

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/14/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00190765.</p> <p>Complaint IN00190765 - Substantiated. Federal/State deficiency related to the allegation is cited at F514.</p> <p>Survey date: January 14, 2016.</p> <p>Facility number: 000346 Provider number: 155543 AIM number: 100288320</p> <p>Census bed type: SNF/NF: 27 Total: 27</p> <p>Census payor type: Medicaid: 27 Total: 27</p> <p>Sample: 6</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on January 19, 2016.</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 0514 SS=C Bldg. 00	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview and record review, the facility failed to ensure accurate documentation for resident's attending actives in the activity book for 3 of 6 residents reviewed for activities (Resident B, C and E). The facility also failed to provide residents with an accurate Activity Schedule. This deficient practice had the potential to impact 27 of 27 residents who participated in activities.</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 1/14/16 at 5:10 p.m. Diagnoses included, but were not limited to, mood disorder, intellectual disability, bipolar, major depression and psychotic.</p>	F 0514	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Huntington respectively requests that this Plan of Correction be accepted and considered for paper compliance. The date of compliance is February 12th, 2016. F514 This facility maintains clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized, including the activity participation records for each</p>	02/12/2016

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	<p>Review of the Pathfinder Service Book for January, Resident B was scheduled to be out of the building with Pathfinder staff every Wednesday from 1:00 p.m. to 4:00 p.m.</p> <p>Review of Resident B's January activities, indicated Resident B attended "cooking club" on Wednesday, 1/13/16 at 2:00 p.m.</p> <p>During an interview on 1/14/16 at 4:07 p.m., the Activity Director indicated she did highlight Resident B as having attended cooking club. She indicated the resident was not at cooking club, but was out with Pathfinder staff.</p> <p>2. The clinical record for Resident C was reviewed on 1/14/16 at 5:30 p.m. Diagnoses included, but were not limited to, mood disorder, profound mental retardation, heart failure, dysphagia, pseudobulbar affect and dementia.</p> <p>Review of the Pathfinder Service Book for January, Resident C was scheduled to be out of the building with Pathfinder staff every Tuesday and Thursday from 8:30 a.m. to 11:30 a.m. and every other Wednesday from 1:00 p.m. to 4:00 p.m.</p> <p>Review of Resident C's January</p>		<p>resident, as well as the activities that are scheduled and conducted as part of the facility's activity program. 1. <u>What corrective action will be accomplished for residents affected?</u> On 1/20/16, the Administrator met with the Activity Director and reviewed her job responsibilities and job performance with her, as well as inservicing her on specific issues identified in her department, including the need to document resident attendance at activities accurately; provision of One on One visits for those residents who have been care planned to receive One on One activities; and completion of all activities on the calendar that are posted and distributed to all of the residents and staff.</p> <p><u>1. 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 these practices. The Activity Director has completed a new Activity Assessment on all residents in the facility. As a result, she is updating the Activity Care Plans as needed to reflect the activity needs of residents whose current status requires One on One activities. These activities will be placed on the monthly calendar and completed timely and documented accurately by the Activity Director. If the</p>		

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	<p>activities, indicated Resident C attended "cooking club" on 1/13/16 at 2:00 p.m.</p> <p>During an interview on 1/14/16 at 4:07 p.m., the Activity Director indicated she did highlight Resident C as having attended cooking club. She indicated the resident was not at cooking club, but was out with Pathfinder staff.</p> <p>3. The clinical record for Resident E was reviewed on 1/14/16 at 4:20 p.m. Diagnoses included, but were not limited to, diabetes mellitus, depression, chronic kidney disease, morbid obesity, hypertension and rheumatoid arthritis.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment dated 11/12/15, indicated Resident E was cognitively intact. Resident E received the following Activities of Daily Living (ADL) assistance; transfer-total assist with two person mechanical lift.</p> <p>During review of the Activity Book on 1/14/16 at 3:26 p.m., Resident E was listed as having attended "cooking club" on 1/13/16 at 2:00 p.m.</p> <p>During an interview on 1/14/16 at 4:00 p.m., Resident E indicated she "was not at cooking class yesterday." She indicated "I am not her [Activity Director] favorite</p>		<p>Administrator or member of the IDT observesthat activities are not occurring as scheduled, including one-to-one visits, or that documentation of resident participation is not being accurately completed,he will address those concerns with the Activity Director immediately, as well as re-training her on correction of the areas of concern. He will also render progressive disciplinary action for continued noncompliance. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> The Administrator will meet with the Activity Director weekly for eight weeks to review Activity Directors progress. The Activity Director will update the Interdisciplinary Team during morning management meetings which occur at least 5 days a week regarding the status of activities scheduled and held, as well as resident attendance and documentation of resident participation. Any identified concerns will be addressed as outlined in question #2.</p> <p><u>1. What measures will be put into place to ensure this practice does not recur?</u> The Activity Director will update the Interdisciplinary Team during monthly Quality Assurance meetings to ensure resident attendance during activities are</p>		

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	<p>person."</p> <p>During an interview on 1/14/16 at 10:58 a.m., the Activity Director indicated she did not currently have any resident requiring one on one activity. She indicated the "Bluebird" activity was on the schedule, but it had not been done for a while.</p> <p>Review of the January Activity Schedule, "Bluebirds" was listed 14 times.</p> <p>This Federal tag relates to complaint IN00190765.</p> <p>3.1-50(a)(2)</p>		<p>being documented, that residentrequiring One on One's are properly Care Plannedfor them and that activities that meeting their needs are being completed and documented correctly, and toensure all activities on the Activity Calendar are being completed timely,accurately, and that meet the needs of the residents. The QA Committee will review her report andmake recommendations where needed. At the end of 3 months when 100% complianceis reached, the Committee may decide to stop requesting a regular report fromthe Activity Director; however, she will continue to update the IDT at themorning management meetings on an ongoing basis.</p>		