

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 27, 28, 29, 30 and November 2, 2015</p> <p>Facility number: 000341 Provider number: 155459 AIM number: 100286550</p> <p>Census bed type: SNF/NF: 26 Total: 26</p> <p>Census payor type: Medicare: 1 Medicaid: 21 Other: 4 Total: 26</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on November 9, 2015.</p>	F 0000		
F 0248 SS=D Bldg. 00	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive 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 individual activities to meet resident needs as assessed in the activity assessment and written plan of care. This affected 3 of 11 residents who met the criteria for activities. (Resident #29, #17, and #35)</p> <p>Findings include:</p> <p>On 10/27/2015 at 2:23 p.m., Resident #29 was observed asleep in bed.</p> <p>On 10/27/2015 at 12:06 p.m., Resident #29 was observed up in his wheelchair, in the dining room and staff were unable to wake him to eat lunch. Staff took him back to his room. He had been observed in bed, asleep all morning and not observed awake or in any activities. He spoke but kept his eyes closed.</p> <p>On 10/28/2015 at 3:07 p.m., Resident #29 was observed asleep in bed; his TV was on, resident was facing the head of his bed, and his TV was at the foot of his bed.</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 New Castle desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 12/02/15. It is the policy of this facility to provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident, including provision of individual activities to meet resident needs as assessed in the activity assessment and written plan of care. 1. <u>What corrective action will be done by the facility?</u> A new Activity Assessment has been completed for Resident #29, #17 and #35 and was updated to reflect the needs and interests of this resident. The plan of care has been revised as of 11/30/15 to</p>	12/02/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/02/2015	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE				STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362			
(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 10/29/2015 at 9:59 a.m., Resident #29 was observed asleep in bed, lying with his head at the foot of his bed.</p> <p>On 10/29/2015 at 12:17 p.m., CNA #2 took his lunch in his room and tried to feed him and she had to keep waking him up. He was in bed and had been asleep when she entered the room.</p> <p>On 10/29/2015 at 1:03 p.m., Resident #29 was observed in bed, asleep.</p> <p>On 10/30/15 at 9:30 a.m. Resident #29 was observed in bed asleep.</p> <p>On 10/30/15 at 3:30 p.m. Resident #29 was observed in bed asleep.</p> <p>On 11/02/2015 at 9:24 a.m., Resident #29 was observed asleep in bed and his breathing was loud.</p> <p>On 11/02/2015 at 11:45 a.m., Resident #29 was asleep in bed and when spoken to, awoke, spoke, then went back to sleep.</p> <p>On 11/02/2015 at 3:32 p.m., RN #3 indicated Resident #29 is in bed a lot, but all of that time he is not sleeping. She said she took him the phone yesterday to talk to his son, and he was awake.</p>		<p>reflect any changes from earlier assessments. The 2567 did not reflect the fact that the former Activity Director left without notice prior to the annual survey. Since the time of survey, a designated staff member has been assigned to coordinate the daily activities program full-time while the facility is securing a permanent replacement. The facility is arranging consultation to this temporary replacement from outside professional resources during this time. The facility has employed Lacy Beyl and Company, Inc. for weekly consultation for the next month to the facility designated staff member. In addition, the facility continues to run advertisements and to conduct interviews in an effort to fill the vacant position as quickly as possible with the most qualified candidate. 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 this practice. A new Activity Assessment has been completed on all residents in order to update and ensure that current individual needs and interests have been identified. The IDT will update all residents' plan of care by 11/30/15 with interventions designed to meet these needs and interests identified in the recent activity assessments. If any member of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/02/2015	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE				STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362			
(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 #29's record was reviewed on 10/29/2015 at 2:38 p.m. Current physician's orders, dated October 2015, indicated Resident #29 had diagnoses that included, but were not limited to; Alzheimer's disease, dementia, behavioral disturbances, high blood pressure, prostate problems, non insulin dependent diabetes mellitus, chronic urinary tract infections, depression, urinary retention, gastro esophageal reflux disorder, insomnia, and blind in his right eye. The physician's orders included the following activity orders: 11/3/14 - up as the residents wants in a wheelchair, and 10/31/14 - may participate in activities per plan.</p> <p>A Quarterly Minimum Data Set assessment, dated 8/7/15, indicated Resident #29 was moderately impaired in cognitive decisions for daily decision making, makes self understood, understands others, and has had no behaviors including hallucinations or delusions.</p> <p>An Activity Assessment ,dated 11/3/14, indicated Resident #29's current interests were sports, music, spiritual/religious activities, watching movies, helping others/volunteer, and parties/social events. The assessment indicated he</p>		<p>the IDT identifies a resident who is not participating in activities or who does not appear to be receiving activities in accordance with his/her individual needs or interests, the manager identifying the issue will bring this resident's situation to the next scheduled morning IDT meeting which occurs at least 5 days a week for review and discussion by the entire team. Interventions that are developed as a result of this review will be added to the resident's care plan and the Activity Director will develop activities appropriate to the identified needs or interests at that time. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> The Activity Assessment for all new admissions and re-admissions will be reviewed after day fourteen by the IDT at the next scheduled morning management meeting. In addition, the facility has a Guardian Angel program wherein each IDT manager is assigned specific residents to visit at least 5 days a week with the purpose of talking with them and making observations about their care and services. The following questions/observations have been added to the forms that the Guardian Angels use for each visit to identify if there are any activity needs or interests that are not being met. The results of these interviews/observations are brought to the IDT morning</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>preferred morning activities in his room.</p> <p>A care plan dated 9/18/15, indicated: "I am not able to attend any activities due to my confusion. I sometimes don't want to do one on ones. Goals: I will participate in 1 - 1 's consist of current event, conversations, porch time (weather permitting), family visits (Daughter visits). I will refuse 1 - 1's at times. Interventions: Offer me opportunities for success and praise me as often as possible, introduce yourself to me before each interaction I get confused easily. AD will encourage me to do 1 - 1 's at time I can be talked to doing 1 - 1's."</p> <p>Activity Progress Notes, dated 8/7/15, indicated: "Quarterly Review Resident attend[s] very little activities - porch time, Bible study. Res has 1-1's (one on one activities) consist[ing] of current events, conversation, porch time. Is confused most of time. Comes to two meals out of three. Needs assistance to most meals. Naps off & all throughout day. Listens to TV daily in room. Well proceed to care plan."</p> <p>September 2015 activity tracking logs indicated Resident #29 had no activities highlighted that he had attended for the entire month.</p>		<p>management meeting that same day for review by the entire IDT. If any concerns or issues are identified by the IDT at that time, they will be addressed as outlined in question #2. The facility receives regular consultation about every 60 days for the services provided by the activities' programs. The consultant will continue to visit and monitor the activities programs that are scheduled and conducted, as well as the documentation of participation for each resident, including those requiring 1:1 visits. The Administrator will make the results of the Guardian Angel rounds specific to activities' needs available for review by the consultant, as well. Any specific recommendations made by the consultant in response to her visit will be followed up by the Activity Director and the Administrator.</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator or Activity Director will bring the results of the Guardian Angel rounds and admission/readmission assessments as related to identified needs and interests of residents, and the changes in interventions done in response to those concerns, to the monthly QA&A Committee meeting for review and recommendation. Any recommendations made by the committee will be followed</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>October 2015 activity tracking logs indicated Resident #29 had attended 6 activities for the entire month.</p> <p>On 11/02/2015 at 3:10 p.m., CNA #4 indicated Resident #29 used to go to activities when he could walk, but he doesn't like to now because he hears others and they make him mad.</p> <p>Resident #29 was not observed to participate in any activities during the survey, on 10/27/15, 10/28/15, 10/29/15, 10/30/15, and 11/2/15.</p> <p>2.) During observation on 10/27/15 at 11:08 a.m., Resident #17 was sitting in his broda chair awake in his room, there was no type of activity occurring.</p> <p>During observation on 10/27/15 at 1:47 p.m., Resident #17 was sitting in his broda chair in his room, there was music playing. Resident #17 indicated he liked music.</p> <p>During observation on 10/28/15 at 2:56 p.m., Resident #17 was laying in bed awake, there was no type of activity occurring.</p> <p>During observation on 10/29/15 at 10:17 a.m., Resident #17 was laying in bed awake, there was no type of activity</p>		<p>through by the Administrator and Activity Director who will report the results of those recommendations at the next scheduled QA&A Committee meeting. The process of reporting the results of the Guardian Angel rounds and the activity assessments done on admission and readmission will be continued on an ongoing basis. Date of Compliance: 12/2/15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>occurring.</p> <p>During observation on 10/29/15 at 10:50 a.m., Resident #17 was laying in bed talking to himself, there was no type of activity occurring.</p> <p>During observation on 10/29/15 at 12:13 p.m., Resident #17 was sitting in his broda chair awake in his room, there was no type of activity occurring.</p> <p>During observation on 10/29/15 at 12:35 p.m., Resident #17 was being assisted with his lunch by staff.</p> <p>During observation on 10/29/15 at 12:48 p.m., Resident #17 was brought back to his room by staff and was sitting in his broda chair talking to himself.</p> <p>During observation on 10/29/15 at 1:29 p.m., Resident #17 was sitting in his broda chair awake in his room, there was no type of activity occurring.</p> <p>During observation on 10/29/15 at 2:00 p.m., a female staff asked two female residents if they wanted to attend an activity. Resident #17 was not invited to the activity.</p> <p>During observation on 10/29/15 at 2:10 p.m., the Administrator in Training (AIT)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>was reading Halloween facts to residents in the dining room, Resident #17 was not in the activity.</p> <p>During observation on 10/30/15 at 10:37 a.m., Resident #17 was laying in bed awake with his glasses on, there no type of activity occurring.</p> <p>During observation on 10/30/15 at 10:42 a.m., the Administrator indicated a religious activity was getting ready to begin. Resident #17 was not invited to the activity.</p> <p>During observation on 10/30/15 at 11:45 a.m., Resident #17 was sitting in his broda chair in his room. Resident #17 asked the Social Service Director (S.S.D.) as she was walking by his room if it was time to go up to the dining room yet, the S.S.D. stated "in a little bit".</p> <p>During observation on 10/30/15 at 2:12 p.m., CNA #5 asked Resident #17 if he wanted to go the Halloween party. Resident #17 indicated yes he wanted to go and asked if she would take him. Resident #17 asked the aide what he needed to bring to the party. The resident appeared happy.</p> <p>Review of the record of Resident #17 on 10/29/15 at 1:18 p.m., indicated the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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's diagnoses included, but were not limited to, dementia, Parkinson disease, anxiety, insomnia and chronic pain.</p> <p>The Annual Minimum Data Set (MDS) assessment for Resident #17, dated 1/30/15, indicated it was very important to him to have books, newspaper, magazines, music, be around pets, keep up with the news and participate in religious activities.</p> <p>The Quarterly MDS assessment for Resident #17, dated 8/31/15, indicated the resident's vision was highly impaired, was totally dependent of two staff to transfer and totally dependent of one staff for locomotion on and off the unit.</p> <p>The activity plan of care for Resident #17, dated 9/24/15, indicated "my eyesight is highly impaired." The resident preferred activities were bible study, church services, trivia, "did you know", movies and porch time. The interventions were Activity director (A.D.) will encourage the resident to attend activities and the A.D. and aides will bring the resident to and from activities.</p> <p>The Activity review for Resident #17, dated 10/30/15, indicated the resident was blind which limited his active</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>participation in activities, but he did attend church, movies, bible study and porch time weather permitting.</p> <p>The October 2015 participation log for Resident #17 indicated on 10/18/15 the resident had music and coffee at 7:00 a.m. and church service at 3:00 p.m. The resident had a visit on 10/19/15 at 11:00 a.m. The resident did not attend or have any activities on 10/20/15, 10/21/15, 10/22/15, 10/23/15, 10/24/15, 10/25/15, 10/26/15, 10/27/15, 10/28/15 or 10/29/15. The resident attended a Halloween party on 10/30/15 at 2:00 p.m.</p> <p>3.) During observation on 10/28/15 at 3:04 p.m., Resident #35 was sitting in the hallway on a bench drinking juice.</p> <p>During observation on 10/29/15 at 9:38 a.m., Resident #35 was walking around the facility. When queried how she was doing, the resident stated "just waiting".</p> <p>During observation on 10/29/15 at 10:24 a.m., Resident #35 was walking up and down the hallway going into other residents rooms. The staff would redirect the resident out of the rooms.</p> <p>During observation on 10/29/15 at 10:55 a.m., Resident #35 was sitting in the dining room eating a snack and drinking</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>juice, there was no activity occurring.</p> <p>During observation on 10/29/15 at 12:07 p.m., Resident #35 remained in the dining room. The resident attempted to leave the dining room and the S.S.D. directed her to sit back in her chair. There was no activity occurring.</p> <p>During observation on 10/29/15 at 12:21 p.m., Resident #35 was sitting in the dining room with her head down on the table and her eyes closed.</p> <p>During observation on 10/29/15 at 12:28 p.m., Resident #35 was telling the resident next her "lets go, lets go" and was attempting to get the resident's hand.</p> <p>During observation on 10/29/15 at 12:30 p.m., Resident #35 was served her lunch.</p> <p>During observation on 10/29/15 at 1:36 p.m., Resident #35 was laying in her bed.</p> <p>During observation on 10/29/15 at 2:10 p.m., Resident #35 was sitting in the dining room while the AIT was reading Halloween facts. The resident was not engaging in the activity.</p> <p>During observation on 10/29/15 at 2:36 p.m., Dietary staff was playing a board game with 4 residents. Resident #35 was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>sitting in the dining room not engaging in any type of activity.</p> <p>During observation on 10/30/15 at 11:05 a.m., Resident #35 was in a religious activity. The resident was asleep.</p> <p>Review of the record of Resident #35 on 11/2/15 at 12:00 p.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, dementia, diabetes and anxiety.</p> <p>The Admission MDS assessment for Resident #35, dated 7/7/15, indicated it was very important for her to have books, newspaper and magazines to read, listen to music, do things with groups of people and participate in religious activities.</p> <p>The activity plan of care for Resident #35, dated 9/9/15, indicated "I have Alzheimer but still attend most activities". The resident preferred bible study, easy bingo, painting class, church services, nail time, visiting, taking a walk, humming/singing, bird watching and family visits. The interventions were engage the resident in group activities, give verbal reminders of activities before they start, praise all efforts, assist me to access TV and radio, encourage family involvement, provide an materials or objects I enjoy and provide brief positive</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>interactions throughout the day.</p> <p>The October 2015 activity participation log for Resident #35 indicated on 10/18/15 the resident had music and coffee at 7:00 a.m. and church services at 3:00 p.m., the resident did not participate in any activity on 10/19/15, 10/20/15, 10/21/15 or 10/22/15. The resident had an activity of bible study on 10/23/15 at 10:30 a.m. The resident did not participate in any activities on 10/24/15, 10/25/15, 10/26/15, 10/27/15 or 10/28/15. The resident watched TV game shows on 10/29/15 at 10:00 a.m. and had candy and board game at 2:00 p.m. The resident had bible study on 10/30/15 at 10:30 a.m.</p> <p>Interview with the Administrator on 11/2/15 at 11:12 a.m., indicated the facility did not have an Activity Director. The Administrator indicated the facility was using cooks, housekeeping staff, S.S.D. and managers to provide activities until the facility was able to obtain a Activity Director.</p> <p>The Activity policy provided by the Administrator on 11/2/15 at 1:45 p.m., indicated residents who do not consistently actively participate in group activities will receive individual programming. "An individualized</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/02/2015	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE				STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362			
(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 0279 SS=D Bldg. 00	<p>program plan will be completed for those residents identified as needing one to one programming.</p> <p>3.1-33(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview the facility failed to create appropriate interventions for a fall for 1 of 17 residents reviewed for care plans, Resident #12.</p> <p>Findings include:</p>	F 0279	F279 It is the policy of this facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment, including appropriate interventions	12/02/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Review of Resident #12's record indicated the resident's diagnoses included but were not limited to Schizophrenia, Bipolar disorder, unspecified dementia without behavioral disturbance, arthropathy, essential hypertension, major depressive disorder, unspecified osteoarthritis and edema.</p> <p>10/29/15 at 10:20 a.m., interview with RN #1 indicated "resident fell in her room, she got up to get something out of her chest of drawers did not have her walker, tripped and fell."</p> <p>Review of falls investigation report dated 10/22/15 at 6:15 p.m., indicated Nursing Description: "Resident noted to be lying on the floor of her room. Resident lying on her back with her head oriented toward the south wall and her feet oriented toward the door. Resident noted to be in the space between the beds and overbed tables. Resident states that she was walking back toward her bed after getting her pajamas from the closet. She states that she fell, but doesn't know what caused her fall." "Immediate Action Taken: Resident assisted. Assisted to a sitting position. Then assisted to her feet and onto the bed. Predisposing environmental: furniture. Predisposing physiological: other. Predisposing situation: none. Other information:</p>		<p>for those residents identified as being at risk for falls.</p> <p>1. <u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u> After reviewing the results of the fall investigation for Resident # 12, she has agreed to having hot pink duct tape applied to her walker to help her remember to use her walker. Staff will continue to remind her to use her walker if observed without it. Care plans and C.N.A assignment sheet were updated to show this new intervention. The IDT (Interdisciplinary Team) members will be re-trained by the Nurse Consultant on the process of reviewing fall investigation results, current interventions, and developing new interventions designed to prevent future falls by 11/30/15.</p> <p>2. <u>How other residents having the potential to be affected by the same practice will be identified and what corrective actions(s) will be taken?</u> All residents who fall or have been assessed as having a fall risk have the potential to be affected by this practice. 100 % audit of care plans for residents identified as at risk for falls has been completed and interventions were updated as deemed necessary by the IDT for fall prevention. No other residents have been identified as being affected;</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/02/2015
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE			STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362		
(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 stated "Right before I fell my right ear was aching." Nurse assessed right ear and found a large piece of wax in ear canal. Wax removed and she stated "My ear is not aching anymore." No further complaints."</p> <p>Nursing notes dated 10/22/15 6:50 p.m., indicated resident is alert and oriented x 3. Speech is clear. Resident is able to make needs and wants known without difficulty. Resident has laceration to back of head. Measures approximately 2 cm in length. Area closed. PEARLLA (pupils equal, round, reacts to light and accommodation). Bilateral hand grips good. Bilateral lower extremity strength good. Resident is able to follow commands well. Active range of motion is as per normal for resident. No other injuries noted.</p> <p>Fall assessment completed 10/22/15 with a score of 65, high risk for falls.</p> <p>Review of quarterly Minimum Data Assessment dated 10/9/15 indicated resident's mental status was alert, oriented, reliable with no cognitive impairments.</p> <p>Interview on 11/2/15 at 2:10 p.m., with Resident #12 indicated "the laceration on the back of my head is healed", doesn't</p>		<p>however, if the DON or other members of the IDT identify a resident who has fallen but has not had new interventions developed to prevent future falls, they will bring the resident's fall investigation results to the next scheduled interdisciplinary morning meeting for review and development of new interventions. Any changes or additions to interventions will be added to the resident's care plan and CNA assignment sheet at the same time. Communication of the change in interventions will also be placed on the 24 hour report for communication to oncoming shifts.</p> <p>Once the resident's needs have been taken care of, the Administrator or DON will re-train any staff involved in not identifying or communicating fall investigation results or development of new interventions. Written counseling will be rendered as indicated by the situation.</p> <p>3. <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>Fall investigation results will be brought to the next scheduled IDT morning management meeting which occurs at least 5 days a week for review by the team and development of new or revised interventions to prevent future falls. Care plans and CNA</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/02/2015	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE				STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362			
(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>know why she fell, "it just happened." Resident indicated "I did not have my walker with me at the time of my fall."</p> <p>Care plan for falls in place. "Focus: Is at risk for falls, Goal: I will not get hurt if I fall. Interventions: Remind her to wear nonskid footwear. Created 1/16/15 Complete my fall risk assessment at least quarterly. Created 10/10/15 Follow facility falling star program. Created 10/10/15 Monthly med review. Created 10/10/15 Notify my family and MD if I would fall. Created 10/10/15 Assess ears for possible ear infection and contact MD accordingly. Created 10/26/15"</p> <p>Review on 11/2/15 at 12:30 p.m., of the facility care plan policy indicated ... Purpose: To identify problems and developmental solutions for the coordination of resident care... 6. Problems will be identified through completion of interdisciplinary assessments, interviews and observations, and the Resident Assessment Instrument... 8. Measurable, specific, time limited goals for each identified concern will be established.</p> <p>3.1-35 (a)(b)(1)</p>		<p>assignment sheets will be updated at that time, with communication of the change in interventions placed on the 24 hour report for communication to oncoming shifts. The DON or designee will monitor care plans at least 5 days a week to make sure that a new intervention has been added as indicated by the results of the fall investigation. In addition, residents who have experienced falls will be brought to the weekly Standard of Care meeting for further review of current interventions for effectiveness. (See attachment #1) Any identified concerns or issues with this process will be addressed as indicated in question #2. 4. <u>How will corrective actions be monitored to ensure the deficient practice does not recur and what QA will be put in place? ..</u> The DON/designee will bring the results of the audits to the monthly QA meeting for further review and consideration by the committee members. Any recommendations that are made will be followed through by the DON, who will report the results of those recommendations at the next monthly QA Committee. The written audits by the DON will continue for the next 60 days. After that time, if there is 100% compliance, the QA Committee may decide to stop the audits; however, the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/02/2015
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE			STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362		
(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 0280 SS=D Bldg. 00	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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 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 record review and interview the facility failed to revise a care plan with an appropriate intervention after a resident's fall, for 1 of 18 residents reviewed for care plan revisions. (Resident #37)</p>	F 0280	<p>DON's/designee's review of the care plans at least 5 days a week will continue on an ongoing basis. Date of Compliance: 12/02/15</p> <p>F280 It is the policy of this facility that the resident has the right to participate in planning care and treatment of changes in care and treatment, including revision of care plans with appropriate interventions after a resident fall.</p>	12/02/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>Findings include:</p> <p>During an interview, on 10/28/15 at 9:40 a.m., Resident #37 indicated he has a chair alarm and demonstrated it by placing his hands on the arm rests of his wheelchair and pushing up until he lifted up off the seat and the alarm sounded. He said he has gotten up and had fallen. He was alert, oriented, and able to remember details</p> <p>On 10/28/2015 at 3:10 p.m., Resident #37 was observed in the therapy room sitting in his wheelchair, and said he was waiting for his wife. His wheel chair alarm was on his wheel chair.</p> <p>On 10/29/2015 at 9:57 a.m., Resident #37 was observed lying on his right side in bed with his oxygen tubing in place under his nose, his eyes closed, and he was fully dressed in street clothes.</p> <p>On 10/29/2015 at 12:15 p.m., Resident #37 was observed sitting in his wheelchair in the small dining room eating lunch.</p> <p>Resident #37's record was reviewed on 10/30/2015 at 11:28 a.m. Physician's orders, dated October 2015, indicated Resident #37 had diagnoses that</p>		<p><u>1.What corrective actions(s)will be accomplished for those residents found to have been affected by thedeficient practice?</u> Resident # 37 has had his careplan reviewed and revised to include screening by therapy for safe transfer. Physical therapy has done an evaluation andhas treated the resident. Once therapy has treated him, his careplans and CNA assignment sheet will be updated to include any therapyrecommendations. The IDT (Interdisciplinary Team)members will be re-trained by the Nurse Consultant on the process of reviewingfall investigation results, current interventions, and developing newinterventions designed to prevent future falls by 11/30/15.</p> <p><u>2.How other residents havingthe potential to be affected by the samepractice will be identified and what corrective actions(s) will be taken?</u> All residents who fall or havebeen assessed as having a fall risk have the potential to be affected by thispractice. 100 % audit of care plans for residents identified as at risk forfalls has been completed and interventions were updated as deemed necessary by the IDT for fallprevention. No other residents have beenidentified as being affected; however, if the DON or other members of the IDTidentify a resident who has fallen but has not had new interventions</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>included, but were not limited to, end stage chronic obstructive pulmonary disease, high blood pressure, prostate problems, edema, weakness, hyperlipidemia, and gastro esophageal reflux disease.</p> <p>An Admission Minimum Data Set assessment, dated 10/2/15, indicated Resident #37 was moderately impaired in cognitive skills for daily decision making, he required extensive assist of one for transfers and walking, used a wheel chair, was unsteady with balance; he needed human assistance, and had fallen in the past 6 months prior to admission.</p> <p>An unwitnessed incident report indicated Resident #37 fell on 10/16/15 at 7:20 p.m. The incident report included, but was not limited to, "Resident noted to be on floor of his room, lying in the space between the beds. Resident's body oriented perpendicular to his bed. Noted to have a small area to back of his head. Area measures 0.5 cm (centimeters). Moderate amount of blood noted on floor next to resident's head. Resident stated that he fell." The new intervention added on 10/19/15, and was "Re-educated staff on all fall precautions."</p> <p>Progress notes dated 10/17/15 at 12:24</p>		<p>developed to prevent future falls, they will bring the resident's fall investigation results to the next scheduled interdisciplinary morning meeting for review and development of new interventions. Any changes or additions to interventions will be added to the resident's care plan and CNA assignment sheet at the same time. Communication of the change in interventions will also be placed on the 24 hour report for communication to oncoming shifts.</p> <p>Once the resident's needs have been taken care of, the Administrator or DON will re-train any staff involved in not identifying or communicating fall investigation results or development of new interventions. Written counseling will be rendered as indicated by this situation.</p> <p><u>3. 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>Fall investigation results will be brought to the next scheduled IDT morning management meeting which occurs at least 5 days a week for review by the team and development of new or revised interventions to prevent future falls. Care plans and CNA assignment sheets will be updated at that time, with communication of the change in interventions placed on the 24 hour report for communication to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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.m. indicated: "Resident noted to be lying on floor of his room in the space between the beds. Resident noted to have head turned toward the door and oriented toward roommates bed, with his body perpendicular to his own bed. Noted to have 0.5 cm area to the back of his head with moderate amount of blood noted on the floor next to his head. Area cleansed. No further bleeding noted from area. Resident assessed. No dislocations or deformities noted. No further injuries noted. AROM (active range of motion) as per normal for resident. Resident assisted per two staff to sitting position, and then to bed. Resident alert and oriented as per normal for resident. PEARLLA. (Pupils equally reactive to light and accommodation) Resident denies any pain or discomfort at this time."</p> <p>During an interview, on 11/02/2015 at 3:43 p.m., RN #3 indicated she did not know why Resident #37 fell on 10/16/15. She said she doesn't have any of that information, and the new intervention was to re-educate staff on all the interventions that are currently in place. She said when they re-educate staff on the interventions it is because one of the interventions wasn't followed.</p> <p>On 11/02/2015 at 4:23 p.m., RN #3</p>		<p>oncoming shifts. The DON or designee will monitor care plans at least 5 days a week to make sure that a new intervention has been added as indicated by the results of the fall investigation. In addition, residents who have experienced falls will be brought to the weekly Standard of Care meeting for further review of current interventions for effectiveness. (See attachment #1) Any identified concerns or issues with this process will be addressed as indicated in question #2. <u>4. How will corrective actions be monitored to ensure the deficient practice does not recur and what QA will be put into place? .</u> The DON/designee will bring the results of the audits to the monthly QA meeting for further review and consideration by the committee members. Any recommendations that are made will be followed through by the DON, who will report the results of those recommendations at the next monthly QA Committee. The written audits by the DON will continue for the next 60 days. After that time, if there is 100% compliance, the QA Committee may decide to stop the audits; however, the DON's/designee's review of the care plans at least 5 days a week will continue on an ongoing basis. Date of Compliance: 12/2/15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>indicated Resident # 37 was trying to transfer himself, but she didn't know if he was trying to get to the bed or get up out of the bed. He had fallen before, and they put notes out with new interventions and wasn't sure if that information was put out so they went over all of them again with the staff. No new intervention was put in place after that fall except for re-educating the staff.</p> <p>A policy for "Care Planning" was provided by RN #3 on 11/2/15 at 12:30 p.m. The policy indicated, but was not limited to, "Policy: A care plan is initiated upon the admission/readmission of each resident to the facility, reviewed, and updated at intervals throughout the resident's length of stay. Purpose: To identify problems and developmental solutions for the coordination of resident care...Each discipline is to initiate or revise his/her portion of the care plan...."</p> <p>A policy for "Fall Prevention Program" was provided by the Administrator on 10/30/15 at 1:22 p.m. The policy indicated, but was not limited to, "Policy: It is the policy of this facility to identify residents at risk for falls and to implement a fall prevention program to reduce the risk of falls and possible injury...11. The care plan will be updated to show the resident's risk of falls and all</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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 0309 SS=D Bldg. 00	<p>interventions put into place to prevent falls, including the identifying marker that the facility uses...."</p> <p>3.1-35(d)(2)(B)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to address and implement interventions for a resident who complained of dry mouth and lips and extreme thirst, for 1 of 2 resident reviewed for hydration of 2 who met the criteria (Resident #32) and failed to identify, provide timely treatment, and document ongoing assessments for a great toe wound for 1 of 1 residents reviewed for skin conditions (non-pressure related). (Resident #15)</p> <p>Findings include:</p> <p>1. Resident #32's record was reviewed on 10/29/15 at 10:59 a.m. Her diagnoses documented on her October 2015, physician recapitulation orders included, kidney disease, diabetes, hypertension,</p>	F 0309	<p>F309</p> <p>It is the policy of this facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive care plan, including implementing interventions for residents who have dry lips and mouth and complain about thirst, as well as those who require timely treatment and ongoing assessments for wounds.</p> <p>1. <u>What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?</u> Resident #15 was seen again by the podiatrist on 11/16/15 and was treated for an ingrown toenail. The treatment done by the podiatrist on that date resulted in a small open area. An order was</p>	12/02/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/02/2015	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE				STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362			
(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>malnutrition, and debility.</p> <p>Resident #32's October 2015 physician's recapitulation orders indicated she received 237 ml (milliliters) of Nova Source Renal 2 Cal by bolus tube feeding 5 times a day, followed by 100 ml water flush after each feeding. Her free water would be limited to 1800 ml a day. She received dialysis on Monday, Wednesday, and Friday. She received oxygen at 2 liters per minute (LPM) from a nasal cannula to keep her oxygen saturation above 90%.</p> <p>Resident #32's quarterly Minimum Data Set (MDS) assessment dated 9/4/15, indicated she was understood and had the ability to understand others. She was moderately impaired in her daily decision making skills. She required extensive assistance of 2 persons for bed mobility and transfer. She did not walk. She required extensive assistance of 1 person to eat.</p> <p>A plan of care for Resident #32 initiated 9/8/15, and revised on 9/30/15, indicated she was at risk for dehydration due to her tube feedings and she didn't drink very much. Her goal was to not experience any symptoms of dehydration. Her interventions to prevent dehydration included but were not limited to, her</p>		<p>received for a treatment to that area, which is being documented as ordered. Resident # 32 is in the hospital at this time due to development of spleen abscess. All nursing staff has been re-trained on oral care, including the need for reporting observations and resident complaints regarding dry lips, tongue, or complaints of thirst to the charge nurse (if a CNA) and the physician (if a nurse). In addition, the licensed staff has been re-trained on the need for ongoing assessments and appropriate treatments for open areas or wounds that are observed on residents, including those obtained as a result of treatment done through the services of a contracted provider. All nursing staff was also re-trained on the facility policy for CNAs documenting skin checks on shower/bath days for each resident and communicating the findings to the charge nurse. The licensed staff was re-trained on the facility policy for documentation of weekly skin assessments for all residents, with communication to the attending physician if any skin issues were identified as a result of the assessments or shower day skin checks.</p> <p>2. <u>How will other residents be identified and what corrective action will be taken?</u></p> <p>All residents have the potential to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/02/2015	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE				STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362			
(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>hydration status would be assessed daily or as ordered. Her tube feedings and flushes would be provided as ordered. Her dehydration plan of care did not indicate interventions to relieve her dry mouth and lips or her complaints of extreme thirst.</p> <p>An interview with Resident #32 on 10/27/15 at 11:11 a.m., indicated she had not received the fluids she wanted between meals. She was on a fluid restriction. She complained of her mouth being dry and being thirsty several times during the interview. She indicated she felt like she could drink a tub of water. Her lips were dry with thick peeling skin.</p> <p>An interview with CNA #7 on 10/27/15 at 11:16 a.m., indicated Resident #32 was on a fluid restriction. She indicated Resident #32 forgot sometimes when she had something to drink and Resident #32 asked for something to drink about every 3 minutes.</p> <p>An interview with CNA #7 on 10/27/15 at 11:17 a.m., indicated she had informed LPN #8 of Resident #32's request for something to drink and LPN #8 had informed her Resident #32 could not have anything to drink and would receive fluids at lunch.</p>		<p>be effected by this practice. Totalbody assessments were completed on all residents. The attending physician wasnotified of any newly identified skin issues and treatments were ordered. Theresidents' care plans were updated as a result. No other residents have beenidentified with dry lips, mouth, tongue, or having complaints of thirst. If a concern arises as the resultof the Guardian Angel rounds regarding the condition of a residents' tongue,lips, mouth or documented complaints of thirst by the resident, or if apreviously identified wound is found without an ordered treatment, the DON willintervene on the resident's behalf immediately by assessing the resident's needherself and following through with physician notification for orders to addressthe needs. Once the resident is taken care of, the DON will follow up with thestaff involved by re-training each in the facility policy for oral care andobservations of the tongue, lips, mouth or complaints of thirst by theresident, or the policy on routine skin assessments, physician notification,and follow through with ordered treatments. The DON will also renderprogressive disciplinary action for instances of continued non-compliance withfacility policies affecting resident care and services.</p> <p>3. <u>What measures will be put</u></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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 10/29/15 at 10:13 a.m., Resident #32 was observed lying in bed with her head elevated 30 degrees. She had oxygen running through a nasal cannula at 2 LPM. She complained of being thirsty and stated "I could drink a barrel of water." Her lips and tongue were dry and her tongue had a white appearance on both sides. She denied brushing her tongue or mouth or using any type of mouth drops to relieve her dry mouth.</p> <p>On 10/29/15 at 1:35 p.m., Resident #32 was observed lying in bed with her head elevated 30 degrees. She asked if she could have a drink of water. Staff were notified of Resident #32's request.</p> <p>On 10/29/15 at 1:40 p.m., CNA #9 gave Resident #32 a toothette wet with water per instructions from the Director of Nursing (DON). The DON had informed CNA #9, Resident #32 could not have any fluids to drink at that time.</p> <p>An interview with the DON on 10/29/15 at 1:42 p.m., indicated she had spoken with a nurse at Resident #32's dialysis center on 10/28/15, and was informed by the dialysis nurse Resident #32 could not receive any extra fluids by mouth through out the day exceeding her fluid restriction. The DON indicated the nurse at Resident #32's dialysis center informed</p>		<p><u>into place or what systemic changes will be made to ensure the deficient practice does not recur?</u></p> <p>The DON/designee will audit weekly skin assessments for compliance at least 5 days a week. (See Attachment #3) The DON will bring any identified issues to the next scheduled IDT morning management meeting which meets at least 5 days a week, as well as the weekly Standard of Care meeting. (See attachment # 4). Podiatry progress notes will be reviewed by the charge nurse, who will note any physician orders that have been received. In the next scheduled morning meeting, the DON /designee will compare orders with "Schedule Report of Podiatry Visit" to ensure that all orders have been noted for all residents seen by the podiatrist. In addition, the facility has a Guardian Angel program wherein each IDT manager is assigned specific residents to visit at least 5 days a week with the purpose of talking with them and making observations about their care and services. The guardian angel rounds check list has been revised to include observations or complaints about "oral care/lips-tongue-moist", complaint of thirst" (see attachment # 2). The results of these interviews/observations are brought to the IDT morning management meeting that same</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>her Resident #32 could receive a toothette wet with water.</p> <p>On 10/30/15 at 10:03 a.m., Resident #32 was observed lying in bed with her head elevated 30 degrees. She indicated she was so thirsty it was pitiful. Her tongue was dry with a white coating and her lips were dry with white flaked areas. On her bedside table she had 4 toothette in a cup with a small amount of water and 3 toothette's lying loose on the table. Resident #32 indicated she had tried the toothette's and they didn't help to relieve her dry mouth. She indicated if she could drink a little water that would help.</p> <p>An interview with RN #12 on 10/30/15 at 10:52 a.m., indicated the physician had been in that morning and had written new orders for Resident #32 to have 50 ml flushes after her tube feedings instead of 100 ml of flushes to increase the amount of fluids she could have by mouth. Resident #32 would now be allowed to have 150 ml of fluids by mouth on day and evening shift and 65 ml of fluid by mouth on night shift. Resident #32 would also be allowed to have a toothette moistened with water, which the facility had started allowing her on 10/29/15. If Resident #32 continued to yell out for fluids, the facility would notify dialysis and inform them she was requesting to</p>		<p>day for review by the entire IDT and development of an appropriate careplan and interventions.</p> <p>If any concerns or issues are identified by the IDT or the DON at the time of observations, interviews, or audits, they will be addressed as outlined in question #2.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>The Administrator will bring the results of the Guardian Angel visits concerning oral care and complaints of thirst and the DON/designee will bring the results of her audits regarding identified skin issues and treatment orders to the monthly QA&A meeting for further review and consideration by the committee members. Any recommendations that are made will be followed through by the DON, who will report the results of those recommendations at the next monthly QA&A Committee. The written audits by the DON will continue for the next 60 days. After that time, if there is 100% compliance, the QA&A Committee may decide to stop the audits; however, the DON's/designee's review of the weekly skin assessments and treatment of them will be done at least weekly on an ongoing basis. The process of reporting the results of the Guardian Angel</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>exceed her 1800 ml fluid restriction and she would be provided a waiver to sign to consume more than 1800 ml of fluid. Resident #32 had been educated on the consequences of exceeding her 1800 ml fluid restriction but had not been offered to sign a waiver. Resident #32 made her own decisions.</p> <p>On 10/30/15 at 11:02 a.m., Resident #32 was yelling out for something to drink. She had been heard yelling out for a drink periodically throughout the survey.</p> <p>On 11/2/15 at 10:11 a.m., Resident #32 was observed lying in bed with her head elevated 45 degrees. She had dry lips and dried skin hanging off of her top lip that she was pulling on. Her tongue was rough and dry looking with some white discoloration. She complained of her mouth being dry. LPN #8 was informed of Resident #32's dry lips.</p> <p>2. Resident #15's record was reviewed on 10/30/15 at 2:10 p.m. His diagnoses documented on his October 2015 physician recapitulation orders included but were not limited to, diabetes, neuropathy, and deep vein thrombosis.</p> <p>Resident #15's annual MDS assessment dated 10/16/15, indicated he understood and had the ability to understand others.</p>		<p>rounds will be continued on an ongoingbasis as well.</p> <p>Date of Compliance: 12/2/15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>He was moderately impaired in his daily decision making skills. He required extensive assistance of 2 persons for bed mobility and transfer. He required extensive assistance of 1 person for personal hygiene and dressing. He had no foot problems.</p> <p>A podiatry exam for Resident #32 dated 9/14/15, indicated the following: "Nail Border Pathology: ...Painful borders noted on left foot toe 1 - lateral and medial and toe 2 - lateral and medial. I also noted: bleeding to medial border of left Hallux... Procedure & Plan: I Debrided 10 nail(s) using a Bur, Nail Nipper and Rasp. applied TAO to medial border L 1st toe as prophylaxis, will monitor, no new orders. I Treated xerosis using a Therapeutic Lotion. Instructions: Follow the medications and treatments described as follows: recommend emollient daily to both feet. Ongoing Pressure Relief will not be necessary. I applied Band-Aid using a Bandage, applied betadine ointment to left Hallux medial nail border and covered with a Band-Aid...."</p> <p>A Progress Note for Resident #15 dated 10/13/15, indicated Resident #15 had an area to his left great toe on the side of the nail. The area was not open and no dressing was noted. The MD was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>notified of the need for treatment to the area.</p> <p>A Progress Note for Resident #15 dated 10/14/15, indicated a new order was received for treatment to his left great toe.</p> <p>A physician's order for Resident #15 dated 10/14/15, indicated he received bacitracin and a Band-Aid treatment to his left great toe daily until healed.</p> <p>A Licensed Nurse Weekly Skin Assessment dated 10/16/15, indicated he had a dark area on his left great toenail. No further assessments were documented on his left great toe until 10/28/15.</p> <p>A Non-Pressure Ulcer Skin Assessment dated 10/28/15, indicated the Podiatrist was in on 10/13/15, and trimmed Resident #15's toenails. Resident #15 had an area on the inner side of his left great toenail. The measurements documented 10/28/15, indicated the area measured 1.7 centimeters (cm) long by 0.5 cm wide by 0.1 cm deep. Resident #15 would continue to receive a bacitracin ointment and Band-Aid treatment every day. There was no description of the wound documented on the assessment. No other measurements were documented prior to 10/28/15.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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 plan of care for Resident #15 initiated 10/19/15, and revised 10/30/15, indicated he had an open area on his toe. His goal was the area would be healed. His interventions indicated but were not limited to, his treatment would be completed as ordered. The area would be measured weekly.</p> <p>On 10/28/15 at 1:51 p.m., an observation was made of Resident #15's left great toe with RN #12. Resident #15's inner left great toenail was red with a wet appearance down the crease of the entire inner toenail and it appeared a small amount of skin was missing near the top of the toenail. RN #12 indicated when she pulled the bandage off it bled. RN #12 indicated the Podiatrist had trimmed Resident #15's toenails and caused the area and the toenail might have been ingrown. RN #12 cleaned and measured the area on the left great toenail and then placed bacitracin and a Band-Aid on it. RN #12 indicated she had no previous assessments documented on his left great toenail.</p> <p>An interview with RN #13 on 11/2/15 at 3:47 p.m., indicated Resident #15's last podiatry visit was 9/14/15, and not 10/13/15.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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 0311 SS=D Bldg. 00	<p>The Non-Pressure Skin Conditions procedure provided by the DON on 11/2/15 at 5:11 p.m., indicated the following: "Procedure: ...4. To document the healing process, the nurse looks at the non-pressure skin area, and using the "Assessment Of Other Skin Abnormalities" form (Hc-N-41), documents the condition of the skin area each week...."</p> <p>3.1-37(a)</p> <p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. Based on observation, interview, and record review, the facility failed to thoroughly assess a resident's bladder function and develop a plan of care to address her incontinence status, for 1 of 3 residents reviewed for Activities of Daily Living (ADL's), of 14 who met the criteria for ADL's. (Resident #32)</p> <p>Findings include:</p> <p>1. Resident #32's record was reviewed on 10/29/15 at 10:59 a.m. Her diagnoses documented on her October 2015, physician recapitulation orders included, kidney disease, diabetes, hypertension,</p>	F 0311	<p>F311 It is the policy of this facility for each resident to be given the appropriate treatment and services to maintain or improve his or her abilities, including assessment of a resident's bladder function in order to develop a plan of care to address the resident's incontinence status. 1. <u>What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?</u> Resident # 32 was admitted to the hospital due to development of spleen abscess prior to initiation of the 5 day voiding pattern and</p>	12/02/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>malnutrition, and debility. She was admitted to the facility on 5/30/15.</p> <p>Resident #32's quarterly Minimum Data Set (MDS) assessment dated 9/4/15, indicated she was understood and had the ability to understand others. She was moderately impaired in her daily decision making skills. She required extensive assistance of 2 persons for bed mobility and transfer. She required total assistance of 1 person to toilet. She did not walk.</p> <p>A New Admission Bladder Assessment Form for Resident #32 with no date indicated she was incontinent of bladder. The Bladder Assessment Form was incomplete. The Bladder Assessment Form indicated if a resident was incontinent, the facility would begin documentation of a 5 day voiding pattern. No 5 day voiding pattern was available in Resident #32's record.</p> <p>An interview with Resident #32 on 10/29/15 at 10:13 a.m., indicated she knew when she needed to urinate. She stated "they keep depends on me so I don't have to get up and go." She demonstrated the knowledge to use her call light.</p> <p>On 10/29/15 at 1:49 p.m., CNA #9</p>		<p>care plan update. She will have her bladder function reassessed upon return to the facility.</p> <p>The nurses have been re-trained on the facility policy for assessment of bladder function upon admission and readmission to the facility, including the development of a care plan based on the results of the bladder assessment and the 5 day voiding pattern.</p> <p>2. <u>How often resident having the potential to be affected by the same practice will be identified and what corrective actions(s) will be taken</u></p> <p>All incontinent residents have the potential to be affected by this practice. A 5-day voiding pattern will be completed on all residents with a BIMSScore > 7 or who require limited assist or less with transfers/ambulation to assist in developing plan for addressing the resident's incontinence. In the future, if the DON or other member of the IDT finds that a resident's incontinence is not being addressed by staff, the DON will make sure that a bladder assessment is current with the resident's condition at that time. If not, a bladder assessment will be redone, and a 5-day voiding pattern will be documented. Once completed, the 5 day voiding pattern will be assessed for any patterns of incontinence and a postvoid assessment will be completed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/02/2015
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE			STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362		
(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>indicated Resident #32 did not walk and transferred with a Stand-Up Lift. CNA #9 indicated staff did not normally get Resident #32 up to toilet but would if she requested.</p> <p>On 10/29/15 at 3:30 p.m., Resident #32 was observed receiving perineal care and a brief change in bed with the assistance of CNA #4 and CNA #9.</p> <p>On 10/30/15 at 10:28 a.m., RN #12 indicated occasionally Resident #32 would inform staff she needed to toilet, but most often would not. She indicated Resident #32 was not on a toileting program.</p> <p>On 10/30/15 at 1:18 p.m., RN #12 indicated no 5 day voiding pattern had been documented for Resident #32.</p> <p>On 11/2/15 at 4:09 p.m., RN #13 indicated Resident #32 did not have any plan of care for her bladder incontinence.</p> <p>The Bladder Incontinence Program policy and procedure provided by the Administrator on 11/2/15 at 5:10 p.m., indicated the following: "Policy: Any resident identified as incontinent of urine will be evaluated for causal factors and appropriate actions will be undertaken to obtain the most effective results,</p>		<p>Acare plan and CNA assignment sheet will be updated to reflect the interventions instituted as a result of the 5 day voiding pattern. As the resident is assessed and progressing through the process for identifying a care plan and interventions for incontinence, the DON will address the lack of a current bladder assessment and plan with the nurse(s) involved. She will re-train them regarding the facility policy and will render counseling as indicated by the situation.</p> <p>3. <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>During the weekly Standard of Care meeting, all newly admitted or readmitted residents will be reviewed for their continence status as indicated by the bladder assessment. If they are incontinent an audit will be completed for the 5 day voiding assessment, post void assessment and care plan with appropriate interventions. The MDSC will note any declines in urinary continence when she completes an MDS and will initiate a 5 day voiding pattern for the resident. She will bring the voiding plan assessment results to the next scheduled Standard of Care meeting (scheduled weekly) for review by the IDT within 14 days of completion of MDS. (See attachment #5)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>depending on the source and cause of the incontinence... Procedure: 1. The admitting nurse will fill out a "Bladder Assessment Form", HC-N-19 within seven days when a resident is admitted to the facility, has had a change in condition, or when the resident is due for his/her annual assessment. 2. If the resident's condition does not allow for an adequate bladder assessment at the time of admission, the nurse may delay it until sometime later in the 7 day period following the admission and will document the reason why on the bladder assessment form. 3. Whether the resident is continent or incontinent, the nurse will fill out the history portion of the assessment form. If the resident is unable to give a history, the nurse will talk to accompanying family members, in an attempt to get as much information as possible... 5. If the resident is incontinent, the nurse will skip to #6 and initiate a 5-day bladder record... Bladder Assessment - Post Voiding Pattern: 1. When the 5 day bladder record is completed, the MDS Coordinator will complete the "Bladder Assessment - Post Voiding Pattern", HC-N-21 in order to finalize the development of a toileting plan. 2. Once the form is completed, the MDS Coordinator will formulate the type of treatment program that appears to be best suited to the resident, based on the</p>		<p>Any identified concerns with lackof assessment as per facility policy will be followed up as indicated inquestion #2.</p> <p>4. <u>Howwill corrective action be monitored to ensure the deficient practice does notrecur and what QA will be put into place?</u> The DON/Designee will bringresults of audits to the QA&A meeting monthly for review by the committeemembers. The QA&A committee will review and monitor progress ofimplementation of bladder assessments and resulting new interventions on anon-going basis. At the end of 60 days, once 100 % compliance is met, theQA&A committee may decide to stop the written audits; however, the DON andMDS Coordinator will continue to examine the bladder assessment of newadmissions/readmissions weekly, and the bladder assessment documentation on aquarterly basis for each resident. Date of Compliance: 12/2/15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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
	information obtained through the admission history, the 5 bladder record, and the results of areas #1 - #5 on the post voiding bladder assessment. 3. The MDS Coordinator will indicate the most likely type of incontinence being experienced by the resident in #6, and then will indicate the type of treatment program and other interventions that might benefit the resident. 4. Once the form is completed, the MDS Coordinator will add the appropriate bladder program to the resident's plan of care, nursing assistant assignment sheets, and other relevant documents, such as the ADL sheets, restorative nursing form & 24 hour report form to assure staff knowledge and follow through. She will also discuss the proposed plan with the resident and/or legal representative, and document this discussion in the resident's medical record. 5. The MDS Coordinator will reassess the resident at least weekly to ensure success in the bladder program for the first month on the new program. Reassessment will occur at least quarterly after that as indicated by the resident's condition and the outcome of the bladder program. Toileting times will be adjusted as needed - the revision time schedule will vary depending on how successful the resident is. It may take several months for the resident to reach the highest level of independence...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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 0314 SS=G Bldg. 00	<p>3.1-38(a)(2)(C)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to timely identify, accurately assess and document a stage 4 pressure ulcer, and failed to provide timely interventions with updated care plans for 1 of 2 residents who met the criteria for pressure ulcer development. (Resident #7)</p> <p>Findings include:</p> <p>Resident #7's record was reviewed on 10/29/2015 at 10:06 a.m. The record indicated Resident #7 had diagnoses that included, but were not limited to, multiple sclerosis, recurrent urinary tract</p>	F 0314	<p>F314</p> <p>It is the policy of this facility to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infections and prevent new sores from developing, including timely identification, accurate assessment and documentation, and development of timely interventions as part of the care plan.</p> <p>1. <u>What corrective action (s) will be accomplished for those residents found to have been</u></p>	12/02/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>infections with infections in the blood, difficulty swallowing, spastic quadriplegia, and hypothyroidism.</p> <p>A Braden Scale for Predicting Pressure Sore Risk, dated 5/1/15, indicated a score of 14, and "A score of 17 and below requires a weekly skin assessment and documentation in the medical record."</p> <p>A Quarterly Minimum Data Set assessment (MDS), dated 5/1/15, indicated Resident #7 had severe impairment in cognitively skills for daily decision making, was able to make herself understood, usually understands others, had no behaviors of rejecting care, had no long term memory or short term memory problems, was extensive assistance of one for bed mobility and personal hygiene, totally dependent of two staff physical assistance for transfers, did not walk, was always incontinent of bowel, had a Foley catheter, had no pressure ulcers but is at risk for pressure reducing devices in her chair and bed. The area on the MDS that would have indicated she was on a turning and repositioning program was not checked.</p> <p>A Significant Change MDS, dated 7/20/15, indicated Resident #7 was moderately impaired in cognitive skills</p>		<p><u>affected by the deficient practice?</u></p> <p>Resident # 7 care plan was updated to reflect 2 staff for all care given. In examining the resident's placement in her bed, it was decided to add width extenders to the bed. This provides more space for turning and repositioning the resident from side to side and increases the ability of staff to clearly observe all parts of her skin on her back and buttocks when turned. All interventions for care have been reviewed and are current.</p> <p>All nursing staff has been in-service on the facility policies regarding the prevention, care, treatment of residents who are at risk for pressure ulcers and those who develop them, including close observation of residents' skin during showers and personal care; documentation and communication of the status of residents' skin condition, including observations of abnormal skin conditions; the need for timely interventions for pressure ulcer prevention, such as turning and repositioning at least every 2 hours, appropriate pressure relieving support surfaces for beds and chairs/wheelchairs, timely physician notification of skin issues with administration and documentation of ordered treatments and supplements to aid in wound healing, accurate identification and documentation of wound size,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>for daily decision making, was able to make herself understood, usually understands others, no long term or short term memory problems, required extensive assistance of one for bed mobility and personal hygiene, required extensive assistance of two for transfers, did not walk, was always incontinent of bowel, had a Foley catheter, had a stage 4 pressure area that was not present at a lesser stage . The area on the MDS that would have indicated Resident #7 was on a turning and repositioning program was not checked.</p> <p>During an interview, on 10/27/15 at 1:44 p.m., LPN # 8 indicated Resident #7 had a stage 3 pressure ulcer.</p> <p>A care plan, dated 6/23/14, indicated a Problem of: "I am at high risk for pressure ulcers due to diagnosis of spastic quad and being incontinent of bowel. Goal and target date: I will remain free of skin breakdown thru 9/24/15, 12/14, 2/15, 5/15, 8/15. Approaches: Reposition me every 2 hours, place my pressure-reducing device/product on bed/chair, I sometimes need two persons to assist with repositioning to avoid skin friction/shearing, encourage my good nutritional intake, I need a daily observation of skin with routine care, I need a daily observation of skin with</p>		<p>appearance, and staging by licensed staff.</p> <p>2. <u>How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken?</u></p> <p>All residents at risk for skinbreakdown have the potential to be affected. Every resident in the facility has had their skin condition assessed by the DON and other licensed staff since survey. Braden scale assessments were updated on every resident and care plans were updated with current interventions as indicated by the residents' needs. CNA assignment sheets were also updated with interventions identified for residents, such as turning and positioning, support surfaces in chairs, etc. If the DON should find a resident who has not been assessed timely, who is not receiving ordered treatments or other planned interventions for pressure ulcer prevention or care, has a lack of needed documentation, or has not had skin care/prevention needs addressed as required by facility policy, she will intercede immediately to make sure that the resident is receiving what he/she needs according to the plan of care and physician's orders. Once the resident is taken care of, the DON will re-train the staff involved regarding the facility's policies for</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>routine care, I need a full skin evaluation weekly with bath/shower, I need to float my heels off the bed, notify my MD if breakdown noted."</p> <p>A care plan, dated 6/23/14, indicated a problem of: "I am unable to do my own care, (feeding, transfers, etc) and require staff assistance for all ADL's due to MS and spastic quad. I do have contractures. Goal and target date: I will have a neat clean appearance daily thru 9/24/15, 12/14, 2/15, 5/15, 8/15. Approaches: One person to assist me with bathing...Staff to do ROM to all my extremities during AM and PM care, give me a partial bath daily with either shower and shampoo or bed bath 2x weekly...mechanical lift for transfers."</p> <p>An Electronic Record Care Plan, dated 10/18/15, indicated: "I have a pressure ulcer on my coccyx. Goal: Area will decrease in size by 0.5 cm (centimeters). Interventions: Do treatment as ordered. Keep all appointments with wound center. Keep my MD and family aware of any changes. Measure area weekly. Pressure reducing mattress on my bed and cushion in my wheelchair. Provide me pro-stat as ordered to aid with wound healing. Reposition me at least every 2 hours."</p>		<p>pressure ulcer prevention,treatment, and documentation. She will also render progressive disciplinaryaction for noncompliance.</p> <p><u>3.What measure will be put into place or what systemic changes will be made to ensure that the deficientpractice does not recur?</u></p> <p>CNAs will document their observations of residents' skin condition at least 2x per week on shower/bathdays. The CNAs will give the completed forms to the licensed nurse for her review and follow up on skin areas that have not been identified before.Completed shower day skin sheets will be forwarded to the DON for her review bythe nurse at the end of the shift.</p> <p>The nurse will assess the new areas, document her assessment, and contact the physician for appropriate treatmentorders, if needed. She will use the "New Ulcer Checklist" as a guide for heractivities to make sure that the follow up is complete. She will forward thecompleted checklist to the DON for her review and follow up on any areas thatmay require further action.</p> <p>In addition to the shower day skinaudits, weekly skin assessments will continue to be completed by the licensednurse as part of the weekly summary.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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 11/02/2015 at 4:51 p.m., the Business Office Manager indicated Resident #7 received the air mattress on 6/18/15 and provided an invoice with that date. The air mattress was placed on the resident's bed 35 days after the initial observation of the stage 3 pressure ulcer.</p> <p>During an interview, on 11/02/2015 at 3:53 p.m., RN #3 indicated the new computer system doesn't have the dates that interventions were put in place. The mattress on Resident #7's bed before was a pressure redistributing mattress. She indicated the care plan has not been re-written that when she adds something new, she dates it, and there were no dates added.</p> <p>Nurse's notes dated 3/29/15 through 5/13/15 failed to indicate any documentation Resident #7 is turned and repositioned.</p> <p>Nurse's weekly summary notes, dated 2/28/15, 3/8/15, 3/15/15, 3/21/15, 3/28/15, 4/4/15, 4/12/15, 4/26/15, 5/3/15, and 5/10/15 did not have the box checked that would have indicated the resident would have been turned and repositioned.</p> <p>The "Weekly Skin Assessments", dated 3/1/15, 3/8/15, 3/15/15, 3/21/15, 3/29/15, 4/5/15, 4/12/15, 4/26/15, 5/3/15, and</p>		<p>TheDON /designee will do audits of the weekly skin assessment for completion andaccuracy. (See attachment #3) The documentation of all pressure ulcers' statusis done electronically on the Wound-Tracc system by the DON on a weekly basis.The Nurse Consultant will review the weekly documentation for all pressureulcers and will follow up with the DON regarding any questions or need forclarification of the documentation and wound status.</p> <p>The Administrator, DON, and othermembers of the IDT will observe residents' appearance and positioningthroughout their tour of duty and as part of the Guardian Angel rounds thatoccur at least 5 days a week. If they should identify an issue, they willnotify the licensed nurse and DON (if she is not already aware of the issue).</p> <p>Any identified concerns orobserved issues in any parts of the skin prevention/care process will beaddressed by the DON immediately and followed through as indicated in question#2.</p> <p><u>4.How will corrective action bemonitored to ensure the deficient practice does not recur and what QA will beput into place?</u></p> <p>The DON will bring the results ofher weekly summary audits and the status of any pressure wounds in the facilityto the weekly</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/02/2015
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE			STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362		
(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>5/10/15, did not have any identified areas of skin breakdown.</p> <p>Nurse's Notes, dated 5/13/15 at 2:15 p.m., indicated: "Open area on coccyx (tail bone area) measured 1.5 cm (centimeters) X 1.2 cm X 2.5 cm. Undermining from 9 - 3 2.3 cm, [no] drainage. MD faxed for tx order."</p> <p>A pressure ulcer healing chart for the coccyx, dated 5/13/15, indicated the area was found on 5/13/15, and was a stage 3 that was 1.5 cm in length, 1.2 cm width, and 2.5 cm depth, with no tunneling, no drainage, and a treatment was ordered to clean with normal saline then apply a wet to dry dressing twice a day until healed.</p> <p>On 10/30/2015 at 4:01 p.m., RN #1 indicated on 5/13/15, an aide came and got her to look at an area, on Resident #7's bottom, and those were the measurements when she found it. There were shower sheets that the CNA's documented skin conditions on, but no one had documented anything on them for Resident #7. She said she looked through a month's worth of shower sheets with the Director of Nursing at that time, and there wasn't anything documented. RN #1 indicated she couldn't find any thing to justify how the wound occurred or how it became a stage 3 before it was</p>		<p>Standards of Care meeting for review and discussion with the IDT. In addition the DON will review this same information with the QA&A Committee at least monthly for further review and recommendations. The DON will follow through on any recommendations that are made by the committee and report the results of those recommendations at the next scheduled QA&A committee meeting. Once 100% compliance is reached, the committee may decide to stop the written audits done by the DON; however, the process as outlined in question #3 will continue on an ongoing basis, and the DON will continue to apprise the QA&A Committee on the status of pressure ulcers and related issues every month on an ongoing basis.</p> <p>Date of Compliance: 12/2/15</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>found.</p> <p>On 10/29/2015 at 1:08:27 p.m., Resident #7 was observed in her wheelchair in the dining room, and had been observed wheeling herself down the hallway with her right arm.</p> <p>On 1/28/15 at 3:05 p.m., Resident #7 was observed in her wheel chair in the dining room watching a pumpkin carving activity.</p> <p>On 10/29/2015 at 9:56 a.m., Resident #7 was observed in bed, supine with the head of the bed up 20 degrees, and had her blanket over her head. Resident #7 had an air mattress on her bed at that time.</p> <p>On 10/29/2015 at 10:54 a.m., the pressure area was observed with LPN #11. The wound was clean, no drainage, no redness, and it was deep, observed to be a stage III.</p> <p>On 10/30/2015 at 3:55 p.m., Resident #7 sat in her wheel chair in her room watching TV. She indicated staff didn't turn her in bed before she got the pressure ulcer, and said "they didn't have a reason to" and now they do turn her, but that area on her bottom doesn't hurt as much as it used to.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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 11/02/2015 at 9:29 a.m., Resident #7 was observed in bed, laying supine, the head of her bed was raised 25 degrees. At 11:45 a.m., she had been gotten up for lunch and sat in her wheelchair.</p> <p>Resident #7 had physician's treatment orders for the pressure area that included, but were not limited to:</p> <p>5/13/15: Wet to dry dressing to coccyx area twice a day until healed.</p> <p>6/4/15: Cleanse wound with soap and water. Avoid using excessive force, pat dry completely. Apply silver alginate directly to wound bed. Apply Optifoam Gentle dressing over primary dressing.</p> <p>6/23/15: Physician's order to reposition every 2 hours while in bed, and the head of the bed not to be elevated greater than 30 degrees for more than 30 minutes.</p> <p>7/17/15: Hyperbaric Oxygen treatments for 40 treatments at the wound clinic. Restart the wound vac at 125 mmHg pressure. Change 3X weekly M-W-F, apply calcium alginate to wound then wound vac.</p> <p>9/9/15: "Cleanse coccyx wound [with] soap & H2O. Pat dry. Apply wound vac</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>- change 3X wkly. Apply thin duoderm to areas of excoriation on buttocks & leave in place. Change when soiled or comes off on own wound vac pressure 125."</p> <p>9/26/15: "DC Duoderm to buttocks - Causing further skin breakdown."</p> <p>9/30/15 - "1) DC current tx to coccyx & wound vac. 2) Start - cleanse wound [with] soap [and] water. Avoid using excessive force. Pat dry completely. Saline wet to dry. Apply directly to wound bed. Avoid contact [with] surrounding skin, cover [with] Optifoam gentle [change every day]."</p> <p>10/14/15 - "(1) D/C saline wet [to] dry drssg (dressing) to coccyx. (2) Cleanse coccyx with soap and water. Pat dry. Apply Betadine gauze directly to wound bed. Cover [with] optifoam [daily]."</p> <p>10/23/15 - "Tx changed to Coccyx: Use Saline wet to dry directly on wound bed; Avoid contact with surrounding skin and cover primary dressing with Optifoam daily dressing changes."</p> <p>Supplements ordered to help aid in wound healing indicated: 7/9/15: Multi-vitamin tab 1 every day 7/13/15: Med pass 2.0, 60 milliliters</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>twice a day for wound.</p> <p>7/16/15 - Prostat (protein supplement) 30 milliliters daily to promote wound healing and increase protein.</p> <p>9/3/15: Med pass was D/C'd. New order for Prostat 30 milliliters twice a day.</p> <p>Review of Medication Administration Records (MARs) dated July 2015 indicated the Prostat 30 milliliters daily was not initialed as given until 7/20/15, a lapse of 3 days after the order was obtained.</p> <p>Review of MARs dated August 2015, indicated the Prostat was initialed as not given from August 1 through August 7, with no explanation of the reason the Prostat was not given.</p> <p>During an interview, on 11/02/2015 at 3:53 p.m., RN #3 indicated she looked in the record and could not find a reason the Prostat had not been given.</p> <p>A History and Physical from a local hospital, dated 7/2/15, indicated, but was not limited to, "The patient is a [age of resident] year-old-female with advanced multiple sclerosis, who is here with finding of osteomyelitis in distal sacral and coccyx wound. She has been having this treated in the Wound Care Center, and a MRI performed 07/01/2015</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>showed osteomyelitis in this area. The MRI also showed moderate bilateral hydronephrosis with debris in the renal collecting systems, possibly blood or pus...She is very disabled from the multiple sclerosis and reside at [name of nursing home]. She is unable to care for herself. She is unable to transfer...."</p> <p>A progress note from a wound center at a local hospital, dated 7/16/15, indicated: "...Coccyx is a stage 4 pressure ulcer and has received a status of not healed. Subsequent wound encounter measurements are 2.5 cm length x 1.2 cm width x 1.8 cm depth, with an area of 3 sq cm and a volume of 5.4 cubic cm. There is muscle exposure. Tunneling has been noted at 12:00 with a maximum distance of 2.8 cm. There is additional tunneling and at 3:00 with a maximum distance of 3 cm. No undermining has been noted. There is a moderate amount of sero-sanguineous drainage noted which has a mild odor...."</p> <p>A progress note from a wound center at a local hospital, dated 10/21/15, indicated: "...Integumentary (Hair, Skin) Depth same but opening decrease. Wound is clean with healthy tissue...Wound #1 status is open. Original cause of wound was pressure injury. The wound is currently classified as a category/stage IV</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>wound with etiologies of pressure ulcer and acute osteomyelitis (infection in the bone) and is located on the Coccyx. The wound measures 1 cm length x 0.4 cm width x 2 cm depth; 0.4 cm 2 area and 0.8 cm 3 volume. There are muscle exposed. There is no tunneling noted, however, there is undermining starting at 12:00 and ending at 4:00 with a maximum distance of 2.1 cm. There is a large amount of serosanguineous drainage noted. The wound margin is distinct with the outline attached to the wound base. There is medium (34-66%) pink granulation within the wound bed. There is a small (1-33%) amount of necrotic tissue within the wound bed including adherent slough...."</p> <p>A policy for "Skin Integrity/Wound Care Program" was provided by RN #3 on 11/2/15 at 4:53 p.m. The policy included, but was not limited to, "All residents will be assessed for their risk of pressure ulcer development by a licensed nurse using the Braden Scale assessment form. All residents will be assessed as follows...quarterly, in accordance with the MDS schedule...with significant changes in health status. Residents with a Braden Scale score of 14 (moderate risk) or below (high risk) will receive preventive care. Residents with scores above 14 may have preventive care</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>initiated as warranted by assessment...Purpose: To identify residents at risk for developing a pressure ulcer and to initiate preventive individualized interventions to address resident risk factors. Examples of risk factors include, but are not limited to: Impaired/ decreased mobility and decreased functional ability...cognitive impairment; exposure of skin to urinary and fecal incontinence...After conducting a risk assessment to identify risk factors, then focus the prevention program on minimizing their negative effects. When addressing pressure ulcers, prevention is the number one solution...Positioning: Frequent positioning of the resident is recommended to prevent capillary occlusion, which leads to tissue ischemia and pressure ulcers...Moisture and incontinence: Urinary incontinence results in overhydration or maceration of the perineal skin. In an overhydrated state, the skin is at greater risk for erosion and impairment of skin integrity. Maceration compromises the skin's ability to function as an effective barrier. Fecal incontinence is even more damaging because of the presence of bacteria and digestive enzymes...Documentation of the skin care plan: Once the nurse has determined the resident's risk factors and has used the Risk Management Protocol and Pressure</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>Ulcer Prevention Tool to select and institute appropriate interventions, he/she documents the skin/wound plan of care on the "Initial Care Plan"... "Interdisciplinary Care Plan" or "Episodic Care Plan Open Area" ...By using the care plan forms available, the nurse should document: The date the plan is initiated, a list of selected approaches and interventions, the goal(s) and the date on which the goal will be reviewed, the responsible disciplines...Review of the prevention plan: Each week the nursing assistant performs a skin audit of each resident on his/her shower or bath days. The nursing assistant documents the findings on the "Shower Day Skin Audit" form...signs it, and turns it in to the licensed nurse. If there are any skin areas noted, the nurse observes the areas, contacts the physician, and begins treatment as ordered. The nurse signs the audit form...The completed forms are forwarded to the Director of Nursing for his/her review before filing. Additionally, the licensed nurse performs a hear-to-toe assessment of all residents weekly. The results of these assessments are documented on the "Nurses' Weekly Summary Note" form (HC-N-7) with detailed information written in the nurses' notes. Whenever a nurse or other team member decides that a new intervention</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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 0329 SS=D Bldg. 00	<p>is more appropriate, that person updates the resident's care plan and notes the change on the nursing assistant assignment sheet...The four stages of pressure ulcers are...Stage III: Full thickness skin loss involving damage or necrosis of subcutaneous tissue, which may extend down to , but not through, underlying fascia. The ulcer presents clinically as a deep crater, with or without undermining of the adjacent tissue. Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures, such as tendon or joint capsule...."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/02/2015	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE				STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362			
(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>antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident's drug regimen was free of medications that had adverse side effects of sedation for 1 of 5 residents who met the criteria for unnecessary medication use. (Resident #29)</p> <p>Findings include:</p> <p>On 10/27/2015 at 2:23 p.m., Resident #29 was observed asleep in bed.</p> <p>On 10/27/2015 at 12:06 p.m., Resident #29 was observed up in his wheel chair, in the dining room and staff were unable to wake him to eat lunch. Staff took him back to his room. He had been observed in bed, asleep all morning and not observed awake or in any activities. He spoke but kept his eyes closed.</p> <p>On 10/28/2015 at 3:07 p.m., Resident #29 was observed asleep in bed; his TV was on, resident was facing the head of his bed, and his TV was at the foot of his</p>	F 0329	<p>F 329</p> <p>It is the policy of this facility to ensure that each resident's drug regimen is free from unnecessary drugs, including those medications that have adverse side effects of sedation.</p> <p>1. <u>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>The physician for resident #29 was notified of the resident's periods of lethargy. The physician ordered that the Trazodone was discontinued on 11/10/15. His medications were reviewed by the IDT and consultant pharmacist in the behavior meeting on 11/10/15.</p> <p>The licensed staff has been in-serviced on the signs/symptoms indicating adverse side effects of psychoactive drugs, including sedatives, the documentation on side effect monitoring flow sheets, and the importance of contacting the physician when side effects such as lethargy are observed.</p> <p>2. <u>How other resident having the potential to be affected by the same practice will be identified and what corrective actions(s) will</u></p>	12/02/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/02/2015
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE			STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362		
(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>bed.</p> <p>On 10/29/2015 at 9:59 a.m., Resident #29 was observed asleep in bed, with his head at the foot of his bed.</p> <p>On 10/29/2015 at 12:17 p.m., CNA #2 took his lunch in his room and tried to feed him and she had to keep waking him up. He was in bed and had been asleep when she entered the room. He did hold a sandwich she made out of his roll and turkey when he said he wanted a sandwich and he held the sandwich in one hand and his drink in the other hand. CNA #2 fed him his vegetables and dessert.</p> <p>On 10/29/2015 at 1:03 p.m., Resident #29 was observed in bed, asleep. An interview CNA #2 indicated he had consumed half of his sandwich and half of his dessert, and when he is in a 'mood' it is hard to get him to do anything.</p> <p>On 10/30/15 at 9:30 a.m. Resident #29 was observed in bed asleep.</p> <p>On 10/30/15 at 3:30 p.m. Resident #29 was observed in bed asleep.</p> <p>On 11/02/2015 at 9:24 a.m., Resident #29 was observed asleep in bed, his breathing was loud, and he was wearing an adult</p>		<p><u>be taken?</u></p> <p>All residents who are taking psychoactive medication have the potential to be affected by this practice. The DON and other members of the IDT have observed residents on psychoactive medications and no other resident has been found to be adversely affected by the medication he/she is taking. If any member of the IDT or other staff observes a resident who is lethargic or otherwise demonstrates an adverse reaction to medication, he/she will notify the licensed nurse and DON immediately. The DON will follow up to make sure the resident is assessed and the physician notified of the resident's condition. Once the resident is taken care of, the DON will follow up with nursing staff involved with the care of the resident to make sure that they are knowledgeable regarding the signs/symptoms of possible side effects of psychoactive medication, including lethargy, and that they understand the need to notify the licensed nurse as quickly as possible if an adverse side effect is observed.</p> <p>3. <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 licensed staff will document the presence or absence of adverse side effects on</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/02/2015	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE				STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362			
(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>diaper with his cubicle curtain pulled around him.</p> <p>On 11/02/2015 at 11:45 a.m., Resident #29 was asleep in bed and when spoken to, awoke, spoke then went back to sleep.</p> <p>On 11/02/2015 at 3:32 p.m., RN #3 indicated Resident #29 is in bed a lot, but all of that time he is not sleeping. She said she took him the phone yesterday to talk to his son, and he was awake. She said a lot of his behaviors seem to occur when he has a urinary tract infection; he has hallucinations, sees things, and hears kids.</p> <p>Resident #29's record was reviewed on 10/29/2015 at 2:38 p.m. Current physician's orders, dated October 2015, indicated Resident #29 had diagnoses that included, but were not limited to; Alzheimer's disease, dementia, behavioral disturbances, high blood pressure, prostate problems, non insulin dependent diabetes mellitus, chronic urinary tract infections, depression, urinary retention, gastro esophageal reflux disorder, insomnia, and blind in his right eye.</p> <p>A Quarterly Minimum Data Set assessment, dated 8/7/15, indicated Resident #29 was moderately impaired in</p>		<p>the psychotropic drug side effect monitoring flow sheets for each shift for residents receiving psychotropic medications. Psychotropic drug side effect monitoring flow sheets will be audited weekly by the DON/designee for any indications of lethargy or sedation. The Behavior Committee will review the psychotropic drugs being given to residents on a monthly basis. In addition, the DON or SSD will update the Committee on any side effects noted by the nurses as documented on the psychoactive drug side effect monitoring flow sheets, any physician notification that has occurred, and any changes in drug regimen that has been ordered by the physician. The Administrator, DON, and other members of the IDT will observe residents' appearance and any indication of adverse side effects from medication, such as lethargy, throughout their tour of duty and as part of the Guardian Angel rounds that occur at least 5 days a week. If they should identify an issue, they will notify the licensed nurse and DON (if she is not already aware of the issue). Any identified concerns or observed issues regarding the presence of adverse side effects will be addressed by the DON immediately and followed through as indicated in question #2.</p> <p>4. <u>How will corrective action be</u></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>cognitive decisions for daily decision making, makes self understood, understands others, had no problems falling asleep, staying asleep, or sleeping too much, and has had no behaviors including hallucinations or delusions.</p> <p>Physician's ordered dated October 2015 included, but was not limited to the following medications that can cause sedation:</p> <ul style="list-style-type: none"> - Lexapro 20 milligrams (mg) by mouth every day for depression/anxiety started on 1/20/15 - Zyprexa 2.5 mg by mouth every day for hallucinations/psychosis, started on 7/15/15 - Trazodone 50 mg, take 1/2 tablet by mouth at bedtime for insomnia, started on 3/10/15 - Lorazepam 0.5 mg, 1/2 tablet (0.25 mg) every six hours as needed for anxiety, was started on 7/15/15, and had been given one time in the last 30 days; on 10/27/15. <p>A psychotropic drug side effect monitoring flowsheet, dated for August 2015 indicated Resident #29 had no side effects for the Lexapro, Trazodone, and Zyprexa, including #12 for lethargy, sedation.</p> <p>A Monthly Psychotropic Medication</p>		<p><u>monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>The DON will report the results of the audits of the psychoactive side effects flow sheet, and the DON/SSD will report the presence of adverse side effects in residents receiving psychotropic medication, the physician notification, and any resulting changes in psychoactive medication to the IDT as part of the morning management meeting which occurs at least 5 days a week, at the Standards of Care meeting which occurs weekly, and to the monthly QA&A Committee meeting. The QA&A Committee may decide to stop the written audit done by the DON at the end of 60 days when 100% compliance is achieved, but the weekly monitoring of the flowsheets, as well as the process outlined in question #3 will continue on an ongoing basis. In addition, the status of psychoactive medication and any adverse side effects will continue to be reported to the QA&A Committee on an ongoing basis for review and further recommendations.</p> <p>Date of compliance 12/2/15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>Summary, dated September 2015 indicated Resident #29 had one episode of verbal aggression on 9/25/15 when he yelled and kicked another resident.</p> <p>A behavior log for October 2015 indicated Resident #29 had no behaviors in October.</p> <p>A care plan dated 11/4/14, and last reviewed 8/2015, indicated a problem of: "I have a dx (diagnosis) of and hx (history) of insomnia. I take Trazodone. Goal: I will be able to fall asleep and stay asleep thru next review. (11/15) Interventions: 1) Meds as ordered 2) Psych services 3) Keep MD informed 4) Encourage me to stay awake during the day 5) Encourage me to be active during the day 6) If awake at night, offer me snack, drink."</p> <p>A care plan dated 11/4/14, and last reviewed 8/2015, indicated a problem of: "I may display mood disturbance d/t (due to) DX Alzheimer's [with] behavior disturbance, depression, anxiety, insomnia, frustration with health problems. Goal: I will remain calm and positive thru next assessment. Interventions: 1) allow me to express my feelings. 2) Attempt to help me problem solve. 3) Psych services as needed. 4) Meds as ordered. 5) Ask my family for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
---	--

(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>suggestions & support."</p> <p>A care plan dated 11/4/14, and last reviewed 8/2015, indicated a problem of: "I sometimes display inappropriate behaviors: name-calling, cursing, yelling related to behavior. Goal: I will behave in a socially acceptable manner thru next review. I will accept redirection when needed. Interventions: 1) Approach me calmly and ask me to stop behavior. 2) Try to determine if I have an unmet need or problem. 3) Assist me as needed. 4) Assist me to a quiet/private area to calm as needed. 5) Refer to SSD, MD, Psych as appropriate."</p> <p>A care plan dated 11/7/14, and last reviewed 8/2015, indicated a problem of: "I sometimes experience hallucinations & delusions. (This is usually r/t (related to) a UTI or other infection) Goal: I will accept staff reassurance & redirection when I hallucinate or have delusions. Interventions: 1) Respond to me calmly. 2) Reassure me I am safe...4) Offer to help "take care of" problem if possible...."</p> <p>A Policy for "Medication - Unnecessary" was provided by the Social Services Director on 11/2/15 at 4:15 p.m. The policy indicated, but was not limited to, "1. Each resident's drug regimen will be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/02/2015
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE			STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362		
(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	
	free from unnecessary drugs. An unnecessary drug is any drug when used...In the presence of adverse consequences which indicate the dose should be reduced or discontinued..." 3.1-48(a)(5) 3.1-48(a)(6)				