

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 07/13/2012
--	---	--	---

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 PERCEDED 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
F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>July 9, 10, 11, 12 and 13, 2012</p> <p>Facility number: 000341 Provider number: 155459 AIM number: 100286550</p> <p>Survey team: Leslie Parrett, RN- TC Sharon Lasher, RN Barbara Gray, RN Angel Tomlinson, RN</p> <p>Census bed type: SNF/NF: 32 Total: 32</p> <p>Census payor type: Medicare: 2 Medicaid: 25 Other: 5 Total: 32</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 20, 2012 by Bev Faulkner, RN</p>	F0000		

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 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/13/2012
--	---	--	---

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 PERCEDED 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

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 07/13/2012
--	---	--	---

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
F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, interview and record review, the facility failed to notify the physician to obtain an order for treatment for a resident with numerous red bumps on his body for</p>	F0157	This Plan of Correction constitutes the written allegation of compliance for	08/07/2012

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 07/13/2012
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>1 of 5 residents that met the criteria for skin conditions (non pressure related) Resident #44.</p> <p>Finding include:</p> <p>During observation on 7-10-12 at 10:46 a.m., Resident #44 had scabbed areas on his left hand and the lower part of both arms. The resident had a long sleeve shirt on. The resident indicated he did not know what happened to his skin.</p> <p>Review of the record of Resident #44 on 7-11-12 at 10:42 a.m., indicated the resident's diagnoses included, but were not limited to, hypertension, Degenerative Joint Disease (DJD), dementia, confusion, psychotic disorder and organic brain syndrome.</p> <p>The admission assessment for Resident #44, dated, 7-6-12, indicated the resident had ecchymotic patches all over the trunk of the body, nothing was open and there was a three centimeter scab area over the left leg.</p> <p>Review of the record of Resident #44 on 7-11-12 at 10:42 a.m., indicated there no plan of care or treatment for the skin patches on the resident's body. The record indicated there was</p>		<p>the deficiencies cited.</p> <p>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.</p> <p>Hickory Creek at New Castle desires this Plan of Correction to be Considered the facility's Allegation of Compliance.</p> <p>Compliance is effective on 8/12/12.</p> <p>F157</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 07/13/2012	
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>no notification to the physician related to the resident's skin problem.</p> <p>The nursing note for Resident #44, dated, 7-8-12 9:00 p.m., indicated the resident had numerous skin areas where he picks at them.</p> <p>The nursing note for Resident #44, dated, 7-9-12 at 1:10 a.m., indicated the resident has numerous skin areas, some old and scabbed, some red.</p> <p>Interview with Resident #44's family member on 7-11-12 at 2:50 p.m., indicated the resident had the skin issues before admission to the facility. The family member indicated the resident's physician had ordered some ointment to put on the areas and it had been helping. The family member indicated he did not know why the current facility did not call the resident's physician and get an order for the ointment to treat the areas. The family member indicated he went to the prior facility to get the ointment so the current facility could treat the areas and the prior facility was unable to find the ointment. The family member indicated he had taken Resident #44 to an dermatologist one month ago.</p>		<p>It is the policy of this facility to notify the Physician of any change in resident condition, including notification of skin conditions.</p> <p>-</p> <p><u>1. What corrective action will be accomplished for those residents found to be affected by the deficient practice?</u></p> <p>-</p> <p><u>Resident #44 continues to receive the treatment which was ordered on 7-12-12 including order of Selen Moisturizer cream is applied to the arms, Legs, torso and any other dry areas of skin during the pm care as well as Baby Magic also applied to all skin areas after each shower. The resident currently voices no complaints of itching and/or discomfort.</u></p> <p>-</p> <p><u>Nursing staff and IDT will 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 07/13/2012	
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>During observation on 7-12-12 at 10:03 a.m., Resident #44 had numerous raised red bumps all over both his arms, trunk front and back and his buttocks. CNA #3 indicated the resident had the bumps on his body since admission. Resident #44 was scratching his right arm and indicated the skin areas itched.</p> <p>Interview with RN #1 on 7-12-12 at 11:50 a.m., indicated Resident #44 was not receiving a treatment for skin areas.</p> <p>The physician order for Resident #44, dated 7-12-12 at 4 p.m., indicated add the diagnosis of pemphigus (autoimmune skin disorder) Prednisone 20 milligrams (MG) for three tablets for seven days, then 20 mg two tablets for seven days, then 20 mg, one tablet for seven days.</p> <p>The physician order for Resident #44, dated 7-12-12 at 4:00 p.m., indicated Vaseline with non stick gauze to blisters if more than three blisters occur call the Medical Doctor (MD), do call and give report on the progress of condition to MD in two weeks.</p> <p>The "Change of Condition" policy provided by the Administrator on</p>		<p><u>re-educated by the DON and Administrator regarding the admission/readmission assessment,</u></p> <p><u>physician notification, initial care plan development and chart review</u></p> <p><u>on 8-07-12.</u></p> <p>-</p> <p><u>2 How will other residents be identified and what corrective action will be taken?</u></p> <p>-</p> <p><u>There have been no other residents identified as being affected by this issue.</u></p> <p>-</p> <p><u>If there any unmet needs identified by the DON or IDT, the DON will</u></p> <p><u>ensure that the physician is notified immediately. Once the physician</u></p> <p><u>has been notified of any identified concerns, and the resident's needs</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 07/13/2012
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	
	7-13-12 at 3:15 p.m. indicated the resident's primary physician or designated alternate will be notified immediately of any change in the resident's physical or mental condition. 3.1-5(a)(3)		<p><u>have been taken care of. the DON will retrain the nurses involved.</u></p> <p><u>Once they are retrained, she will render progressive disciplinary action for continued noncompliance.</u></p> <p>-</p> <p><u>3. What measures will be put into place to ensure the deficient practice does not recur?</u></p> <p>-</p> <p><u>The clinical record of all new admissions and readmissions will be reviewed by the IDT at the next scheduled morning management meeting which is held at least 5 days each week. Each section of the record will be reviewed to assure all resident care areas are identified. If an area is identified that has not been addressed, the Physician will be notified.</u></p> <p>-</p> <p><u>In addition, the DON will perform a full body assessment of</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 07/13/2012
--	---	--	---

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><u>each new admission the next working day after the admission/</u></p> <p><u>readmission to assure all skin issues have been identified on the initial</u></p> <p><u>nursing assessment with Physician notification as appropriate. The</u></p> <p><u>initial care plan will be reviewed to make sure that it is complete and</u></p> <p><u>reflective of the resident's needs which were evident upon admission. Any</u></p> <p><u>identified concerns will be addressed as indicated in question #2.</u></p> <p>-</p> <p>-</p> <p><u>4. How will the corrective action be monitored:</u></p> <p>-</p> <p><u>The DON will bring the results ofher reviews and corrective action taken</u></p> <p><u>for identified concerns to the monthly QA&A Committee meeting for</u></p> <p><u>review and recommendation. Any recommendations made by the</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 07/13/2012
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	
			<u>committee will be followed through by the Administrator or DON</u> <u>who will report the results of those recommendations at the next</u> <u>scheduled QA&A Committee meeting. The monitoring for completion and follow through</u> <u>of new admissions/readmissions will continue on an ongoing basis.</u> - - <u>Date of Compliance: 8/07/12</u>		

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 07/13/2012
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	
F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview and record review, the facility failed to implement a plan of care for a resident's skin impairment, elopement prevention and plan of care to prevent falls with appropriate interventions for a confused resident for 1 of 18 residents sampled for careplans (Resident #44).</p> <p>Finding include:</p> <p>Review of the record of Resident #44 on 7-11-12 at 10:42 a.m., indicated the resident's diagnoses included, but</p>	F0279	<p><u>F279</u></p> <p>-</p> <p>It is the policy of this facility to develop comprehensive care plans based on resident assessments for resident conditions, including skin issues, elopement prevention and fall prevention.</p>	08/07/2012	

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 07/13/2012	
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>were not limited to, hypertension, Degenerative Joint Disease (DJD), dementia, confusion, psychotic disorder and organic brain syndrome.</p> <p>The "Discharge Summary/Recapitulation of Resident's Stay" from the prior long term care facility for Resident #44, dated 7-6-12, indicated the resident's psychosocial status was "upset at times misses family." The resident was admitted with acute confusion. The resident propels himself in a wheelchair. The resident had made several attempts to get on the elevator. The resident had stated several times he wants to go home.</p> <p>The Brief Interview for Mental Status (BIMS) for Resident #44, dated 7-11-12, indicated the resident's score was a five, this indicated the resident had cognitive impairment.</p> <p>During observation on 7-11-12 at 9:54 a.m., Resident #44 was wheeling himself around the facility. The resident asked if I had a car and would I take him home. The resident was tearful.</p> <p>Interview with the Social Service Director (S.S.D.) on 7-11-12 at 3:47 p.m., indicated the facility did not do</p>		<p>-</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>-</p> <p><u>Nursing staff and IDT will be re-educated by the DON and Administrator regarding</u></p> <p><u>the admission/readmission assessments that include identification of skin</u></p> <p><u>impairments, need for fall prevention and elopement prevention. physician</u></p> <p><u>notification, and initial care plan development on 8-07-12. They will also</u></p> <p><u>be in-serviced on the facility policy and procedure for fall prevention and</u></p> <p><u>measures to take upon admission and the need to closely inspect any material</u></p> <p><u>accompanying the resident in order to gain as much information about the</u></p> <p><u>resident's history and needs as possible.</u></p> <p>-</p> <p><u>The schedule for assessments</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 07/13/2012
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>an elopement assessment or plan of care for elopement for five days after admission. The Social Service Director indicated the resident talks about leaving, but had not attempted to leave the facility.</p> <p>The admission assessment for Resident #44, dated 7-6-12, indicated the resident had eccyomotic patches all over the trunk of the body, nothing was open and there was a three centimeter scab area over the left leg.</p> <p>During observation on 7-12-12 at 10:03 a.m., Resident #44 had numerous raised red bumps all over both his arms, trunk front and back and his buttocks. CNA #3 indicated the resident had the bumps on his body since admission. Resident #44 was scratching his right arm and indicated the skin areas itched.</p> <p>Interview with RN #1 on 7-12-12 at 11:50 a.m., indicated Resident #44 was not receiving a treatment for skin areas.</p> <p>Review of the record of Resident #44 on 7-11-12 at 10:42 a.m., indicated no plan of care or treatment for the skin patches on the resident's body or an elopement plan of care with interventions to prevent elopement.</p>		<p><u>indicates that the elopement assessment should</u></p> <p><u>be done within 72 hours – not 5 days as indicated in the 2567 - of the</u></p> <p><u>resident's admission/readmission. The Nurse Consultant will review this policy</u></p> <p><u>and the content of the assessment with the SSD to make sure that she is updated</u></p> <p><u>on the requirements of this assessment.</u></p> <p><u>2. How will the facility identify other residents having the potential to be affected</u></p> <p><u>by the same practice and what corrective action will be taken?</u></p> <p>-</p> <p><u>All residents newly admitted/Readmitted to the facility have the potential to be</u></p> <p><u>affected by this practice.</u></p> <p>-</p> <p><u>If there any unmet needs identified by the DON or IDT, the DON will</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 07/13/2012	
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 fall risk assessment for Resident #44, dated 7-6-12, indicated the resident was considered high risk for falls.</p> <p>The initial care plan for Resident #44, dated 7-6-12, indicated the resident was "risk for initial fall." The interventions were call light in reach, orient to new surrounding and staff, reinforce safety awareness.</p> <p>The nursing note for Resident #44, dated 7-8-12 at 12:15 a.m. indicated the resident was found on the floor next to the bed. The resident had no injury. The resident did not indicate what happened. The resident stated " get a rope and get me up."</p> <p>The nursing note for Resident #44, dated 7-9-12 at 10:15 a.m., indicated the Interdisciplinary Team (IDT) reviewed the fall with no injuries. A scoop mattress was placed on the resident's bed and therapy notified.</p> <p>The "Fall Prevention Program" provided by the Director Of Nursing (DON) on 7-12-12 indicated it was the policy of the facility to identify residents at risk for falls and to implement a fall prevention program to reduce the risk of falls and possible</p>		<p><u>ensure that a care plan has been initiated to reflect the resident's condition, assessed needs, and interventions designed to address those needs. When that is completed, the DON will re-train the staff involved.</u></p> <p><u>Once they are retrained, the Administrator or DON will render progressive disciplinary action for continued noncompliance.</u></p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>-</p> <p>The SSD will begin using the Admission Questionnaire when a resident is admitted to the facility which will identify pertinent information from the resident's history & prior living arrangements to assist the staff in meeting</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 07/13/2012
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	
	injury. "Upon admission or readmission, if the resident's fall risk score is "10" or greater and/or if the resident has a history of falls, interventions will be put into place which may include alarms, low bed, mat on floor, etc. until a thorough assessment of the resident's risk for falls is completed." 3.1-35(a)		the resident's needs more effectively upon admission. The SSD will give it to the charge nurse at the time of admission or shortly after so that it can be available to all staff. It is part of the resident's medical chart. The DON will review the focus charting, 24 hour report, any reported incidents including falls, and copies of physician telephone orders each morning of her tour of duty, at least 5 days a week. The DON will bring the results of those reviews, as well as the charts of new admissions and readmissions to the morning IDT management meeting which occurs at least 5 days a week.		

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 07/13/2012
--	---	--	---

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 MDSC or designated IDT member will then write a care plan</p> <p>for identified issues, including any interventions that are a result of the interdisciplinary team review and discussion at the morning meeting.</p> <p>The care plan will be placed on that resident's chart at that time. In addition,</p> <p>the MDSC or designee will indicate a change in the care plan on the 24 hour report so that subsequent shifts are aware of the addition or change in care plan and interventions. The DON will update the CNA assignment sheets at that same time, so that they are current with the resident's care plan.</p> <p>The interdisciplinary team</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 07/13/2012
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 PERCEDED 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>will continue to monitor care plans during the weekly care plan meeting and as physician order changes are received.</p> <p>Any concerns or issues that are identified will be addressed by the DON or Administrator as indicated in question #2.</p> <p>-</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></p> <p>-</p> <p><u>The DON will bring the results of her reviews and corrective action taken for identified concerns to the monthly QA&A Committee meeting for review and recommendation. Any recommendations made by the committee will be followed through by the Administrator or</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 07/13/2012
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 PERCEDED 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><u>DON who will report the results of those recommendations at the next</u></p> <p><u>scheduled QA&A Committee meeting. The monitoring for</u></p> <p><u>completion and follow through of new admissions/readmissions'</u></p> <p><u>care plans will continue on an ongoing basis.</u></p> <p>-</p> <p><u>Date of Compliance: 8/07/12</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 07/13/2012
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	
F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to provide a resident with a scoop mattress according to the resident's plan of care, for 1 of 18 residents reviewed for care plans and failed to follow a physician's order for strict intake and output for 1 of 2 residents reviewed for hydration. (Resident #16 and 2).</p> <p>Findings include:</p> <p>1.) On 7/11/12 at 10:23 A.M., Resident #16 was observed for care. Resident #16 sat up on the side of the bed with minimal assist from CNA #8. A gait belt was placed and Resident #16 stood with minimal assist from CNA #8. A standard mattress was observed on Resident #16's bed.</p> <p>On 7/12/12 at 10:06 A.M., Resident #16 was observed lying in bed on her back with her eyes closed. A standard mattress was observed on Resident #16's bed.</p>	F0282	<p><u>F282</u></p> <p>-</p> <p>It is the policy of this facility to Provide services to all residents in</p> <p>Accordance with each one's plan of care.</p> <p>Resident #16 expired on 7/14/12. The scoop mattress was immediately replaced on the bed when brought toour attention on 7/13/12.</p> <p>Resident # 2 was admitted 5/30/12 and discharged to home 6/07/12.</p> <p>-</p> <p><u>1. What corrective action will be</u></p>	08/07/2012	

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 07/13/2012	
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 #16's record was reviewed on 7/12/12 at 11:19 A.M., Diagnoses included but were not limited to primary peritoneal carcinoma, hypertension, chronic obstructive pulmonary disease, arthritis, osteoporosis, and dementia.</p> <p>A nurses note for Resident #16, dated 5/23/12 at 9:30 P.M., indicated the following: The nurse had given Resident #16 her medications at 8:30 P.M. Resident #16 had been sitting on the edge of the bed at that time. The nurse heard Resident #16 yell for help. The nurse found Resident #16 sitting on her bedroom floor next to her bed. Resident #16 had slid off of her bed, pulling the bed covers off with her as she slid. The Fall Investigation Report for Resident #16, dated 5/23/12, indicated a scoop mattress would be placed on Resident #16's bed.</p> <p>A Fall Care Plan for Resident #16 indicated the following: Problem onset: 2/15/11. Problem: Resident #16 was at risk for falls/injury related to a fall risk score of 10 or higher and impaired vision. Approaches: Added 5/24/12 - Resident #16 would have a scoop mattress on her bed.</p> <p>On 7/13/12 at 9:28 A.M., Resident</p>		<p><u>done by the facility?</u></p> <p>-</p> <p><u>All staff will be in-serviced on 8/07/12 regarding policy and procedures on assessments, fall prevention, accurate documentation on intake and output records, approved intake and output forms, and care plans.</u></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></p> <p>-</p> <p><u>There have been no other residents identified as being affected by this practice.</u></p> <p>-</p> <p><u>In the future, if there any unmet needs identified by the DON or IDT,</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 07/13/2012
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>#16 was observed lying in bed on her back with her eyes closed. A standard mattress was observed on Resident #16's bed.</p> <p>On 7/13/12 at 9:35 A.M., the Director of Nursing (DON) indicated Resident #16 did not have a scoop mattress on her bed. The DON indicated she did not know why someone had changed the mattress out from a scoop mattress to a standard mattress.</p> <p>2.) Resident #2's closed record was reviewed on 7/11/12 at 10:30 A.M.</p> <p>A hospital note for Resident #2, dated 5/22/12, indicated the following: Resident #2 had been taken to the hospital where she again demonstrated marked dehydration with acute renal insufficiency, typical of her high output ileostomy. Resident #2 had been dehydrated several times before. The hospital assessment indicated Resident #2 had recurring dehydration with renal shutdown and electrolyte disturbance with tremors and clonic-tonic movements as a result of the dehydration. Resident #2 had metabolic syndrome with diabetes. The hospital plan indicated they would rehydrate Resident #2 aggressively which seemed to work</p>		<p><u>including fall prevention and tracking of intake and output, the DON will</u></p> <p><u>ensure that a care plan has been initiated to reflect the resident's condition, assessed needs, and interventions designed to address those needs. When that is completed, the DON will retrain the staff involved.</u></p> <p><u>Once they are retrained, the Administrator or DON will render progressive disciplinary action for continued noncompliance.</u></p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>-</p> <p>The DON will review the focus charting, intake and output records, 24 hour report, any reported incidents including falls, and copies of physician telephone</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 07/13/2012	
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 her. The nephrologist and wound center would take a look a Resident #2 also, as well as a consult for port of PICC(central IV line) placement because of her recurring basis and need for access.</p> <p>Resident #2's record indicated she was admitted to the facility on 5/30/12. Resident #2's admission physician order, dated 5/30/12, indicated the following: Intravenous fluids per PICC 1/2 normal saline with 20 potassium chloride at 180 milliliters (ml) per hour.</p> <p>Additional physician's orders for Resident #2 indicated the following: 5/30/12-Draw labs per PICC line. Follow the facility protocol before and after labs. Change the PICC dressing every 7 days. Strict Intake and Output. Notify the MD if fluid intake is less than 3000 ml a day. 1000 ml of fluid by mouth 3 times a day between meals. Measure upper arm weekly with PICC line. 5/31/12-500 ml of fluid by mouth every shift. Keep intravenous fluids at 180 ml and hour. Have dietary get drinks res prefers. 6/5/12-Discontinue intravenous fluids at 6:00 A.M., until 11:00 P.M., but run all night.</p> <p>A 5-Day Bladder Record For</p>		<p>orders each morning of her tour of duty, at</p> <p>least 5 days a week. The DON will bring the results of those reviews, as</p> <p>well as the charts of new admissions and readmissions to the morning IDT</p> <p>management meeting which occurs at least 5 days a week.</p> <p>The MDSC or designated IDT member will then write a care plan for identified</p> <p>issues, including any interventions that are a result of the interdisciplinary</p> <p>team review and discussion at the morning meeting. The care</p> <p>plan will be placed on that resident's chart at that time. In addition, the MDSC</p> <p>or designee will indicate a change in the care plan 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 07/13/2012	
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>Incontinence for Resident #2, beginning on 5/31/12 and ending on 6/4/12, indicated she voided in the toilet and bedpan. A review of Resident #2's Activities of Daily Living flow record for June, 2012 indicated Resident #2 was continent of her bladder.</p> <p>A Nutritional Assessment for Resident #2, dated 5/31/12, indicated the following: Resident #2 was independent in her feeding ability and was able to make her needs known. Resident #2 had a diagnosis of recurrent dehydration with renal shutdown and electrolyte disturbance and metabolic syndrome with diabetes mellitus. Resident #2 had a need for increased fluid intake related to a high output ostomy with dehydration.</p> <p>An initial nutritional care plan for Resident #2 dated 5/30/12, indicated the following: Problem-Resident #2 required a therapeutic diet related to diabetes mellitus and wounds. Resident #2 was at risk for weight loss related to dehydration. Approach-Resident #2's intake and output would be monitored every shift.</p> <p>Resident #2's June, 2012 Intake</p>		<p>the 24 hour report so that subsequent shifts are aware of the addition or change in care plan and interventions. The DON will update the CNA assignment sheets at that same time, so that they are current with the resident's care plan. The interdisciplinary team will continue to monitor care plans during the weekly care plan meeting and as physician order changes are received.</p> <p>The IDT will check for fall prevention Devices that have been put into place as interventions for residents at fall risk as part of the Guardian Angel rounds which occur at least 5 days a week. If a member of the IDT finds that interventions</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 07/13/2012
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>record provided documentation space for oral, enteral formula, flush, intravenous, and total. Resident #2's Output record provided space for voided, catheter, other, and total. The intake and output were combined on the same form. Resident #2 had two Intake and Output records for June, 2012 that provided documentation space for the same information. If the totals were combined from the two Intake and Output forms, Resident #2's Intake and Output records still had numerous documentation missing. The documentation filled in some of the spaces designated for voided had the number of times voided instead of the ml's voided.</p> <p>An interview with the DoN on 7/13/12 at 12:12 P.M., indicated Resident #2 had a high output ileostomy. The DoN indicated she did not know why Resident #2's June, 2012 intake and output was documented on two different forms and why some of the documentation was missing. The DON indicated if Resident #2 was able to urinate using the toilet and bedpan, her urine should have been measured in ml's. The DON indicated an inservice was needed concerning the use of the Intake and Output forms and the forms were confusing.</p>		<p>are not in place, he/she will notify the charge nurse immediately and will</p> <p>make sure that someone remains with the resident until the interventions are</p> <p>back in place. Once the resident is safe, the IDT member will bring the results</p> <p>of his/her findings to the next scheduled morning management meeting for review,</p> <p>further recommendations by the team, and care plan revision, if needed.</p> <p>Any concerns or issues that are identified By the Administrator or IDT member</p> <p>will be addressed by the DON or Administrator as indicated in question #2.</p> <p>-</p> <p>-</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 07/13/2012	
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>An interview with the DON on 7/13/12 at 12:49 P.M., indicated the following: After she investigated she discovered one Intake and Output form was kept in the resident's room for staff to document what intake she took in her room and one Intake and Output form was kept in the charting book for intravenous fluids. There was also a Fluid and Meal Intake Log that was kept in a binder to document fluids that came with meals, snacks, and medications. The nurses did not transfer all the totals on to a single June, 2012 Intake and Output record. The DON indicated the flow records were "definitely confusing" and if all of the totals for June, 2012 were transferred to a single Intake and Output record, some of the totals were still missing. The resident's urination was not documented in ml's and should have been since Resident #2 was able to use the toilet and bed pan.</p> <p>A Intake and Output Measurement policy and procedure provided by Maintenance on 7/13/12 at 3:45 P.M., indicated the following: "Purpose: To maintain an accurate record of the resident's fluid balance. Assessment: Amount of urine. Dehydration and fluid balance. Guidelines: The</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></p> <p>-</p> <p><u>The DON will bring the results of her reviews and corrective action taken for identified concerns to the monthly QA&A Committee meeting for review and recommendation. Any recommendations made by the committee will be followed through by the Administrator or DON who will report the results of those recommendations at the next scheduled QA&A Committee meeting. The monitoring for completion and follow through of residents' needs and care plans will continue on an ongoing basis.</u></p> <p>-</p> <p><u>Date of Compliance: 8/07/12</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 07/13/2012
--	---	--	---

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>following residents require measurement and documentation of intake and output at the end of every shift, including 24-hour total: All residents with indwelling catheter. All residents receiving enteral nutritional therapy. All residents receiving intravenous feeding, including TPN. All residents with specific physician's orders for measurement of intake and output. All residents with an order or fluid restriction or encouragement. For accuracy in measuring, a picture poster and/or list of facility drinking utensils and their equivalent ml will be posted where needed. Equipment: Intake and Output record form, HC-N-47. Bedpan and/or urinal. Graduated container. Procedure: 1. Record fluid intake on the "Resident Fluid and Meal Percentage Intake Log", HC-D-3014, at each meal. 2. Add between meal intake to other intake. 3. Instruct resident to urinate in bedpan or urinal, if possible, and notify nurse. measure urine and record amount on individual record. 4. If any bleeding, emesis or diarrhea occur, measure and record as output. 5. when enteral nutritional therapy or intravenous fluid is administered, record amount on individual record. 6. The intake is to be totaled and recorded on the permanent intake and output record, HC-N-47. 7.</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 07/13/2012
--	---	--	---

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 PERCEDED 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>Leave resident in a comfortable position and with the call light within reach. Documentation: Date, amount of intake and output every shift. Twenty-four hour total of intake and output. Staff responsible: RN, LPN, and Nursing Assistant".</p> <p>3.1-35(g)(2)</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 07/13/2012
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	
F0309 SS=D	<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 treatment orders were obtained for a resident who had severe skin issues for 1 of 5 residents that met the criteria for skin conditions (non pressure related) (Resident #44).</p> <p>Finding include:</p> <p>During observation on 7-10-12 at 10:46 a.m., Resident #44 had scabbed areas on his left hand and the lower part of both arms. The resident had a long sleeve shirt on. The resident indicated he did not know what happened to his skin.</p> <p>Review of the record of Resident #44 on 7-11-12 at 10:42 a.m., indicated the resident's diagnoses included, but were not limited to, hypertension, Degenerative Joint Disease (DJD), dementia, confusion, psychotic disorder and organic brain syndrome.</p>	F0309	<p><u>F309</u></p> <p>-</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, including obtaining treatment orders for residents who have skin issues.</p> <p><u>1. What corrective action will accomplished for those residents found to be affected by the deficient practice?</u></p>	08/07/2012	

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 07/13/2012
--	---	--	---

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 PERCEDED 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 admission assessment for Resident #44, dated 7-6-12, indicated the resident had ecchymotic patches all over the trunk of the body, nothing was open and there was a three centimeter scab area over left leg.</p> <p>Review of the record of Resident #44 on 7-11-12 at 10:42 a.m., indicated there was no plan of care or treatment for the skin patches on the resident's body. The record indicated there was no notification to the physician related to the resident's skin problem.</p> <p>The nursing note for Resident #44, dated 7-8-12 9:00 p.m., indicated the resident had numerous skin areas where he picks at them.</p> <p>The nursing note for Resident #44, dated 7-9-12 at 1:10 a.m., indicated the resident has numerous skin areas, some old and scabbed, some red.</p> <p>Interview with Resident #44's family member on 7-11-12 at 2:50 p.m., indicated the resident had the skin issues before admission to the facility. The family member indicated the resident's physician had ordered some ointment to put on the areas</p>		<p><u>Resident #44 continues to receive the treatment which was ordered on 7-12-12 including order of Selen Moisturizer cream is applied to the arms. Legs, torso and any other dry areas of skin during the pm care as well as Baby Magic also applied to all skin areas after each shower. The resident currently voices no complaints of itching and/or discomfort.</u></p> <p>-</p> <p><u>Nursing staff and IDT will be re-educated by the DON and Administrator regarding the admission/readmission assessment, physician notification, initial care plan development and chart review on 8-07-12.</u></p> <p>-</p> <p><u>2 How will other residents be identified and what corrective action will be taken?</u></p> <p>-</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 07/13/2012	
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>and it had been helping. The family member indicated he did not know why the current facility did not call the resident's physician and get an order for the ointment to treat the areas. The family member indicated he went to the prior facility to get the ointment so the current facility could treat the areas and the prior facility was unable to find the ointment. The family member indicated he had taken Resident #44 to an dermatologist one month ago and they did a biopsy on the skin lesions. The family member indicated he had not gotten the results back from the biopsy yet. The family member indicated Resident #44 itches and scratches the areas.</p> <p>During observation on 7-12-12 at 10:03 a.m., Resident #44 had numerous raised red bumps all over both his arms, trunk (front and back), and his buttocks. CNA #3 indicated the resident had the bumps on his body since admission. Resident #44 was scratching his right arm and indicated the skin areas itched.</p> <p>Interview with RN #1 on 7-12-12 at 11:50 a.m., indicated Resident #44 was not receiving a treatment for skin areas and does not have a non pressure skin sheet assessment for the areas. RN #1 indicated she was</p>		<p><u>There have been no other residents identified as being affected by this issue.</u></p> <p>-</p> <p><u>If there any unmet needs identified by the DON or IDT, the DON will ensure</u></p> <p><u>that the physician is notified immediately. Once the physician has been notified of</u></p> <p><u>any identified concerns, and the resident's needs have been taken care of, the DON</u></p> <p><u>will retrain the nurses involved. Once they are retrained, she will render</u></p> <p><u>progressive disciplinary action for continued noncompliance.</u></p> <p>-</p> <p><u>3. What measures will be put into place to ensure the deficient practice</u></p> <p><u>does not recur?</u></p> <p>-</p> <p><u>The clinical record of all new admissions and readmissions will be reviewed</u></p> <p><u>by the IDT at the next scheduled morning management meeting</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 07/13/2012
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>doing weekly skin assessment's today and would start a skin sheet today.</p> <p>The physician order for Resident #44, dated 7-12-12 at 4 p.m., indicated add the diagnosis of pemphigus (autoimmune skin disorder) Prednisone 20 milligrams (MG) for three tablets for seven days, then 20 mg two tablets for seven days, then 20 mg one tablet for seven days.</p> <p>The physician order for Resident #44, dated 7-12-12 at 4:00 p.m., indicated Vaseline with non stick gauze to blisters if more than three blisters occur call the Medical Doctor (MD), do call and give report on the progress of condition to MD in two weeks.</p> <p>Interview with the Director Of Nursing on 7-13-12 at 2:28 p.m., when queried what the facility protocol was for when a resident was admitted to the facility with numerous skin issues as far as notifying the doctor and ensuring treatment was provided promptly, the DON indicated it was a head to toe assessment completed on admission. The DON indicated if any issues were observed, the physician would be notified for an treatment order. The DON indicated the family, DON and/or Administrator</p>		<p><u>which is</u></p> <p><u>held at least 5 days each week.</u> <u>Each section of the record will be</u></p> <p><u>reviewed to assure all resident care areas are identified. If an area is</u></p> <p><u>identified that has not been addressed, the Physician will be notified.</u></p> <p>-</p> <p><u>In addition, the DON will perform a full body assessment of</u></p> <p><u>each new admission the next working day after the admission/</u></p> <p><u>readmission to assure all skin issues have been identified on the initial</u></p> <p><u>nursing assessment with Physician notification as appropriate. The</u></p> <p><u>initial care plan will be reviewed to make sure that it is complete and</u></p> <p><u>reflective of the resident's needs which were evident upon admission. Any</u></p> <p><u>identified concerns will be addressed as indicated in question #2.</u></p> <p>-</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 07/13/2012
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 PERCEDED 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	
	would be notified of the treatment orders. The DON indicated the department managers also review nurses notes five days a week to see if there were any notations of a red area, a rash or anything that needed follow up. 3.1-37(a)		- 4. <u>How will the corrective action be monitored:</u> - <u>The DON will bring the results of her reviews and corrective action taken for identified concerns to the monthly QA&A Committee meeting for review and recommendation. Any recommendations made by the committee will be followed through by the Administrator or DON who will report the results of those recommendations at the next scheduled QA&A Committee meeting. The monitoring for completion and follow through of residents' needs and care plans will continue on an ongoing basis.</u> - <u>Date of Compliance: 8/07/12</u>		

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 07/13/2012
--	---	--	---

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
			-	

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 07/13/2012
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	
F0323 SS=D	<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, interview and record review, the facility failed to implement interventions and assess accurately a resident that was at high risk for elopement and failed to train and educate the staff how to safely transfer a resident for 1 of 6 residents that met the criteria for accidents (Resident #44).</p> <p>Findings include:</p> <p>1.) Review of the record of Resident #44 on 7-11-12 at 10:42 a.m., indicated the resident's diagnoses included, but were not limited to, hypertension, Degenerative Joint Disease (DJD), dementia, confusion, psychotic disorder and organic brain syndrome.</p> <p>Review of the record of Resident #44 on 7-11-12 at 10:42 a.m., indicated no elopement assessment or plan of care with interventions for elopement.</p> <p>During observation on 7-11-12 at 9:54 a.m., Resident #44 was wheeling</p>	F0323	<p>F323</p> <p>It is the policy of this facility to 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, including elopement prevention and staff training to make sure assistance with resident needs is accomplished in a safe manner.</p> <p><u>1.What corrective action will be Accomplished for those resident found</u></p>	08/07/2012	

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 07/13/2012
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>himself around the facility. The resident asked if I had a car and would I take him home. The resident was tearful.</p> <p>During interview with Resident #44 on 7-11-12 at 11:30 a.m., the resident stated "sis do you got your truck here, will you take me home?" During observation at that time, the resident asked numerous staff members if they would take him home.</p> <p>During observation on 7-11-12 at 2:12 p.m., Resident #44 was in the therapy department. The resident stated " do you have a car here? lets go."</p> <p>During observation on 7-12-12 at 2:46 p.m., Resident #44 was telling the Occupational Therapist that he wanted to go home.</p> <p>During observation on 7-12-12 at 4:00 p.m., Resident #44 told the Director Of Nursing that he had to get "out of this cage. "</p> <p>The "Discharge Summary/Recapitulation of Resident's Stay" from the prior long term care facility for Resident #44, dated 7-6-12, indicated the resident's psychosocial status was "upset at times misses family." The resident</p>		<p><u>to have been affected?</u></p> <p>An elopement risk assessment was completed for Resident #44 on 7-11-12.</p> <p>The assessment revealed the resident required a care plan for risk of elopement.</p> <p>This care plan was developed on 7/11/12. Another elopement risk assessment was completed on 7-16-12 and it confirmed that the resident remains at risk for elopement the current care plan will remain in effect. The resident has not made comments regarding going home nor has he exhibited any exit seeking behaviors.</p> <p>Resident #44 was evaluated by therapy on 7/09/12 and is currently receiving services for transfer and ambulation. Until therapy provides further instruction, Resident #44 is being transferred with 1-2 staff as he can stand and get his self up with stand-by assist..</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 07/13/2012
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 admitted with acute confusion. The resident propels himself in a wheelchair. The resident had made several attempts to get on the elevator. The resident had stated several times he wants to go home.</p> <p>The nurses note for Resident #44, dated 7-6-12 at 5:00 p.m., indicated the resident was mad and wanted to go home. The resident became very agitated with "the whole set up."</p> <p>The nurses note for Resident #44, dated 7-7-12 at 9:00 p.m., indicated the resident kept talking about going home and was found in other resident rooms.</p> <p>The nurses note for Resident #44, dated 7-10-12 at 2:45 p.m., indicated the resident continuously asked to go home. The resident wanted staff to let him out.</p> <p>The nurses note for Resident #44, dated 7-10-12 at 7:30 p.m., indicated the resident wanted various staff to take him home. The resident was wandering around the facility in his wheelchair.</p> <p>The nurses note for Resident #44, dated 7-11-12 at 3:30 p.m., indicated the resident had asked several times</p>		<p>Staff has received training from therapy in the correct manner of transferring that is to be used until further instructions are available.</p> <p><u>2.How other residents will be identified and what corrective action will be taken?</u></p> <p>-</p> <p>There have been no other residents identified as being affected by this practice;</p> <p>however, in the future if the Administrator or any member of the IDT find that a resident is exit seeking or has a history of exit seeking without a care plan in place, he/she will bring that issue to the Administrator immediately so that a care plan and interventions can be developed.</p> <p>Likewise, if staff is observed to be rendering care, such as transferring a resident in a manner that does</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 07/13/2012
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>to go home. The resident had been asking staff if they had a car at the facility. The resident had made no attempts to elope or exit the facility. The resident was sitting by the door today watching out the window. The resident did not push on the door as to open it or attempt to leave as visitor exited the facility.</p> <p>Interview with Resident #44's family member on 7-11-12 at 2:50 p.m., indicated the reason the resident was discharged from the prior long term care facility to the current facility was because the resident had left in the facility elevator two times and got to the front parking lot before the resident was found. The family member indicated the resident had gotten on the elevator of the prior facility numerous times attempting to leave. The family member indicated the resident had been at the prior long term care facility one week, prior to that the resident had lived at home with the family member.</p> <p>Interview with the DON on 7-11-12 at 3:31 p.m., indicated the facility had not done an elopement assessment or plan of care for Resident #44. The DON indicated Social Services was doing the assessment today. The DON indicated the facility did the</p>		<p>not indicate appropriate</p> <p>technique or safety for the staff or resident, the Administrator or IDT member</p> <p>will stop the transfer immediately.</p> <p>The DON will be notified at that time, and she will direct staff how to transfer or other-</p> <p>wise care for the resident safely. Once the resident is safe, she will review the appropriate</p> <p>technique with the staff involved and retrain them accordingly.</p> <p>Once staff training has taken place and the resident's care plans are in place and updated</p> <p>to match the current needs of the resident, the Administrator or DON will render progressive</p> <p>disciplinary action as indicated by thenoncompliance.</p> <p><u>3. What measures will be put into place to ensure this does not recur?</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 07/13/2012
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>elopement assessment after five days of admission. The DON indicated the resident had made no attempts to go out the door. The DON indicated the resident talked about leaving, but had not tried to leave.</p> <p>Interview with the Social Service Director (S.S.D.) on 7-11-12 at 3:47 p.m., indicated the facility did not do an elopement assessment or plan of care for elopement for five days after admission. Social Services indicated the resident talks about leaving, but had not attempted to leave the facility.</p> <p>The elopement risk assessment for Resident #44, dated 7-11-12, indicated the resident was a score of 4. The elopement risk assessment indicated a care plan must be developed and implemented if the total score was 5 or more or if number 4 or number 5 was checked. Resident #44's assessment indicated for number four (historical behavior patterns. Purposeful exit seeking, frequently searching for home or something familiar) zero points. This indicated the assessment was inaccurate.</p> <p>The Social Service Progress Note for Resident #44, dated 7-11-12 (no time), indicated the resident had an</p>		<p>The SSD will begin using the Admission Questionnaire when a resident is admitted to the facility which will identify pertinent information from the resident's history & prior living arrangements to assist the staff in meeting the resident's needs more effectively upon admission.</p> <p>The SSD will give it to the charge nurse at the time of admission or shortly after so that it can be available to all staff. It is part of the resident's medical chart.</p> <p><u>The schedule for assessments indicates that the elopement assessment should be done within 72 hours – not 5 days as indicated in the 2567 - of the resident's admission/readmission. The Nurse Consultant will review this policy and the</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 07/13/2012
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>elopement risk of 4- not at risk. The resident did verbalize several times throughout the day he needed to go home. The staff are able to redirect the resident without any argument or aggression. The resident had made no attempts to go outside on his own. The resident had not pushed on exit doors to try to get out. The resident exhibited some delusions stating he was in jail.</p> <p>The "Resident Elopement" policy provided by the DON on 7-12-12 at 1:50 p.m., indicated the definition was "A situation where a cognitively impaired resident with impaired safety judgement leaves the facility without staff knowledge." The purpose of the policy was to identify the risk of, prevent, detect, and respond to the resident elopement. The procedure included, but were not limited to, all residents shall have an elopement risk assessment done by Social Services upon admission, any resident with an episode of elopement or any resident who has not eloped, but demonstrates behavior indicating a risk of elopement shall be assessed using the post-elopement protocol. The resident's care plan will be updated with any interventions that are put into place by IDT to assure resident safety.</p>		<p><u>content of the assessment with the SSD to make sure that she is updated on the</u></p> <p><u>requirements of this assessment.</u></p> <p>The SSD will perform an elopement assessment on all admissions to the facility within 72 hours of entry to the facility. She will initiate a care plan with interventions for keeping the resident safe, if indicated by the results of that assessment.</p> <p>The DON will review the focus charting, intake and output records, 24 hour report, any reported incidents including falls or attempted elopement, and copies of physician telephone orders each morning of her tour of duty, at least 5 days a week. The DON will bring the results of</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 07/13/2012	
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>2.) During observation on 7-11-12 at 9:54 a.m., Resident #44 was wheeling himself around the facility, the resident had a built up platform shoe on his right foot and his right leg was straight out.</p> <p>During observation on 7-11-12 at 2:12 p.m., Resident #44 was in therapy. The Occupational Therapist and the Physical Therapist was assisting the resident with a gait belt to stand, the resident had a walker in front of him. The resident was unable to stand but one second. When queried if the resident had walked prior to admission to the facility, the Occupational Therapist indicated she was unsure due to the resident was a poor historian.</p> <p>During interview with Resident #44's family member on 7-11-12 at 2:50 p.m., indicated the resident had been admitted to another facility for therapy approximately two weeks ago. The family member indicated the resident did walk prior to nursing home placement two weeks ago. The family member indicated the resident was at home prior to long term care placement and had become unsteady. The family member indicated the resident had fell at</p>		<p>those reviews, as well as the charts of new admissions and readmissions to the morning IDT management meeting which occurs at least 5 days a week.</p> <p>The MDSC or designated IDT member will then write a care plan for identified issues, including any interventions that are a result of the interdisciplinary team review and discussion at the morning meeting.</p> <p>The care plan will be placed on that resident's chart at that time. In addition, the MDSC or designee will indicate a change in the care plan on the 24 hour report so that subsequent shifts are aware of the addition or</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 07/13/2012
--	---	--	---

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>home and he was concerned that the resident would fall again, so he wanted the resident to have therapy.</p> <p>During observation on 7-12-12 at 10:03 a.m., CNA # 3 and CNA #4 transferred Resident #44 from his recliner to the wheelchair using a gait belt. During the observation it took CNA #3 and CNA #4 three attempts to get the resident transferred. Resident #44 would attempt to help transfer himself, but was unable to help. CNA #3 and CNA #4 had to return the resident back to his recliner two times due to the resident was hardly able to bear weight or pivot. CNA #3 and CNA #4 wheeled Resident #44 to the bathroom and moved the resident's wheelchair around in order to transfer him to the toilet. CNA #3 indicated that maybe the resident could use a stand-up lift. When queried if they had been educated or trained on how to transfer the resident, both CNA's indicated they had not. CNA #4 indicated it was difficult to transfer the resident because his right leg does not bend and he had the built-up shoe. CNA # 5 came in the bathroom to assist with transferring Resident #44 back into his wheelchair. CNA #5 indicated she had never transferred the resident.</p>		<p>change in care plan and interventions. The DON will update the CNA assignment sheets at that same time, so that they are current with the resident's care plan. The inter-disciplinary team will continue to monitor care plans during the weekly care plan meeting and as physician order changes are received.</p> <p>Any identified or observed concerns or issues will be addressed as indicated in question #2.</p> <p><u>4. How will the corrective action be monitored?</u></p> <p>-</p> <p><u>The DON will bring the results of her reviews and corrective action taken</u></p> <p><u>for identified concerns to the</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 07/13/2012
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>During interview with the Director Of Nursing (DON) on 7-13-12 at 2:28 p.m., when queried who was responsible to assess and obtain history of the new admission residents and implement interventions for the residents safety, the DON indicated the charge nurse was responsible for the initial assessment for medical or nursing. When queried how the facility ensured continuity of care was done for newly admitted residents, the DON indicated the Social Service and the DON assessed the residents prior to admission. The admission team meets prior to admission to determine if the facility can meet the residents care needs. The DON indicated all department heads are notified of resident needs or equipment needs prior to admission, as well as therapy.</p> <p>3.1-45(a)(2)</p>		<p><u>monthly QA&A Committee meeting for</u></p> <p><u>review and recommendation. Any recommendations made by the</u></p> <p><u>committee will be followed through by the Administrator or DON</u></p> <p><u>who will report the results of those recommendations at the next</u></p> <p><u>scheduled QA&A Committee meeting. The monitoring for</u></p> <p><u>completion and follow through of residents' needs and</u></p> <p><u>care plans will continue on an ongoing basis.</u></p> <p>-</p> <p><u>Date of Compliance: 8/07/12</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 07/13/2012
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	
F0327 SS=D	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on observation, interview and record review, the facility failed to put in place interventions to ensure hydration or assess for dehydration for 1 resident with a recent history of an admission to the hospital with dehydration, who could not take fluids without assistance or express when she was thirsty for 1 of 2 residents reviewed for hydration. (Resident #25)</p> <p>Findings include:</p> <p>Resident #25's record was reviewed on 7/11/12 at 10:00 a.m. Resident #25's diagnoses included but were not limited to Alzheimer's dementia, depression and diabetes.</p> <p>Resident #25's MDS (Minimum Data Set), assessment, dated 5/31/12, indicated the following: - BIMS, (Brief Interview for Mental Status), scored 2, with a score of 0-7 indicating severe cognitive impairment - unclear speech-slurred or mumbled words</p>	F0327	<p><u>F327</u></p> <p>-</p> <p>It is the policy of this facility to provide each resident with sufficient fluid intake to maintain proper hydration and health including interventions to ensure hydration and assessment of residents' condition for dehydration.</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>-</p> <p><u>Resident #25 has been provided with a special therapeutic drinking cup during</u> <u>time she is up in wheelchair. This</u></p>	08/07/2012	

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 07/13/2012	
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>- eating, extensive assistance, with one person physical assist</p> <p>- dehydration, no</p> <p>A document titled, "Nutritional Assessment and Progress Note," signed by the Registered Dietician on 5/15/12 indicated "fluid needs 1515 cc - 1815 cc."</p> <p>Resident #25's care plan for needing assistance at meals had a problem and intervention added on 5/17/12, and indicated "Problem, I also need assistance drinking fluids. I do not tell you when I am thirsty. Goal, none. Intervention, receives 660 cc's for each meal."</p> <p>Resident #25's physician's admission assessment from her admission to a local hospital on 4/13/12, dated 4/17/12, indicated "...She was subsequently found to have dehydration with elevated BUN (blood urea nitrogen) and creatinine (a test that measures kidney function) and glucose of 406. She was also found to have bronchitis and urinary tract infection....She also had hypercalcemia (high calcium) and hypernatremia (high sodium) secondary to dehydration."</p> <p>During an interview with Occupational</p>		<p><u>will be used for staff to assist her throughout</u></p> <p><u>the day to drink more fluids.</u></p> <p><u>Nurses will give an extra glass of water</u></p> <p><u>with each medication pass; the Guardian Angel assigned to Resident</u></p> <p><u>#25 will encourage fluids during his/her rounds. In addition the Activity</u></p> <p><u>staff will encourage and assist the resident in drinking fluids during activities.</u></p> <p>-</p> <p><u>All staff will be in-serviced on 8/07/12 regarding the facility for</u></p> <p><u>hydration of residents, the importance of encouraging residents to drink, the</u></p> <p><u>hydration care procedure, and the accurate documentation of all</u></p> <p><u>residents' fluid intake on the appropriate forms. The nurses and</u></p> <p><u>IDT members will be in-serviced on the facility policy for the</u></p> <p><u>hydration cart and the hydrationassessment policies.</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 07/13/2012
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>Therapist on 7/13/12 at 9:45 a.m., indicated when Resident #25 was on her case load at one time and she had the motor skills to hold a glass and drink, but just did not have the cognition to think to get the glass to her mouth.</p> <p>During an interview on 7/12/12 at 10:00 a.m., with Resident #25's family member indicated "(Resident #25) was in the hospital around Easter of this year with dehydration and the doctor told me she was dying of dehydration. I have never seen her so sick she was in the fetal position and just real sick. I worry about her not getting enough fluids at Hickory Creek. They come around twice a day but she is not able most of the time to drink on her own and they don't assist her often because of the number of residents they have they just don't have time."</p> <p>During an observation on 7/13/12 from 8:30 a.m. to 11:30 a.m., a fluid cart was not observed being passed. Resident #25 was up in the hall from 8:30 a.m. to 11:30 a.m., with no observation of her being offered fluids.</p> <p>During an interview on 7/13/12 at 11:30 a.m., CNA #6 and CNA #3 both</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></p> <p>-</p> <p><u>All residents have the potential to be affected by this practice.</u></p> <p>-</p> <p>Members of the IDT will monitor Staff assistance in encouraging Resident #25 to drink fluids throughout the day. The DON and Dietary Manager will check the fluid consumption records and intake records of all residents each day. If any are found to have fluid intake below the amount designated in the facility policy or physician's</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 07/13/2012	
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 the fluid cart had not been passed this morning. CNA #6 stated "it has been a crazy morning."</p> <p>During an observation on 7/13/12 at 12:30 p.m., Resident #25 was observed being fed lunch by CNA #3. Resident #25 was not able to fed herself or take her fluids by herself, but could eat and drink when assisted. CNA #7 fed Resident #25 most of her lunch, but did not offer her a drink but a few times. Resident #25 took 120 cc (cubic centimeters) of the 660 cc of fluid that was on her meal tray and 120 cc is what was documented on the "Resident Fluid Meal Percentage Intake Log" under fluids for lunch on 7/13/12 for Resident #25.</p> <p>During an interview with the DON (Director of Nursing) on 7/13/12 at 2:47 p.m., indicated the only new intervention that was put in place when Resident #25 returned from the hospital after being dehydrated was she was to receive 660 cc's each meal.</p> <p>During an interview with the Dietary Manager on 7/13/12 at 3:22 p.m., indicated Resident #25 was not included in the facility policy of residents at risk for dehydration per</p>		<p>order, the DON will follow up with staff to find</p> <p>the reason for the low fluid intake. A dehydration risk assessment will be done</p> <p>by the DON or charge nurse, and the physician will be notified of the resident's</p> <p>condition.</p> <p>Once that is done, if the DON or Administrator find that staff has not</p> <p>been in compliance with the facility policy for hydration, the DON will</p> <p>re-train them at that time. The Administrator or DON will render</p> <p>progressive disciplinary action as indicated by the noncompliance.</p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</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 07/13/2012
--	---	--	---

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 meal consumption sheets because her intake was not that low for her to be at risk for dehydration and the decreased fluid intake checklist was not filled out for her.</p> <p>Review of the CNA assignment sheet on 7/13/12 at 4:00 p.m., indicated fluids for Resident #25 were not addressed.</p> <p>3.1-46(b)</p>		<p>-</p> <p><u>The DON and Dietary Manager will check the fluid consumption and intake records at least 5 days a week for all residents. In addition,</u></p> <p><u>the DON will bring the results of those checks to the interdisciplinary team management meeting that occurs at least 5 days a week for further review and care plan revision if necessary.</u></p> <p>-</p> <p>The MDSC or designated IDT member will then write a care plan for any newly identified issues, including any interventions that are a result of the interdisciplinary team review and discussion at the morning meeting. The care plan will be placed on that resident's chart at that time. In addition, the MDSC or</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 07/13/2012
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>designee will indicate a change in the care plan on the 24 hour report so that subsequent shifts are aware of the addition or change in care plan and interventions. The DON will update the CNA assignment sheets at that same time, so that they are current with the resident's care plan. The interdisciplinary team will continue to monitor care plans during the weekly care plan meeting and as physician order changes are received.</p> <p>Any identified or observed concerns or issues will be addressed as indicated in question #2.</p> <p>-</p> <p>-</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 07/13/2012
--	---	--	---

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><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></p> <p>-</p> <p><u>The DON will bring the results of her reviews and corrective action taken for identified concerns to the monthly QA&A Committee meeting for review and recommendation. Any recommendations made by the committee will be followed through by the Administrator or DON who will report the results of those recommendations at the next scheduled QA&A Committee meeting. The monitoring for completion and follow through of residents' needs and care plans will continue on an ongoing basis.</u></p> <p>-</p> <p><u>Date of Compliance: 8/07/12</u></p>	