will not be permitted to smoke when it is raining or snowing. If the rain or snow</p>	

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			<p>stops within 15 minutes of the smoke time, the smoke time can take place. If the precipitation has not stopped within 15 minutes of the allotted time residents will be taken out to smoke during the next scheduled time.</p> <p>·If the driveway or smoking area has ice or snow accumulation the smoking time will be canceled due to safety issues.</p> <p>The resident's are not permitted to smoke when there is inclement weather. This has been part of the facility's smoking policy since June 15, 2012. All resident's who smoke are made aware of this policy including inclement weather upon admission. Based on the fact there is no regulation pertaining to providing shelter under F241 or any other associated regulations that we can find, and the facility's long standing smoking policy, a shelter is not needed to protect the resident's from inclement weather</p> <p><u>What shelter will the facility provide for the resident's who choose to smoke for protection from the weather?</u></p> <p>Even though the facility does not agree with the survey supervisor's interpretation of the regulation as stated in prior addendum submissions, a covered shelter for the residents to use while smoking will be purchased and in place by 2/13/15.</p>	

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F 279 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>Once again, the facility would like to point out that the deficiency statement on the CMS-2567 related to F241 – Dignity. In the Long Term Survey Guide under F241 483.15 (a) Dignity does not mention smoking or any structure for smoking. Under Interpretive Guidelines for surveyors for F241 there is no mention of the facility having to provide shelter for resident's who smoke. There is also no indication on the CMS-2567 that the resident had any concerns about needing or wanting a shelter for smoking.</p>	

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	<p>Based on observation, record review and interview, the facility failed to ensure a comprehensive care plan was developed for range of motion for 1 of 3 residents reviewed for range of motion in a total sample of 14 residents reviewed for care plans. (Resident #2)</p> <p>Finding includes:</p> <p>During an observation, on 2/18/2014 at 11:00 AM, Resident #2 had visible foot drop. No visible splinting device for the lower extremities was observed.</p> <p>Record review, on 12/18/2014 at 11:17 AM, of the Care Plans for Resident #2 indicated no care plan for Range of motion had been developed or included.</p> <p>The Resident ADL (Activities of Daily Living) information sheet used by the CNAs as their worksheet, provided on 12/15/2014, indicated Resident #2 was to receive Passive Range of Motion (PROM) to bilateral lower extremities (BLE).</p> <p>The Quarterly Minimum Data Set assessment (MDS), dated 7/25/2014, indicated resident #2 had impairment on both lower extremities. The quarterly MDS assessment, dated 10/03/2014, indicated resident #2 was functionally</p>	F 279	<p>F279 Develop comprehensive Care Plans It is the standard of this facility to ensure a comprehensive care plan is developed for each resident, including those who receive range of motion exercises <u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> Resident #2 has been and will continue to receive ROM to her upper and lower extremities. Pre interview of Certified Nursing Aides #3 and #4 they did not indicate to the surveyor on 12/18/14 at 11:03am that resident #2 did not receive ROM exercises to her lower extremities. C.N.A. #3 and C.N.A. #4 indicated that the surveyor questioned if they performed ROM to resident #2 which both C.N.A.s indicated yes but the surveyor never questioned if it was upper or lower. Resident #2 is screened quarterly for physical and occupational therapy. Therapy services have not seen a change in resident #2's foot drop to warrant therapy. A care plan was put into place on 12/18/14 addressing resident #2 foot drop and the current ROM program resident #2 has been on. <u>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</u> An audit was completed on 12/20/14 on all residents who receive ROM to</p>	01/09/2015

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	<p>limited and impaired in range of motion for both lower extremities.</p> <p>During an interview, on 12/17/2014 at 3:13 PM, PT (Physical Therapist) #2, indicated resident #2 had not been getting Physical Therapy or Occupational Therapy.</p> <p>An interview was conducted, on 12/18/2014 at 11:03 AM, with Certified Nursing Aide (CNA) #3 and CNA #4. They indicated Resident #2 received range of motion exercises for her upper body, but no range of motion exercises for her lower extremities.</p> <p>During an interview, on 12/18/2014 at 11:26 AM, the Director of Nursing (DON) indicated CNA staff perform range of motion (ROM) exercises with the residents. The DON provide the "Activities of Daily Living (ADL) Flow Record / Treatment Record". The record indicated Resident #2 was receiving ROM exercises to her lower extremities three times a day. The DON indicated the order for ROM would be a standard CNA procedure.</p> <p>During an interview, on 12/18/2014 at 2:08 PM, the Administrator indicated ROM exercises were a standard CNA practice, and no care plan was needed.</p>		<p>ensure he or she has appropriate care plans in place. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</u></p> <p>_Residents who require ROM will be care planned upon admission or when the need arises. The IDT will continue to monitor care plans weekly during care plan meetings and as new needs for ROM are identified. The IDT will review residents receiving ROM weekly during the weekly Standards of Care meeting.</p> <p>Occupational and physical therapy will continue to perform quarterly screens per facility policy. <u>How will the corrective action be monitored to ensure the deficient practice will not recur?</u></p> <p>_The DON or designee will monitor contractures at least 5 days a week. New ROM needs will be discussed with the IDT as indicated above. A care plan will be put into place as a new need for ROM is needed. The MDSC will complete monthly audits of ROM care plans and bring those audits to the monthly QA committee meeting for review for the next 60 days. After 60 days the QA committee may decide to stop the requirement for the reporting results if 100% compliance has been achieved.</p>	

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F 371 SS=F Bldg. 00	<p>The Administrator indicated if the resident had decreased ROM, the resident should be on a restorative program.</p> <p>During an interview, on 12/19/2014 at 10:48 AM, the DON was asked why Resident #2 had not been care planned for foot drop. The DON indicated, during an audit, Resident #2 was missed.</p> <p>During an interview, on 12/22/2014 at 1:23 PM, the Administrator provided a recently developed Care Plan, dated 12/18/2014, for Resident #2. The Care Plan listed under the "Problem" heading, that the resident was "admitted with foot drop. My foot drop will not get worse." The goal listed stated, "My contractures and foot drop will remain stable thru the next review:" No review date was listed. The interventions listed were, "Provide routine AM & PM ROM care as I [resident] will allow and accept. Therapy to screen prn [as needed]. Therapy to follow prn. Notify MD/RP [Medical Doctor / Responsible Party] prn of changes."</p> <p>3.1-35(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -</p>			

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	<p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review the facility failed to prepare food in a sanitary manner related to duct work located above the food prep area in the kitchen. This had the potential to affect 35 of 35 residents served from the kitchen.</p> <p>Findings included:</p> <p>An observation and interview was conducted during the initial tour of the kitchen, on 12/15/2014 at 11:19 AM, with the Dietary Manager. A section of duct work, near the ceiling, located above the aisle way between the stove and food prep table was observed. The ductwork was covered with a layer of insulation board. The insulation board had several rows of tape holding the pieces of board to the sides of the ductwork. The edge of the insulation board was exposed and yellow insulation was visible. A piece of tape, one inch by one half inch, was wafting in the air current from the air intake vent it was covering. The noon meal of meatloaf, stir fry, brussels sprouts, and hot peach delight was being prepared.</p>	F 371	<p>F371 Food Procure, Store/Prepare/Serve – Sanitary</p> <p>The facility respectfully requests a face to face IDR for F371. The facility believes it has meet the requirement for F371.</p> <p>It is the policy of the facility that food is procured, stored, prepared and served in sanitary conditions.</p> <p><u>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>-</p> <p>The duct work was covered with aluminum foil and taped at 11.45am on 12/15/14. The duct work had been exposed approximately at 11:00am on 12/15/2014 due to condensation leaking.</p> <p>The facility is questioning the relevance of the 2567 mention of the walls and ceiling cleaning schedule when no issues were noted on the walls or ceiling in the kitchen</p> <p><u>How are other residents having the potential to be affected by the deficient practice will be identified and what corrective action will be taken?</u></p> <p>No residents were affected by this</p>	01/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/22/2014
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
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	<p>An interview was conducted on 12/22/2014 at 11:30 AM, with the dietary manager. She indicated the walls around the dishwasher area were washed everyday and produced a kitchen cleaning calendar showing the task was completed. The other walls and the ceiling were not listed on the cleaning calendar to indicate when they were to be cleaned. She further indicated the other walls in the kitchen were washed annually and as needed. The ductwork had a piece of aluminum foil over it, covering the edges of the insulation board, and secured with tape. She indicated the environmental supervisor came in and wrapped the ductwork and was working on ordering " stuff for it " .</p> <p>An interview was conducted, on 12/22/2014 at 2:30 PM, with the environmental supervisor. He indicated he has been " in on some of the deep cleaning in the kitchen " . He further indicated deep cleaning in the kitchen was done once a month and included wiping down the ceilings, walls, vent covers on the walls, dusting pipes and rails near the ceiling. He indicated the ductwork was covered with insulation board for condensation reasons. He indicated there was a leak coming through the duct work and they recently changed the ductwork on the roof. The</p>		<p>deficient practice.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>The DSM will continue to assess the duct work at least five days a week to ensure the board is secured and it is not leaking. If an issue is seen the DSM will alert the Environmental Supervisor of the problem and the necessary action will be taken.</p> <p>- <u>How will the corrective action be monitored to ensure the deficient practice will not recur?</u></p> <p>Any issues noted to the duct work will be brought to the daily management meeting by the DSM. The environmental supervisor will immediately address any issues noted. Issues noted will be brought before the QA monthly committee meeting to ensure appropriate action was taken.</p>	

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT COLUMBUS			STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203		
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	ductwork was the fresh air intake for the hood above the stove. 3.1-21(i)(3)				