

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/10/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00170328.</p> <p>Complaint IN00170328 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309, F353 and F364.</p> <p>Survey dates: April 9 and 10, 2015.</p> <p>Facility number: 000346 Provider number: 155543 AIM number: 100288320</p> <p>Census bed type: SNF/NF: 30 Total: 30</p> <p>Census payor type: Medicare: 1 Medicaid: 29 Total: 30</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000		
F 309	483.25			

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: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/10/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
SS=D Bldg. 00	<p>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 ensure a topical medication was given as ordered to prevent skin break down for 1 of 5 residents reviewed for medication administration. (Resident E)</p> <p>Findings include:</p> <p>The clinical record for Resident E was reviewed on 4/10/15 at 9 a.m. Diagnoses for the resident included, but were not limited to, bilateral blindness, depressive disorder, post gunshot wound and schizoaffective disorder. The Quarterly Minimum Data Set (MDS), dated 1/5/15, indicated Resident E was cognitively intact.</p> <p>During an observation on 4/9/15 at 4:35 p.m., Resident E was seated on a chair in his room. He did not have any pants covering his legs. Resident E was observed to have multiple wounds covering both lower legs. His legs were dark pink in color with fresh blood noted over multiple areas. His finger nails were</p>	F 309	<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 desires this Plan of Correction to be considered the facility's Allegation of Compliance. <u>F309</u> 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</p>	05/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/10/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>observed to be long in length. Resident E's bed linens were covered with dead skin.</p> <p>On 4/9/15 at 4:45 p.m., the nurse was notified of the resident's condition and he indicated he would go and assess his skin.</p> <p>Review of the current Medication Administration Record (MAR), dated 4/15, the following medications were ordered: Gabapentin 400 mg three times daily for itching, montelukast 10 mg daily at night for allergies, Zoloft 150 mg daily for depression and anxiety, and cetirizine 10 mg daily for allergies.</p> <p>Review of the current Treatment Administration Record (TAR), dated 4/15, the following treatments were ordered: Eucerin lotion 250 mL topically to affected areas generously daily and as needed, Nystatin powder to affected areas twice daily as needed and Aristocort to affected areas twice daily as needed.</p> <p>Review of the TAR for January, February and April, Resident E did not receive the daily ordered Eucerin on any day. Resident E only received Aristocort cream on 4/3, 4/6, 4/8 and 4/9.</p> <p>The original order date for Eucerin daily</p>		<p>well-being, in accordance with the comprehensive assessment and plan of care.</p> <p><u>1. What corrective action will be accomplished for residents affected?</u> Resident E was admitted to the facility on 3/14/14 with a diagnosis of pruritic disorder. On 4/9/15 the resident agreed to having his fingernails trimmed and the PRN treatment applied to affected areas was completed. There have been no omissions of treatments since that date. The physician was contacted on 4/10/15 and the topical lotion treatment order was clarified to be completed PRN. The topical medication was ordered twice daily. Both orders have been transcribed to the treatment record.</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> The Director of Nursing</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/10/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was dated 3/18/14.</p> <p>Review of a current care plan, dated 11/4/14, revised 4/15, indicated Resident E had a problem with displaying self-injurious behaviors that included scratching and picking at skin. The interventions included, but were not limited to, keep nails trimmed. Another problem, dated 4/3/14 and revised 3/15, included open sores on the skin. Interventions included, but were not limited to; apply lotion per orders, nursing to complete a weekly skin assessment and medications as ordered.</p> <p>Review of the Shower Day Skin Audits, dated 4/2/15 and 4/5/15, no concerns related to open sores, abrasion or redness were noted.</p> <p>Review of a Weekly Summary Note, dated 4/8/15, indicated Resident E was observed to have dry skin with lotion treatments to various areas.</p> <p>Review of a Nursing Note, dated 4/9/15 at 9:00 p.m., indicated Resident E's nails had been trimmed and treatment to both right and left legs were completed.</p> <p>During an interview on 4/10/15 at 8:30 a.m., the Director of Nursing (DON) indicated she trimmed Resident E's nails</p>		<p>reviewed the current treatment administration records of all residents and no other treatments have been missed. Skin assessments are completed for all residents weekly and findings are reported to the Director of Nursing and attending physician.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u> The Director of Nursing will present an inservice to all nurses addressing the importance of medication administration and documentation on May 1st. The Director of Nursing or Designee will review the treatment administration record three times weekly for 30 days and then weekly for 60 days to ensure completion of treatments as ordered. Results of the audits will be forwarded to the Administrator for further review. A nurse who fails to document the treatment as completed will be re-educated. Any further</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/10/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353 SS=E Bldg. 00	<p>and the order for the Eucerin cream was to have been done daily.</p> <p>No policy related to Physician Orders was provided prior to exit.</p> <p>The federal tag related to Complaint IN00170328.</p> <p>3.1-37(a)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following</p>		<p>failure of thenurse to comply with documentation and completion of orders will result disciplinary action.</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 QA&A committee will review results of the Director of Nursing audit for 90 days and until 100% compliance is attained. Further audits of treatment records will be completed as deemed necessary by the QA&A committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/10/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on interview and record review, the facility failed to ensure there was always sufficient staff on duty to ensure showers were given at least two times weekly, restorative services were provided, oral and peri-care provided as needed for 3 of 6 residents reviewed for provision of nursing care in a sample of 6. (Resident #'s B, C and H)</p> <p>Findings include:</p> <p>During the initial tour on 4/9/15 at 7:45 a.m., 3 CNA's were assisting residents in the Assist Dining room. 1 Nurse was also assisting with breakfast in the Main Dining room.</p> <p>During the room tour on 4/9/15 at 8:00 a.m., residents were still in bed, in rooms 18, 15, 10, 8, 5, 3 and 2. Dirty laundry was noted on the floor in room #17. In room #15, breakfast was at the bedside and the resident was asleep.</p>	F 353	<p><u>F353</u> The facility must have sufficient nursing staff to provide nursing related services to attain or maintain the highest practicable physical, mental, and psycho-social well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p><u>1.What corrective action will be accomplished for residents affected?</u></p> <p>The Facility will ensure sufficient staffing based on facility staffing pattern and individual needs of resident population. A master nursing staff schedule is maintained by the Director of Nursing with a monthly schedule made available to nursing staff on the last full week of each month. Any shift openings are made available to employees before resorting to agency staff to fill available positions. Recruitment of nursing staff continues through online and newspaper advertisements. In addition, Administration has met with employees for recruitment</p>	05/01/2015

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 04/10/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A CNA assignment sheet was provided by Administrator on 4/9/15 at 9:00 a.m. It indicated the following: two CNAs were scheduled to care for 30 residents in the facility. Of these 30 residents, 9 required two staff members to transfer, 22 were incontinent and 2 were totally dependent for all Activities of Daily Living (ADL) care.</p> <p>Review of the Resident Census and Conditions of Residents Form indicated 29 of the 30 residents had a documented psychiatric diagnosis, 12 of the 30 residents were dependent for bathing, 9 of the 30 residents were dependent for dressing, 8 of the 30 were dependent for transferring, 18 of the 30 residents were dependent for toilet use and 8 of the 30 were dependent for eating. 1 of the 30 residents was independent for transferring and toilet use.</p> <p>Review of the 36 Bed Staffing Plan, a facility census of 30 residents would require 6.5 Aides working over a 24 hour period. A facility census of 29 residents would require 6.0 Aides working. 13 of the 15 days in March, 29 residents were in the facility.</p> <p>On 4/9/15 at 11:30 a.m., the Administrator, Director of Nursing</p>		<p>suggestions. 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> _ No residents have been negatively affected by the staffing challenges. Resident Guardian Angel interviews have been completed routinely since the survey exit to ensure concerns are addressed. Breakfast is routinely served in the facility at 7:30 am. Residents 2, 5, 10, and 18 had completed their breakfast on 4/9/15 and at 8:00am and had returned to their rooms. Residents 3 and 15 prefer to eat in their rooms. Resident 8 often refuses breakfast and according to the April food intake log she refused breakfast on both April 9 and 10 2015. 3. <u>What measures will be put into place to ensure this practice does not recur.</u> _ The Administrator has assigned open CNA shifts to managers who are licensed nurses or have active CNA certification to ensure sufficient direct care coverage. A staffing action plan is reviewed weekly by the Administrator, Director of Nursing and Nurse Consultant to update interventions and recruitment plans. 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> Results of the action plan reviews and staffing efforts will be reviewed five days a week</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/10/2015	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON				STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>(DON) and Nurse Consultant were present during an interview. The Administrator indicated the census to CNA ratio had always been the same since he was hired regardless of the acuity. He indicated the Minimum Data Set (MDS) Coordinator often came in early to help the day shift with getting people up and helping with breakfast.</p> <p>Review of the March schedule, 2 CNA's were scheduled on the day shift for the following days: 3/8/15, 3/11/15, 3/13/15, 3/14/15, 3/15/15, 3/17/15, 3/18/15, 3/19/15, 3/20/15, 3/21/15, 3/22/15, 3/23/15, 3/27/15, 3/28/15 and 3/29/15. Of the 15 days with 2 CNA's scheduled, the MDS Coordinator did not work 9 of the 15 days. 1 nurse was scheduled for each shift. 1 CNA was scheduled for third shift for all calendar days.</p> <p>During an interview on 4/9/15 at 9:50 a.m., Resident B indicated when only 2 CNA's were scheduled, she only got one shower a week. She indicated there were not enough staff in the building and she often had to wait a long time. Review of Resident B's most recent MDS, dated 2/19/15, indicated she was cognitively intact. Resident B required total dependence with transfer with 2 staff and extensive assistance with dressing and bathing.</p>		<p>during the morning meeting and ongoing at the QA&A committee monthly until staffing issues are resolved and the QA committee no longer sees the need to continue the staffing oversight. The DON and Administrator will meet at least weekly on an ongoing basis to review staffing and to assure that sufficient staff levels are in place and scheduled to work.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/10/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>During an interview on 4/9/15 at 4:15 p.m., Resident C indicated she occasionally had to wait to be taken to the bathroom, causing her to become incontinent. She indicated the facility needed more help. Review of Resident C's most recent MDS, dated 2/12/15, indicated she had moderately impairment. Resident C required total dependence with transfer with 2 staff and extensive assistance with dressing and bathing.</p> <p>During an interview on 4/10/15 at 8:20 a.m., Resident H indicated staffing had been very short when only 2 CNA's were working. She stated she liked to take a shower daily, but was told she could not get one daily when only 2 CNA's were working. She stated only 1 CNA worked at night.</p> <p>Confidential CNA and Nurse interviews for staff working 4/9-4/10/15 were completed. Exact times and dated withheld to maintain anonymity.</p> <p>LPN #1 indicated it was hard to get your job done with 2 CNA's but possible when 3 CNA's were scheduled.</p> <p>CNA #2 indicated only 1 CNA was scheduled at night. She indicated if a fall or something happened, you cannot catch</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/10/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>up on your work.</p> <p>CNA #3 indicated the residents were not receiving the proper care for oral, peri-care and showers. She indicated they have a lack of time to give extra care to residents. She stated several residents just wander around the facility because there was nothing to do.</p> <p>CNA #4 indicated ADL care does not get done as it should with 2 CNA's on day shift.</p> <p>CNA #5 indicated range of motion and oral care were lacking. She indicated the facility has just now started to use agency staffing.</p> <p>On 4/10/15 at 7:50 a.m., the Administrator and Director of Nursing were in the facility assisting with breakfast.</p> <p>Review of a facility Action Plan dated 12/9/14, provided by the Administrator on 4/10/15 at 11:20 a.m., indicated the following:</p> <p>"...2/26/15 Recently one CNA terminated for 2 NCNS [no call- no show], Night shift nurse resigned effective 2/27/15."</p> <p>This federal tag related to Complaint</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/10/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364 SS=D Bldg. 00	<p>IN00170328.</p> <p>3.1-17(a)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to ensure food was served at a palatable temperature and overall quality of taste for 1 of 6 residents interviewed for food quality. (Resident B)</p> <p>Findings include:</p> <p>During an interview on 4/9/15 at 9:50 a.m., Resident B indicated the dining room was always served first and she often did not get what she originally ordered. She stated the kitchen often ran out of selected foods and the food was served cold. Review of Resident B's most recent MDS, dated 2/19/15, indicated she was cognitively intact. Resident B required only set-up help for meal service.</p>	F 364	<p><u>364</u> Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p><u>1.What corrective action will be accomplished for residents affected?</u> The dietary manager was inserviced on 4/24/15 by the dietitian on the importance of maintaining proper food temperatures on the serving line. Food on the serving line will be kept between 160-180 degrees F to prevent rapid bacterial growth and insure that foods are served to the residents at appropriate, safe eating temperatures.</p> <p><u>1.How will the facility identify other residents having the potential to be affected by the same practice and what</u></p>	05/01/2015

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 04/10/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>She indicated for 4/9/15 lunch she had ordered baked chicken, green beans, mashed sweet potatoes and ice cream.</p> <p>During lunch observation on 4/9/15 at 12:25 p.m., Resident B's lunch tray was brought out from the kitchen. The Dietary Manager was asked to provide a current temperature of the meal. The following temperatures were noted: chicken 115 degrees, green beans 120 degrees and sweet potatoes 150 degrees.</p> <p>Review of a current undated facility policy, titled "Suggested Food Holding Temperatures on Food Service Line", which was provided by the Director of Nursing on 4/9/15 at 3:15 p.m., indicated the following:</p> <p>"Meat, portioned for service 160-180 degrees F Potatos [sic] and vegetables 160-180 degrees F</p> <p>...Food holding temperatures are recommended temperatures above the minimum temperatures of 140 degrees F required to prevent rapid bacterial growth that will help insure that foods are served to the resident are at appropriate eating temperatures."</p>		<p><u>corrective action will be taken?</u> All residents have the potential to be affected by this practice. The dietary manager will create a temperature log and will randomly test temperature of food items on trays to ensure food is at appropriate eating temperatures on an ongoing basis.</p> <p>1. <u>What measures will be put into place to ensure this practice does not recur?</u> Random food temperature checks will be completed by the dietary manager or designee daily all three meals for 30 days. Dietary staff will ensure that through-out the entire meal the stove top remains lit and temperatures are maintained until the last tray is served. The Dietary Manager will create a temperature log sheet and she will sporadically and periodically test temperature of food items on trays to ensure food is at appropriate eating temperatures. The Dietitian will review temperature logs upon her visits and make recommendations upon her findings.</p> <p><u>1.What measures will be put into place to ensure this practice does not recur?</u> The QA&A committee will review the food temperature log at the monthly QA&A committee meeting for 90 days and then continue to monitor food temperatures as deemed necessary. The Dietary Manager will use temperature logs and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155543	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/10/2015
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT HUNTINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1425 GRANT ST HUNTINGTON, IN 46750		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	This federal tag relates to Complaint IN00170328. 3.1-21(a)(2)		continue to test temperature of food items on an ongoing basis, even after the QA&A committee no longer reviews the logs themselves.		