

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155436	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/04/2015
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT WINAMAC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 13TH ST WINAMAC, IN 46996
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00187243.</p> <p>Complaint IN00187243 - Substantiated. No deficiencies related to the allegations were cited.</p> <p>Survey dates: November 30, December 1, 2, 3 and 4, 2015</p> <p>Facility number: 000414 Provider number: 155436 AIM number: 100288550</p> <p>Census bed type: SNF/NF: 27 Total: 27</p> <p>Census payor type: Medicare: 1 Medicaid: 22 Other: 4 Total: 27</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<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 Winamac desires this Plan of Correction to be considered the facility's allegation of Compliance. Compliance is effective 12/31/2015</p>	

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

TITLE

(X6) DATE

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

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F 0156 SS=C Bldg. 00	<p>Quality review completed by 26143, on December 11, 2015.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in</p>			

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	<p>paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and</p>			

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	<p>non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on interview and record review, the facility failed to ensure the residents were aware of who the Ombudsman was, how to contact the Ombudsman, and how to formally complain to the State. This had the potential to affect the 27 residents who resided in the facility. (Residents #12, #9, #34, #2, and #10)</p> <p>Finding includes:</p> <p>1. Interview with Resident #12 on 12/04/15 at 2:15 p.m., indicated that she did not know who or what the Ombudsman (a resident advocate) was or how to contact the Ombudsman. She further indicated, she did not know how to contact the State for a formal complaint.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 10/27/15, indicated the resident was cognitively intact.</p>	F 0156	<p><u>1. What corrective action will be done by the facility?</u> The Administrator has in-serviced the members of the Interdisciplinary Team (IDT) on the requirement that residents and/or their legal representatives be informed of the name of the Ombudsman, how to contact him, and how the residents may formally make complaints to the State. The facility will ensure all current residents and representatives are provided with the contact information of the Ombudsman and information on how to file a formal complaint with the state of Indiana by December 31, 2015.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected. All residents and/or representatives will be shown the postings of the Ombudsman and how to file a formal complaint with</p>	12/31/2015	

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	<p>2. Interview with Resident #9 on 12/4/15 at 2:52 p.m., indicated that he did not know who or what the Ombudsman was or how to contact the Ombudsman. He further indicated, he did not know how to contact the State for a formal complaint.</p> <p>The Quarterly MDS assessment dated 12/1/15, indicated the resident was cognitively intact.</p> <p>3. Interview with Resident #34 on 12/4/15 at 2:57 p.m., indicated that she did not know who or what the Ombudsman was or how to contact the Ombudsman. She further indicated, she did not know how to contact the State for a formal complaint.</p> <p>The Quarterly MDS assessment dated 11/3/15, indicated the resident was cognitively intact.</p> <p>4. Interview with Resident #2 on 12/4/15 at 3:01 p.m., indicated that she did not know who or what the Ombudsman was or how to contact the Ombudsman. She further indicated, she did not know how to contact the State for a formal complaint.</p> <p>The Quarterly MDS assessment dated 12/1/15, indicated the resident was</p>		<p>the state of Indiana. The postings and information will be reviewed at least quarterly with the resident council meeting. Any residents who do not attend the resident council meeting will have this information reviewed by their Guardian Angel from the interdisciplinary manager team at least quarterly. Residents Families will be notified upon admission and quarterly at family gatherings. 3. <u>What measures will be put into place to ensure that this practice does not recur?</u> All new residents or their representatives will be shown the postings and receive the Ombudsman and State of Indiana's contact information by Social Services at the time of admission. The residents will be asked in resident council each month if they wish to meet with the Ombudsman to discuss his duties or any concerns or issues that the residents may have at that time. The resident council minutes will reflect the discussion regarding the ombudsman information and whether or not the residents have requested that the ombudsman visit. 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> The Administrator will review the minutes from each resident council meeting on an ongoing basis to make sure that the residents have been made aware</p>		

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	<p>cognitively intact.</p> <p>5. Interview with Resident #10 on 12/4/15 at 3:04 p.m., indicated that he did not know who or what the Ombudsman was or how to contact the Ombudsman. He further indicated, even though he could not see the phone numbers, he would not have been able to tell his family where the Ombudsman information were located. He further indicated, he did not know how to contact the State for a formal complaint.</p> <p>The Quarterly MDS assessment dated 11/24/15, indicated the resident was cognitively intact.</p> <p>On 12/4/15 at 3:22 p.m., the Resident Council Meeting minutes from 11/24/14 through 11/24/15 were reviewed and indicated, there was no discussion of the Ombudsman's or how to formally contact the state.</p> <p>Interview with the Activities Director on 12/04/2015 at 3:30 p.m., indicated she was new to the position and did not know the Ombudsman's information or how to formally contact the State was to be addressed in the Resident Council Meetings.</p>		<p>of the ombudsman and State agency contact information and that the Ombudsman has been requested to visit as per the residents' decision. The Administrator or Activity Director will bring the results of the resident council minutes and any subsequent visits made by the ombudsman to the QA Committee at its monthly meeting for review and recommendations for improvement. Any recommendations made will be followed up by a designated manager who will report the results of the recommendations at the next scheduled QA committee meeting. This will continue on an ongoing basis.</p>				

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F 0167 SS=C Bldg. 00	<p>Interview with the Administrator on 12/4/15 at 4:20 p.m., indicated important numbers were gone over in "surveyor preparedness" with all residents and staff.</p> <p>3.1-4(j)(3)(C)</p> <p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on interview and record review, the facility failed to ensure residents were aware that the State Inspections were available to read and where they were located. This had the potential to affect the 27 residents who resided in the</p>	F 0167	<p>It is the policy of this facility to make the survey results available to the residents and to make sure that the residents know where the survey results are located. _</p> <p><u>1.What corrective action will be done by the facility?</u> The Administrator has in-serviced the</p>	12/31/2015

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	<p>facility. (Residents #12, #9, #2 and #10)</p> <p>Finding includes:</p> <p>1. Interview with Resident #12 on 12/04/15 at 2:15 p.m., indicated that she did not know where the state inspection results were located, and she attended the Resident Council Meetings.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 10/27/15, indicated the resident was cognitively intact.</p> <p>2. Interview with Resident #9 on 12/4/15 at 2:52 p.m., indicated that he did not know where the state inspection results were located, and he attended the Resident Council Meetings.</p> <p>The Quarterly MDS assessment dated 12/1/15, indicated the resident was cognitively intact.</p> <p>3. Interview with Resident #2 on 12/4/15 at 3:01 p.m., indicated that she did not know where the state inspection results were located, and she attended the Resident Council Meetings.</p> <p>The Quarterly MDS assessment dated 12/1/15, indicated the resident was cognitively intact.</p>		<p>members of the Inter disciplinary Team (IDT) on the requirement that residents and/or their legal representatives be informed of the location of the facility's survey results. The facility will ensure all current residents and or representatives are notified of and/or shown the location of the survey result builder in this facility by December 31, 2015. _ 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. All residents and or representatives will be shown the location of the survey result binder. The location of this binder will be reviewed at least quarterly at the resident council meeting. Any residents who do not attend the resident council meeting will have this information reviewed by their Guardian Angel from the interdisciplinary manager team at least quarterly. Residents' Families will be notified upon admission and quarterly at family gatherings. 3. <u>What measures will be put into place to ensure that this practice does not recur?</u> All new residents or their representatives will be shown the location of the facility's survey results by Social Services at the time of admission. Then quarterly review of the location of the survey results during the resident council meeting will be</p>				

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	<p>4. Interview with Resident #10 on 12/4/15 at 3:04 p.m., indicated that he did not know where the state inspection results were located, and he attended the Resident Council Meetings.</p> <p>The Quarterly MDS assessment dated 11/24/15, indicated the resident was cognitively intact.</p> <p>On 12/4/15 at 3:22 p.m., the Resident Council Meeting minutes from 11/24/14 through 11/24/15 were reviewed and indicated, there was no discussion of the location of state inspections.</p> <p>Interview with the Activities Director on 12/04/2015 at 3:30 p.m., indicated she was new to the position and did not discuss in the Resident Council Meetings where the state inspection results were located.</p> <p>3.1-3(b)(1)</p>		<p>documented in the resident council minutes. The Guardian Angels' review of the location of the survey results with those residents who do not attend resident council will be documented on the Guardian Angel rounds checklist. 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> The Administrator will review the minutes from each resident council meeting on an ongoing basis to make sure that the residents have been made aware of the location of the survey information at least quarterly. The Administrator or Activity Director will report the quarterly review of the location of the survey information as documented in the resident council minutes to the next scheduled monthly QA Committee for review and recommendations. This will continue on an ongoing basis.</p>		

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to provide services in accordance with a resident's written plan of care related to monitoring skin for bruising for 1 of 22 residents whose care plans were reviewed. (Resident #37)</p> <p>Finding includes:</p> <p>Resident #37 was observed sitting in his wheelchair in his room on 12/1/15 at 11:35 AM. At that time, dark discolorations were observed to the backs of both hands with the area on his right (R) hand being larger than the area on his left (L) hand.</p> <p>On 12/1/15 at 4:19 PM, Resident #37 was observed resting in bed working with Speech Therapy (ST). No change was noted to the discolorations to the back of</p>	F 0282	<p><u>F282</u> - It is the policy of this facility to provide services in accordance with a resident's written plan of care for skin conditions including bruising. <u>1. What corrective action will be done by the facility?</u> The bruise was immediately reported on 12/2/15 to the physician and family of resident #37. Resident discharged from facility on 12/3/2015 The Director of Nursing will in-service all nursing staff by 12/15/15 regarding the facility policy on reporting all skin changes, including bruises. The IDT has reviewed all MD orders and care plans to ensure that resident are receiving care as ordered. No other issues were identified by IDT. <u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected by this practice. All nursing staff was in serviced on 12/15/2015 related to accurate</p>	12/31/2015

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	<p>both hands.</p> <p>On 12/2/15 at 1:25 PM, Resident #37 was observed sitting in his wheelchair in his room. Dark discolorations remain to the backs of both hands. He was unsure what happened to cause the discolorations.</p> <p>Interview with CNA #2 on 12/2/15 at 1:49 PM, indicated the CNAs look at residents' skin whenever providing daily care for them. If anything was seen, the CNA then notified the nurse.</p> <p>Interview with RN #1 on 12/2/15 at 1:52 PM, indicated Resident #37 currently had no areas of bruising being followed. She further indicated if a CNA reported any skin issue, the nurse then assessed the resident, filled out an abnormal skin incident paper in the communication binder, measured the area, charted in computer, notified the Physician and family, and continued to monitor weekly until resolved.</p> <p>On 12/2/15 at 2:02 PM, Resident #37 was observed with RN#1, at which time she indicated she was not previously aware of the visible discolorations to the back of both hands. She further indicated these areas should have been seen and monitored. She also indicated no current</p>		<p>completion of skin assessments. All residents have had a weekly skin assessment completed by staff. No additional skin issues were noted. If any unknown skin issues such as bruising are identified by a member of the staff, he/she will notify the charge nurse and DON immediately. Once the skin area has been assessed, the physician and family notified, and appropriate treatment initiated if ordered, the DON will investigate to find the cause, if possible. If the DON has identified an issue with staff job performance, she will review the facility policy on skin prevention and timely identification of skin issues with the staff involved. Written counseling may be rendered, as well, as indicated by the situation.</p> <p>3. <u>What measures will be put into place to ensure that this practice does not recur?</u> The DON or designee will review the weekly skin assessments, followed by observation of at least 3 residents' skin conditions each week for the next 3 months. The DON will review the results of any investigations done in regards to unknown bruising with the IDT team as part of the morning management meeting which takes place at least 5 days a week. Any recommendations for interventions to prevent further bruising will be made by the IDT at that time. Both the resident's care plan and CNA assignment</p>				

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	<p>bruising was charted for Resident #37.</p> <p>Resident #37's record was reviewed on 12/1/15 at 2:39 PM. Diagnoses included, but were not limited to, diabetes mellitus, difficulty walking, peripheral vascular disease, kidney failure, hypothyroidism, and anemia.</p> <p>Weekly nurse skin assessments were completed on 11/7/15, 11/14/15, 11/21/15, and 11/28/15 and indicated no areas noted.</p> <p>Review of Progress notes indicated the following: - 12/1/15 10:12 a.m. "... fall follow up continues without any new areas of redness or bruising ..." - 12/2/15 9:40 a.m. "Fall follow up continues. No latent injury noted..." - 12/2/15 2:52 p.m. "4 cm (centimeter) x 3 cm purple bruise noted to R hand, 1 cm circular bruise noted to R wrist, 4 cm green bruise noted to L hand. MD (Physician) notified and family aware."</p> <p>Review of Care Plans included a care plan for risk for skin breakdown. Interventions included, but were not limited to, any changes in skin to be reported to the MD immediately; staff to assist every two hours and PRN (as needed) with bed mobility; and skin</p>		<p>sheet will be updated at that time as well. MD orders and incident reporting is addressed in morning meeting with the IDT. All care plan issues and MD orders are reviewed with IDT in clinical meeting which takes place at least 5 times a week. Any recommendations for interventions will be made by the IDT at that time. Both the resident's care plan and CNA assignment sheet will be updated at that time as well. Any issues identified will be addressed as outlined in question #2. 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> The DON will bring the results of her reviews, observations, and investigations to the monthly QA committee meeting for review and recommendations. Any recommendations by the QA Committee will be followed up by the Director of Nursing, who will bring the results of those recommendations to the following month's meeting. The QA Committee may decide to stop the skin assessment and resident observation reviews by the DON after 3 months, if 100% compliance is reached. However, the DON or designee will continue to monitor the completion of and accuracy of residents' skin assessments on an ongoing basis. Date of Compliance: December 31, 2015</p>				

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F 0309 SS=D Bldg. 00	<p>condition to be monitored at least twice a week by the CNA during showers and and weekly by the charge nurse.</p> <p>A care plan for ADLs (activities of daily living) indicated Resident #37 required staff assistance with completing daily care, including showers twice a week, getting dressed, oral care twice daily, and transfers.</p> <p>3.1-35(g)(2)</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 ensure each resident received the necessary treatment and services related to the monitoring and assessment of bruises for 1 of 3 residents reviewed for non-pressure related skin conditions of the 4 residents who met the criteria for non-pressure related skin conditions. (Resident #37)</p>	F 0309	<p>It is the policy of this facility to ensure that each resident receives the necessary treatment and services related to the monitoring and assessment of bruising. <u>1. What corrective action will be done by the facility?</u> The bruise was immediately reported 12/2/2015 to the physician and family of resident #37. Resident discharged from facility on 12/3/2015 The</p>	12/31/2015

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	<p>Finding includes:</p> <p>Resident #37 was observed sitting in his wheelchair in his room on 12/1/15 at 11:35 AM. At that time, dark discolorations were observed to the backs of both hands with the area on his right (R) hand being larger than the area on his left (L) hand.</p> <p>On 12/1/15 at 4:19 PM, Resident #37 was observed resting in bed working with Speech Therapy (ST) @ bedside. No change was noted to the discolorations to the back of both hands.</p> <p>On 12/2/15 at 1:25 PM, Resident #37 was observed sitting in his wheelchair in his room. Dark discolorations remain to the backs of both hands. He was unsure what happened to cause the discolorations.</p> <p>Interview with CNA #2 on 12/2/15 at 1:49 PM, indicated the CNAs look at residents' skin whenever providing daily care for them. If anything was seen, the CNA then notified the nurse.</p> <p>Interview with RN #1 on 12/2/15 at 1:52 PM, indicated Resident #37 currently had no areas of bruising being followed. She further indicated if a CNA reported any</p>		<p>Director of Nursing will in-service all nursing staff by 12/15/15 regarding the facility policy on reporting all skin changes, including bruises. 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. All nursing staff was in serviced on 12/15/2015 related to accurate completion of skin assessments. All residents have had a weekly skin assessment completed by staff. No additional issues were identified. If any unknown skin issues such as bruising are identified by a member of the staff, he/she will notify the charge nurse and DON immediately. Once the skin area has been assessed, the physician and family notified, and appropriate treatment initiated if ordered, the DON will investigate to find the cause, if possible. If the DON has identified an issue with staff job performance, she will review the facility policy on skin prevention and timely identification of skin issues with the staff involved. Written counseling may be rendered, as well, as indicated by the situation. 3. <u>What measures will be put into place to ensure that this practice does not recur?</u> The DON or designee will review the weekly skin assessments, followed by observation of at least 3 residents' skin conditions each</p>				

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	<p>skin issue, the nurse then assessed the resident, filled out an abnormal skin incident paper in the communication binder, measured the area, charted in computer, notified the Physician and family, and continued to monitor weekly until resolved.</p> <p>On 12/2/15 at 2:02 PM, Resident #37 was observed with RN#1, at which time she indicated she was not previously aware of the visible discolorations to the back of both hands. She further indicated these areas should have been seen and monitored. She also indicated no current bruising was charted for Resident #37.</p> <p>Interview with the DON (Director of Nursing) on 12/2/15 at 2:19 PM, indicated the last November shower sheet found was dated 11/18/15 with no new skin areas noted. At that time, she was made aware of discolored areas to the backs of Resident #37's hands, then asked the nurse to check into the possibly of a lab draw causing the areas. The DON further indicated even if the areas were due to a lab draw, they still should have been documented, monitored, & then the cause investigated.</p> <p>Resident #37's record was reviewed on 12/1/15 at 2:39 PM. Diagnoses included, but were not limited to, diabetes mellitus,</p>		<p>week for the next 3 months. The DON will review the results of any investigations done in regards to unknown bruising with the IDT team as part of the morning management meeting which takes place at least 5 days a week. Any recommendations for interventions to prevent further bruising will be made by the IDT at that time. Both the resident's care plan and CNA assignment sheet will be updated at that time as well. Any issues identified will be addressed as outlined in question #2. 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> The DON will bring the results of her reviews, observations, and investigations to the monthly QA committee meeting for review and recommendations. Any recommendations by the QA Committee will be followed up by the Director of Nursing, who will bring the results of those recommendations to the following month's meeting. The QA Committee may decide to stop the skin assessment and resident observation reviews by the DON after 3 months, if 100% compliance is reached. However, the DON or designee will continue to monitor the completion of and accuracy of residents' skin assessments on an ongoing basis.</p>	

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	<p>difficulty walking, peripheral vascular disease, kidney failure, hypothyroidism, and anemia.</p> <p>The current Physician's Orders indicated: - Aspirin (a medication which can increase the risk for bruising) 81 mg (milligrams) po (by mouth) qd (daily).</p> <p>Weekly nurse skin assessments were completed on 11/7/15, 11/14/15, 11/21/15, and 11/28/15 and indicated no areas noted.</p> <p>Review of Progress notes indicated the following: - 12/1/15 10:12 a.m. "... fall follow up continues without any new areas of redness or bruising ..." - 12/2/15 9:40 a.m. "Fall follow up continues. No latent injury noted..." - 12/2/15 2:52 p.m. "4 cm (centimeter) x 3 cm purple bruise noted to R hand, 1 cm circular bruise noted to R wrist, 4 cm green bruise noted to L hand. MD (Physician) notified and family aware."</p> <p>Review of Care Plans included a care plan for risk for skin breakdown. Interventions included, but were not limited to, any changes in skin to be reported to the MD immediately; staff to assist every two hours and PRN (as needed) with bed mobility; and skin</p>			

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F 0311 SS=D Bldg. 00	<p>condition to be monitored at least twice a week by the CNA during showers and and weekly by the charge nurse.</p> <p>A care plan for ADLs (activities of daily living) indicated Resident #37 required staff assistance with completing daily care, including showers twice a week, getting dressed, oral care twice daily, and transfers.</p> <p>A policy titled "Skin Assessments" was provided by the DON on 12/4/15 at 9:55 AM and deemed as current. The policy indicated, "Purpose: To observe the resident's skin condition; to identify areas of concern on a timely basis. Guidelines: The Director of Nursing or designated nurse will do weekly skin assessments on all residents. Procedure: Head to toe assessments will be done weekly with special attention being addressed to areas more prone to skin breakdown"</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</p>			

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	<p>her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on interview and record review, the facility failed to provide Activities of Daily Living (ADL) assistance to a resident related to providing showers as scheduled for 1 of 2 residents reviewed for Choices of the 2 residents who met the criteria for Choices. (Resident #10)</p> <p>Finding includes:</p> <p>An interview with Resident #10 on 11/30/15 at 3:23 p.m., indicated he was not receiving the scheduled showers three times a week by staff on the weekends. He further indicated his shower days were Tuesday, Friday, Saturday or Sundays.</p> <p>The resident's record was reviewed on 12/2/15 at 1:48 p.m. The resident's admission date was 3/9/.15. The resident's diagnoses included, but were not limited to, heart failure, depression, diabetes mellitus and blind in both eyes.</p> <p>Review of the Quarterly Minimum Data Set assessment dated 11/24/15, indicated the resident was a one person assist with personal hygiene, bathing, dressing and transferring. The resident was also cognitively intact.</p>	F 0311	<p><u>1. What corrective action will be done by the facility?</u> The facility will ensure all residents receive their scheduled showers according to that resident's preference. All nursing staff was in-serviced on 12/15/15 regarding ensuring resident shower sheets are completed and or nurse is aware of refusal of shower. <u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have the potential to be affected. The Guardian Angels have checked with each of their residents or the residents' families to make sure that any preferences in regards to bathing/showers have been addressed. Preferences will be placed on the residents' care plans and made part of the CNA assignment sheet. If the DON finds that a resident's shower/bathing preference is not being observed, she will make sure that the schedule is in place to meet the resident's preference. Once that is done, she will review the facility policy regarding the resident's right to make choices with the staff involved and will re-train them as necessary. She will also render written counseling as indicated by the situation. <u>3. What measures will be put into place to ensure that this practice does not recur?</u> When the</p>	12/31/2015

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	<p>The "Addendum to Guardian Angel Rounds," indicated the resident preferred a shower three times a week.</p> <p>The resident "Shower Sheets" indicated the resident received showers on the following dates reviewed for the month of November 2015: 11/3, 11/6, 11/10, 11/13, 11/17, 11/20, 11/24. (Tuesdays and Fridays)</p> <p>Interview with CNA #1 on 12/02/2015 at 1:40 p.m., indicated the resident was a 1 person assist and received showers 3 times a week.</p> <p>Interview with the DON (Director of Nursing) on 12/2/15 at 1:44 p.m., indicated there were no shower sheets for the weekends for Nonmember or from 11/14/15 to 12/1/15.</p> <p>Interview with the Administrator on 12/2/15 at 2:16 p.m., indicated the Guardian Angels ask the resident's their preferences on how many times a week to bath upon admission and quarterly. This past October, the "Addendum to Guardian Angel Rounds" were implemented on paper.</p> <p>3.1-38((a)2)(A)</p>		<p>Guardian Angels make rounds of their assigned residents at least 5 days a week, they will ask if bathing/showers are being completed according to the residents' personal preference. Any concerns will be brought to the next scheduled morning management meeting which occurs at least 5 days a week and discussed with the Administrator and members of the IDT. DON will also do random audits of at least 3 residents' shower sheets each week to ensure documentation of completion or refusals are being noted. Any identified concerns will be addressed as indicated in question #2. 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> DON will report the results of the audits of shower sheets as well as any concerns that have been addressed regarding meeting residents' preferences to the monthly QA Committee meeting for the next 3 months. If 100% compliance has been reached at that time, and if the committee agrees, the DON may stop the audits of the shower sheets, but members of the IDT will continue monitoring the residents' preferences as part of the care planning process on a quarterly basis.</p>		

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F 0323 SS=D Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a gait belt was in place when ambulating with a resident resulting in a fall for 1 of 3 residents reviewed for accidents of the 6 who met the criteria for accidents. (Resident #11)</p> <p>Finding includes:</p> <p>On 12/1/15 at 2:13 p.m., Resident #11 was observed sitting in a recliner in her room. The resident was wearing non skid socks and the call light was within reach. The resident had indicated she had a fall recently but did not remember what had happened.</p>	F 0323	<p>It is the policy of this facility to make sure that each resident receives adequate supervision and assistance devices to prevent accidents, including the use of a gait belt when ambulating residents. <u>1. What corrective action will be done by the facility?</u> Director of Nursing inserviced all nursing staff on the facility policy for using a gait belt whenever ambulating residents on 12/15/15. Staff was also educated that if residents are already up and walking when observed by a nursing staff member, a gait belt will be utilized to assist the resident with the remainder of the ambulation activity. <u>2. How will the facility identify other residents having the potential to</u></p>	12/31/2015

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	<p>On 12/3/15 at 10:21 a.m., Resident #11 was observed sitting in a recliner in her room. The resident was wearing non skid socks and the call light was within reach.</p> <p>Record Review for Resident #11 was completed on 12/2/15 at 4:45 p.m. The resident's diagnoses included, but were not limited to, anemia, hypertension, and Parkinson's Disease.</p> <p>The Quarterly Minimum Data Set (MDS) assessment completed on 11/20/15, indicated the resident had a BIMS (Brief Interview of Mental Status) score of 11 which indicated the resident's cognition was moderately impaired. The assessment indicated the resident needed limited 1 person assistance for transfers, walking, and locomotion.</p> <p>Review of a Nursing Note completed on 11/9/15 at 12:15 p.m., indicated a CNA had reported Resident #11 did not lift her foot while ambulating to the bathroom. The resident had lost her balance and started leaning towards the CNA. The CNA then lowered the resident to the bathroom floor. The CNA called for assistance, the nurse completed a head to toe assessment with no injury noted. The nurse instructed the CNAs to use a gait belt with ambulation.</p>		<p><u>be affected by the same practice and what corrective action will be taken?</u> All residents that require staff assistance for transfers and ambulation have the potential to be affected. The DON has checked the care plans and CNA assignment sheets for those residents who require assistance with ambulation to make sure that the use of a gait belt is indicated on each form. If the DON or other staff member should observe a nursing staff member assisting a resident to ambulate without the use of a gait belt, he/she will notify the charge nurse or DON (if not already aware of the situation). The DON or charge nurse will assist the staff member in applying a gait belt to the resident for the remainder of the ambulation activity. Once the resident is safe, the DON will re-train the staff involved in the facility policy for use of gait belts while assisting residents with ambulation. She will also render progressive written counseling for instances of continued noncompliance. 3. <u>What measures will be put into place to ensure that this practice does not recur?</u> The DON will notify the IDT of any falls that have occurred and the resulting investigation of the reasons for those falls to the morning management IDT meeting which occurs at least 5 days a week. Interventions, such as the use of a gait belt while ambulating, will</p>	

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	<p>A Fall Investigation Report completed on 11/9/15 indicated the resident was alert. A description of the accident indicated: the resident lost her balance while ambulating. The CNA lowered the resident to the floor with no injury noted. The investigation indicated what had happened/caused the fall: the CNA was assisting the resident without the use of a gait belt. The investigation indicated how the accident would be prevented from happening again: the CNAs were educated on using a gait belt with residents, wheelchair if needed for increased pain or decreased mobility and 2 person assist when necessary.</p> <p>Interview with CNA #1 on 12/3/15 at 1:37 p.m., indicated the resident had fallen prior to the recent fall and since then she required more assistance and the use of a gait belt with all transfers and ambulation.</p> <p>Interview with the Director of Nursing (DON) on 12/3/15 at 1:52 p.m., indicated the resident needed 1-2 assist with transferring and walking. She further indicated the resident was up and walking towards the bathroom when the CNA approached the resident. The CNA was assisting the resident to the restroom when the resident lost her balance and</p>		<p>be discussed and added to the resident's care plan and CNA assignment sheet if not already in place. The continued need for the use of the gait belt will be discussed by the IDT as part of the care plan review and conference which occurs no less often than quarterly. All members of the IDT will observe staff assisting residents with ambulation as part of their regular frequent rounds which occur throughout their tour of duty. Any concerns or issues that are identified with this process will be addressed as indicated in question #2. 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> The DON will bring the results of the IDT observations, as well as any re-training or written counseling that has been done, to the monthly QA Committee meeting for further review. If any recommendations are made by the committee, the DON will follow up and report back the results of those recommendations at the next QA Committee meeting. This will continue on an ongoing basis.</p>		

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F 0371 SS=E Bldg. 00	<p>she had to be lowered to the floor. She indicated the CNA should have placed the gait belt on the resident when she approached the resident to help with the residents balance while walking. She indicated it was the facility's policy for staff to use gait belts on residents during ambulation and transfers.</p> <p>A policy titled Gait Belt Use and received from the DON on 12/3/15 at 2:43 p.m., indicated,..."WHEN TO USE GAIT BELT: During all ambulation and transfers whether resident requires full assist or standby assist...."</p> <p>3.1-45(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure a beverage was covered during room tray service for 1 of 6 resident who received a room tray. And the facility failed to ensure proper sanitation of a puree blender for 4 of 4 resident who receive</p>	F 0371	It is the policy of this facility to ensure beverages are covered when transported to resident rooms and that equipment is sanitized properly, including the puree blender. <u>1.What corrective action will be done by the facility?</u> All staff was in serviced 12/15/15, by the	12/31/2015

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT WINAMAC	STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 13TH ST WINAMAC, IN 46996
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	<p>puree foods.</p> <p>Findings include:</p> <p>1. On 11/30/15 at 12:14 p.m., the following was observed during room tray service.</p> <p>A cup of coffee was poured from the craft on the beverage cart that was located in the Main Dining Room, placed on a room tray and carried down the hallway uncovered to Resident room #16.</p> <p>Interview with the Activities Director on 11/30/15 at 12:14 p.m., indicated the cup should have been covered with a lid.</p> <p>Interview with the Administrator on 11/20/15 at 4:45 p.m., indicated there was not a policy to cover beverages for room trays.</p> <p>2. On 12/2/15 with Cook #1 at 11:00 a.m., the following was observed.</p> <p>After Cook #1 finished the fortified puree carrots, she rinsed the puree blender and place in chemical, low temperature dishwasher. Cook #1 ran the dishwasher twice.</p> <p>The thermometer on the dishwasher after</p>		<p>Administrator on covering drinks before carrying them through the hallways. All dietary staff was inserviced on 12/15/15 on the correct dish washing temperature and sanitation of dishware and kitchen equipment. 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. The Dietary Manager will monitor drinks being taken for room trays to make sure that they are covered appropriately and will monitor the sanitation of all kitchen equipment, including the puree blender and the operation of the dish machine. If she identifies an issue, she will stop the staff at that time and re-train them on the correct procedures to follow. Once that is done, she may render written counseling for instances of continued noncompliance. 3. <u>What measures will be put into place to ensure that this practice does not recur?</u> The management team will monitor the transport of beverages and trays to the resident rooms to make sure that the beverages are covered. In addition the Administrator or Dietary Manager will check the sanitation bucket for sanitation levels and the dish machine for correct temperature at least 3 times a week. If any issues are identified, they will be addressed as indicated in question #2. 4.</p>	

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	<p>the second cycle, indicated the wash cycle was 116 degrees Fahrenheit.</p> <p>After taking the blender out of the dishwasher, Cook #1 placed a sanitation test strip in the water reservoir and it did not change colors, it remained white.</p> <p>Interview with Cook #1 at 11:15 a.m., indicated the wash and the rinse cycles were to reach 120 degrees and the sanitation cycle (rinse) 50 ppm. (parts per million). She further indicated, she did not know why the test paper did not change colors.</p> <p>Cook #1 then proceeded to make the BBQ beef puree with the blender that was removed from dishwasher.</p> <p>Cook #1 then rinsed the BBQ beef blender and placed the blender in the dishwasher and at 11:31 a.m., the Dietary Manager entered and placed a new sanitation test strip in the water reservoir of the dishwasher and indicated the strip did not change colors as it should have and it remained white. She then further indicated the sanitation bottle was low, but not empty.</p> <p>The Dietary Manager changed the sanitation bottle and re-ran the dishwasher and re-tested the sanitation</p>		<p><u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Dietary Manager will report the results of the observations and checking of the sanitation levels and dish machine temperatures to the QA Committee at its monthly meeting for the next 3 months. At the end of that time, if the QA Committee agrees, the Dietary Manager will report the results on a quarterly basis. Once 100 % compliance is reached after 2 quarters, the Committee may decide to stop the reporting by the Dietary Manager; however, she will continue to monitor the staff performance in these areas on an ongoing basis. Any newly found issues will be brought to the QA Committee for further process improvement at that time.</p>		

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	<p>with a new test strip. The test strip changed colors to indicate the sanitation of the dishwasher was 50 ppm. The wash cycle at that time indicated the wash cycle was 128 degrees Fahrenheit.</p> <p>Interview with the Dietary Manager on 12/2/15 at 11:35 a.m., indicated the Cook should have changed the sanitation bottle, made sure the sanitization test strip read at least 50 ppm, and ran the dishwasher until the wash cycle reached 120 degrees Fahrenheit.</p> <p>The policy titled, "Water Temperatures for Reduced Temperature Dish Machines," provided by the Administrator was current on 12/2/15 at 1:20 p.m., indicated, "...The temperature for washing and sanitizing dishware in the reduced temperature dishwashing machines should not be less than 120 degrees F. (sic)...NOTE ALSO: Dishes must be sanitized with a chlorine or iodine bath containing a minimum of 50 ppm of available chlorine or 12.5 ppm of a iodophor. ..."</p> <p>3.1-21 (i)(3)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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