

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155430	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/16/2012
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 340 E 18TH ST ROCHESTER, IN 46975
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 13, 14, 15, 16, 2012</p> <p>Facility number: 000326 Provider number: 155430 AIM number: 100290770</p> <p>Survey team: Tim Long, RN-TC Julie Wagoner, RN Christine Fodrea, RN (2/13/2012)</p> <p>Census bed type: SNF: 35 Total: 35</p> <p>Census Payor type: Medicare: 5 Medicaid: 21 Other: 9 Total: 35</p> <p>Sample: 10</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 2/21/12 Cathy Emswiller RN</p>	F0000	<p>This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of the plan of correction is not an admission that a deficiency exist or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law.</p> <p>Hickory Creek at Rochester desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective March 17, 2012.</p>	

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

TITLE

(X6) DATE

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

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F0253 SS=B	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation and interview, the facility failed to ensure numerous nail holes were filled in 4 of 6 rooms [rooms 6, 8, 14, and 16] observed.</p> <p>Findings include:</p> <p>During the general observations of the facility tour on 2/13/12 at 1:15 P.M., 4 of 6 resident rooms were noted to have numerous nail holes in the walls: room 6 had 15 nail holes; room 8 had 5 nail holes; room 14 had 27 nail holes; room 16 had numerous nail holes.</p> <p>An interview with the Maintenance Director on 2/13/12 at 1:20 P.M. indicated the holes should have been filled on routine maintenance when a resident moves and the room is empty.</p> <p>3.1-18(a)</p>	F0253	<p>F 253 It is the policy of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. <u>What corrective action will be taken by the facility?</u></p> <p>Nail holes in the walls of rooms 6, 8, 14 and 16 will be patched and repainted by 3/17/12. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents' rooms having resident relocation have potential for holes in the walls. Each resident area will be checked for holes in the walls after discharge of resident. Maintenance will patch and repaint holes in walls prior to another admission or as quickly thereafter as possible. All resident rooms have been reviewed with plan developed to patch and repaint current holes. <u>What measures will be put into place to ensure this practice does not occur?</u></p> <p>Maintenance Director will audit 5 rooms weekly until all rooms have been checked and repaired as needed; when that is done he will check all rooms at least monthly thereafter to identify and prioritize</p>	03/17/2012

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			<p>needed room repairs including filling in of nail holes. As the audits are completed, the Maintenance Director will review the results and action taken with the Administrator. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Maintenance Director will present the results of his audits to the monthly QA meeting for review for the next 60 days. The QA committee will make recommendations as deemed necessary to ensure compliance. Once the 60 day period is completed, the QA Committee can decide not to require the written audits of resident rooms; however, the Maintenance Director's check of all rooms will continue at least monthly on an ongoing basis as part of the facility's preventive maintenance program. <u>Compliance Date:</u> 3/17/12</p>	

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview, the facility failed to ensure a thorough bladder assessment was completed for 1 of 6 residents observed for incontinence issues in a sample of 10. (Resident #25)</p> <p>Finding includes:</p> <p>1. During the initial tour of the facility, conducted on 02/13/12 between 8:00 A.M. - 8:30 A.M., LPN #1 indicated Resident #25 was confused, required minimal assistance for hygiene needs, and toileted himself.</p> <p>The clinical record for Resident #25 was reviewed on 02/13/12 at 8:40 A.M. The resident was admitted to the facility on 10/17/11 with diagnoses, including but not limited to, malignant neoplasm of the prostate.</p>	F0315	<p>F 315 It is the policy of this facility to ensure residents' bladder function will be restored to highest practicable level. <u>What corrective action will be done by the facility?</u> Resident # 25 was reassessed utilizing the B/B assessment tool. A 5-day voiding pattern was initiated, on 2/15/12. Resident # 25 was started on routine Flomax and Flexeril BID, with improvement noted. A revised restorative toileting program has been initiated to include night time voiding. A new care plan for incontinence has been developed to reflect the resident's current status and individualized to restore and maintain as much bladder continence as possible while maintaining as much independence as possible. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u>All</p>	03/17/2012			

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	<p>The initial Minimum Data Set (MDS) assessment, completed on 10/24/11 and the subsequent quarterly MDS review assessment, completed on 01/16/12, indicated the resident was occasionally incontinent of his bladder.</p> <p>Review of the Bladder Assessment Form, completed on 10/26/11 for Resident #25 indicated the resident was continent of his bladder, had a strong urge to go to the bathroom, got up 2 or more times at night to urinate, urinated more than 8 times in a 24 hour time frame, and had a history of a stroke. The form indicated the resident needed assistance to the bathroom as he was new and not familiar with the bathroom locations.</p> <p>A 5 day bladder record form incontinence, completed from 11/13/11 - 11/18/11 indicated the resident displayed a pattern of occasionally incontinence during the evening and night time hours and also displayed almost an hourly voiding pattern on some of the assessment days. A Bladder Assessment - Post Voiding Pattern form, completed on 11/20/11 indicated a post void residual had not been evaluated for Resident #25, nor had a urinalysis, the physical assessment questions for males anatomy had been crossed out, the causes of urinary incontinence assessment had been</p>		<p>residents have been re- assessed utilizing the B/B assessment tool. 5-day voiding patterns have been initiated on residents as indicated. Based on the results of 5-day voiding patterns, individualized care plans and interventions will be completed. <u>What measures will be put into place to ensure this practice does not recur?</u> Nurses have been in-serviced by the Director of Nursing on 2/28/12 on bladder assessments and addressing changes in continence and completion of the post void assessment to include marking all of the risk factors specific to that individual. F 315 (Continued)Once the assessment is completed the DON or her designee will be responsible for developing the care plan and interventions. Review of the care plan and the interventions with all nursing staff will be completed by the DON or her designee. The DON will check to ensure assessments are completed and process it followed <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u>The ADL documentation for continence/incontinence for 5 residents will be checked and compared to the most current assessment and care plan by the MDS coordinator. These will be checked 3 x weekly for four (4)</p>	

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	<p>crossed out, the medications had been documented on the form, the incontinence symptom profile section of the assessment had also been crossed out and a scheduled toileting had been marked.</p> <p>The current health care plan for Resident #25, initiated on 11/30/11 included a plan for a Restorative toileting program and included the problem of the resident's night time incontinence, however, the intervention was to toilet the resident upon rising, before and after meals, and at bedtime. The plan did not address the resident's pattern of hourly night time voiding.</p> <p>In addition, the assessment did not address the possibility that a urinary tract infection might be a causative factor in the resident's frequent need to void, or a potential the resident's bladder was not emptying properly due to his malignant prostate cancer. The most definitive portions of the Bladder Assessment- Post voiding pattern had not been evaluated and the care plan was not individualized to restore as much bladder continence as possible.</p> <p>Review of the facility policy and procedure, titled, "Bladder Incontinence Program, dated 02/09, and indicated as current by the Director of Nursing, on</p>		<p>weeks and then monthly thereafter. Any findings that indicate a change in the resident's continence or incontinence status will be identified and a new assessment will be initiated and followed through as indicated in the previous question. Results of the reviews will be forwarded to the administrator and the interdisciplinary team at the next scheduled morning management meeting that meets at least 5 days a week. The DON will also present the results of the audits and new assessments that are completed to the monthly QA meeting for further review and recommendations for process improvement as deemed necessary. This will continue on an ongoing basis. Compliance Date: 3/17/12</p>	

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	<p>02/14/12, included the following: "Any resident identified as incontinent of urine will be evaluated for causal factors and appropriate actions will be undertaken to obtain the most effect results, depending on the source and cause of the incontinence...a number of factors may contribute to the decline or lack of improvement in urinary continence, for example: underlying medical conditions, an inaccurate assessment of the resident's type of incontinence...when the 5 day bladder record is completed the MDS Coordinator will complete the "Bladder Assessment - Post Voiding Pattern" in order to finalize the development of a toileting plan. Once the form is completed, the MDS Coordinator will formulate the type of treatment program that appears to be best suited to the resident, based on the information obtained through the admission history, the 5 day bladder record, and the results of areas #1 - #5 on the post voiding bladder assessment. The MDS coordinator will indicate the most likely type of incontinence being experience by the resident...then will indicate the type of treatment program an adopter interventions that might benefit the resident...."</p> <p>3.1-41(a)</p>			

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F0329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review, and interview, the facility failed to ensure there were adequate indication for an increase in psychotropic medications for 2 of 6 residents reviewed for psychoactive medications in a sample of 10. (Resident # 23 and 25)</p> <p>Findings include:</p> <p>1. During the initial tour of the facility, conducted on 02/13/12 between Resident #23 was observed seated in a chair in the</p>	F0329	F 329 It is the policy of this facility to ensure that there are adequate indications for an increase in psychotropic medications <u>What corrective action will be done by the facility?</u> A record review for resident # 23, was conducted by the pharmacist and medical director during Behavior meeting. It was recommended to discontinue the Geodon at that time. Order obtained and the medication was discontinued on 2/21/12 Resident # 23 was assessed by Rounding Providers,	03/17/2012

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	<p>front entryway. The resident was dressed and alert. Interview with LPN #1, 7:30 A.M. - 8:00 A.M., indicated Resident #23 was confused at times, transferred and ambulated by himself, and had behaviors of yelling, received the antipsychotic medication, Geodon, which had recently been increased.</p> <p>The clinical record for Resident #23 was reviewed on 02/13/12 at 9:45 A.M. Resident #23 was admitted to the facility on 05/23/08 with diagnoses, including but not limited to, history of alcoholism, dementia with behaviors, and anxiety.</p> <p>Current physician orders for Resident #23 included an order for the antipsychotic medication, Geodon 20 mg three times a day. Review of recent physician orders indicated on 01/31/12 the resident's antipsychotic medication, Seroquel, had been discontinued and the antipsychotic medication, Geodon 20 mg once a day had been initiated. The Geodon medication had been increased to 20 mg three times a day on 02/10/12.</p> <p>Nursing notes, on 01/31/12 at 9:30 A.M., indicated the psychiatrist had visited the resident on 01/31/12 and had discontinued the resident's Seroquel and initiated the medication Geodon.</p>		<p>a new psychiatric service. A behavior modification plan was developed and put into place on 2/27/12. A record review for resident #25 was conducted by the pharmacist and medical director during Behavior meeting, 2/21/12. It was determined at that time to have Rounding Providers staff review resident chart and meet with resident to determine what adjustments might be done to current medication regimen. A care plan meeting was held with resident with family of Resident # 25 and the IDT. Family indicates that current medications are fewer in number and lower doses than when he was at home. The resident has been started on Flomax and Flexeril routinely. Resident has shown improvement. Psychologist for Rounding Providers has done initial assessment with follow up completed 3/3/12. Based on assessment and interview by Rounding Providers, resident will be placed on a reduction of Risperadol to result in discontinuation of the medication. Ativan will be reduced and then discontinued. Seroquel will be reduced. Melatonin will be ordered to assist with restlessness at night. Lexapro dosage will be increased and monitored. Behaviors will be monitored and documented with notification to Rounding Providers as necessary. <u>How will the</u></p>				

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	<p>Interview with the Social Service Director, on 02/14/12 at 2:00 P.M. indicated the dietician had recommended the medication, Seroquel be discontinued due to the resident's increased cholesterol. She indicated the psychiatrist who had visited the resident on 01/31/12 reviewed the recommendation and changed the medication due to the resident's elevated cholesterol.</p> <p>Nursing notes, from 02/01/12 - 02/10/12 indicated the resident had episodes of yelling at breakfast on 02/01/12, and 02/02/12. On 02/02/12 the resident's repeated request for coffee escalated and he started yelling and swearing. The resident was redirected and eventually stopped his behaviors. On 02/06/12 at 2:00 P.M., the resident was repeatedly asking for coffee but there were no other negative behaviors, interventions, or outcomes documented at the time.</p> <p>Review of the behavior tracking forms for Resident #23, for February 2012 indicated there behaviors documented on 02/09/12 at 4:55 P.M. and on 02/09/12 at 4:30 P.M., but both behaviors were successfully changed with interventions of verbally reminding of inappropriateness and/or redirecting with an activity.</p>		<p><u>facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents on psychotropic medications have been reviewed by the pharmacist, medical director and IDT for appropriateness based on resident current status. All medications have been deemed appropriate at this time; however, if any member of the IDT observes a change in any resident's behavior or overall condition, he/she will inform the Social Services Director, DON, and Administrator as soon as possible. The attending physician, in conjunction with the psychiatric service provider, will be contacted regarding the identified concern and any orders given will be followed up as indicated. All residents on psychotropic medications or behavioral plans will be seen by Rounding Providers within the next 30 days. Upon review of the resident behavior during the morning clinical meeting that occurs at least 5 days a week, if the IDT identifies a concern with the orders or interventions given to address the behavior or status change, the Administrator and DON will refer the issue to the facility Medical Director for resolution. All contacts, orders, and results of each will be documented in the resident's clinical record. <u>What measures</u></p>				

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	<p>However, nursing notes, dated 02/10/12 at 2:00 P.M. indicated the psychiatrist was notified of the resident's inappropriate behaviors of swearing, which had occurred on 02/09/12 at 4:55 P.M., and clapping his hands. An order was received to increase the antipsychotic medication, Geodon to 20 mg three times a day.</p> <p>Interview with the Social Service Designee, employee #2, on 02/14/12 at 10:20 A.M.. indicated the telephone call to the psychiatrist, on 02/10/12, was in an attempt to get the psychiatrist to reconsider restarting the medication, Seroquel, because the facility staff felt the resident's behaviors of yelling and self stimulating behaviors of "clapping his hands loudly" were much better controlled on the Seroquel rather than the Geodon. There were no additional or other documented episodes of behaviors provided. The SSD indicated the facility did not want for the Geodon to be increased.</p> <p>Review of the facility's "Assessment of a New Psychotropic Medication or Psychotropic Medication Change", completed on 02/10/12 for Resident #23 acknowledged the increased in the medication, Geodon, but indicated the there was proper diagnosis and indication</p>		<p><u>will be put into place to ensure this practice does not recur?</u> Nursing staff have been in-serviced by the Director of Nursing on 2/29/12 discussing Psychotropic Drug Utilization, documentation, psychotropic medications, diagnosis and the behavior monitoring and related documentation. Any request from families, residents, or nurses for psychotropic medication additions or changes to existing orders will be reviewed by the IDT at least 5 days a week at the morning clinical meeting, prior to calls being made to obtain orders. In emergent situations, Administrator or DON will be contacted for direction of appropriate interventions. The facility has obtained the services for a new Psychiatric Service Consulting team effective 2/27/12. The Social Services Director will review the 24 hour report, focus charting, and incident reports during each tour of duty to make sure that she is informed of changes in residents' behavior or condition that will need review and follow up. She will bring her findings to the morning clinical meeting as indicated in the prior question for review by the IDT. Any change in resident status or behaviors will also be addressed as indicated in the prior question. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA</u></p>		

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	<p>for the use of the medication, adequate monitoring, no side effects.</p> <p>2. During the initial tour of the facility, conducted on 02/13/12 between 7:30 A.M. - 8:00 A.M., LPN #1 indicated Resident #25 was confused, ambulated with a walker, and received the psychoactive medications, Seroquel and Risperdal for anxiety. LPN #1 indicated there were no behavior issues with Resident #25.</p> <p>The clinical record for Resident #25 was reviewed on 02/13/12 at 8:40 A.M. Resident #25 was admitted to the facility on 10/17/11 with diagnosis, including but not limited to anxiety, paralysis agitans, depression, dementia with behaviors, and malignant neoplasm of the prostate.</p> <p>The current physician's orders for Resident #25 included the antianxiety medication, Lorazepam .5 mg twice a day, the antidepressant medications, Lexapro 10 mg once a day and Exelon patch 9.5 mg once a day, and the antipsychotic medications, Risperdal .25 mg twice a day, and Seroquel 50 mg at bedtime. The resident had also recently received the antibiotic, Cipro to treat a urinary tract infection.</p> <p>Review of recent physician's orders for</p>		<p>will be put into place? Social Service Director and the DON will present the results of changes that have occurred in residents' behavior, including addition or decrease in residents' psychotropic medication, to the QA Committee at the monthly meeting. The QA committee will review and provide recommendations for process improvement as deemed necessary. The Administrator will make sure that the follow up to any recommendations made by the committee is done by a designated person and brought back to the QA Committee at the next month's meeting for further review. This will occur on an ongoing basis. Compliance Date: 3/17/12</p>				

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	<p>Resident #25 indicated orders, dated 12/06/11 to discontinue as needed antipsychotic medication, Haldol, initiate the antidepressant medication, Lexapro, and decrease the resident's Risperdal medication to .125 mg twice a day. An order was also received on 12/09/11 to put the resident hypnotic medication, Ambien on hold for one week and then update the physician. On 12/19/11 an order was received to increase the resident's antipsychotic medication, Seroquel 50 mg at bedtime, increase the resident's Risperdal medication back to .25 mg twice a day due to a failed "GDR" (gradual dose reduction), and to discontinue the resident's hypnotic medication, Ambien.</p> <p>Review of the behavior tracking record for Resident #25, for December 2011 indicated there were no behavior issues documented on the form. Nursing notes, from 12/06/11 - 12/29/11 indicated there were multiple documentation of resident up at night, often due to toileting needs. On 12/18/11, at 8:00 P.M., nursing notes indicated the family reported the resident was "grumpy" On 12/19/11, there were nursing notes at 9:00 A.M., indicating the resident spoke sternly to his wife. A nursing note, on 12/19/11 at 10:00 A.M., indicated the nurse practitioner had received a call from the resident's family</p>						

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	<p>regarding the resident's "irritability" and an order was given to increase the Risperdal medication back to .25 mg twice a day. Finally, a note, dated 12/19/11 at 11:00 A.M., indicated the physician visited the resident had in response to the resident's voiced frustration with not being able to sleep, the Seroquel medication was increased.</p> <p>Review of social service notes, dated 12/19/11, indicated the following: "Family reports resident very verbally aggressive over the weekend staff this AM note increased irritability with spouse and staff. Psych increased Risperdal to prior levels. PCP (primary care physician) changed Seroquel hs dose stating it should help with insomnia....will continue to monitor resident behavior: insomnia."</p> <p>Review of nursing notes, dated January 09,2012 indicated the resident's had urinary frequency due to his diagnosis of prostate cancer. In addition, the resident was discovered to have a urinary tract infection and was treated in January 2012 with antibiotics.</p> <p>Interview with the Social Service Director, on 02/14/12 at 10:30 A.M. indicated the primary care physician was making medication changes to the</p>			

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	<p>resident's psychoactive medications. In addition, the physician refused to allow the resident to have his hypnotic medication for insomnia. Finally, the SSD indicated the resident's prostate cancer had metastasized and the family did not wish to pursue any treatment for the issue.</p> <p>The behavior tracking forms included the behaviors of exit seeking/wandering, and hitting staff, but there were no monitoring plans for the resident's continued insomnia, no timely intervention to ensure any medical causes for the resident's behaviors was treated prior to increasing antipsychotic medication, and no behavior to support the increase in the resident's Risperdal.</p> <p>3. Review of the facility's policy and procedure, "Psychotropic Medication Monitoring Program, " dated October 2007 included the following: "1. An assessment for new psychotropic medication/psychotropic medication changes "form will be utilized if a new psychotropic medication is ordered for a resident or if there are changes in the orders for a resident's current psychotropic medications. 2. The team will review the medication after the assessment form has been filled out to ensure compliance with the guidelines for</p>						

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	<p>appropriate drug usage and dosage...3. If the team reaches a consensus that the medication is not in compliance with the regulations, the DON (director of nursing) or designee will notify the attending physician...."</p> <p>3.1-48(a)(4)</p>			

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F0363 SS=D	<p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the menu was followed and correct portions served for 2 of 2 residents receiving pureed diets and 2 of 2 residents receiving ground meat. (Residents #7, 10, 13, and 15)</p> <p>Finding includes:</p> <p>1. During observation of the serving of the noon meal, conducted on 02/13/12 at 12:30 P.M., the cook, Employee #5, served the 2 residents receiving a pureed diet, [Residents #10 and 15] a 4 ounce scoop of pureed chicken and a 4 ounce scoop of mashed potatoes. The 2 residents receiving a pureed diet did not receive any pureed vegetable.</p> <p>The cook also served the 2 residents receiving ground meat, [Residents #7 and 13], a #16, or 2 ounce scoop of ground chicken. The ground chicken did not have any gravy or liquid mixed with it.</p>	F0363	<p>F 363 It is the policy of this facility to meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the national Research Council, National Academy of Sciences; be prepared in advance; and be followed. <u>What corrective action will be done by the facility?</u> Residents 10 & 15 are receiving pureed diets as ordered and as listed on spreadsheet, using appropriate scoop sizes by recipe requirements. Residents 7 & 13 are receiving ground meat as per spreadsheet, using appropriate scoop sizes by recipe requirements. <u>How will facility identify other residents having the potential to be affected by the same deficient practice?</u> All residents are offered menu selections and size of portions served. Several residents request reduced portions size and this is indicated on their menu selection form and their care plans. <u>What measures will be put into place or systematic changes made to ensure that the same practice will not</u></p>	03/17/2012			

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	<p>Review of the menued spread sheet for the noon meal on 02/13/12, received by the facility after the serving of the meal, on 02/13/12 at 2:00 P.M., indicated the pureed residents were to receive a #6, or 6 ounce serving of pureed chicken, and were to receive a #10, or 3 1/2 ounce scoop of pureed tossed salad or a #16, or a 2 ounce, serving of pureed collard greens. In addition, the residents requiring a mechanical soft or ground meat diet were to have received a #8, 4 ounce scoop plus a #16, a 2 ounce scoop of the ground chicken. The recipe for the ground chicken indicated a 4 ounce piece of chicken plus 2 ounces of gravy per serving were supposed to have been prepared.</p> <p>Interview with the Administrator, on 02/14/12 at 9:30 A.M., indicated the dietician had been contacted and the mechanical soft portion should have been a 4 ounce portion. The Administrator indicated it was possible the 2 residents receiving a pureed diet had not chosen to be served any vegetable item. She also provided documentation of weights for the 2 resident receiving pureed diets which indicated neither resident had experienced any weight loss.</p> <p>Finally, during the final exit to the survey, conducted on 02/16/12 at 12:15 P.M., the</p>		<p>recur? All cooks have been in-serviced on scoop sized and proper scoop for recipes. Review of spreadsheets and recipes completed by DSM with RD input. (2/23/12) How will the facility monitor its corrective actions to ensure that the same practice will not recur? DSM will randomly observe 3 meals weekly, x 4 weeks and then 3 x monthly thereafter, to ensue appropriate measurements for puree and ground food items. DSM will confirm that all diet choices are pureed as per recipe. Results of audit will be reviewed weekly with Administrator. Findings will be reviewed at the monthly QA meeting to ensure compliance. The QA committee will make recommendations as deemed necessary. Compliance Date: 3/17/12</p>	
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	<p>Administrator indicated she felt the cook had served the correct portion of ground chicken on 02/13/12 as she could have utilized 2 of the #16 scoops to equal the adjusted portion of 4 ounces of ground chicken. However, the Administrator was informed again that the cook had been observed to serve only 1 - #16 scoop of the ground chicken, not 2 - #16 scoops. The Administrator wanted to know the color of the serving scoops, however, per interview with the cook during the service of the noon meal, conducted on 02/13/12 at 12:30 P.M., a #16 scoop had been utilized for the ground chicken and the color of the scoop had not been documented only the size of the scoop denoted by the #16 engraved onto the scoop had been confirmed.</p> <p>3.1-20(i)(4)</p>			

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview the facility failed to maintain the ice machine in a sanitary manner potentially affecting 35 of 35 residents in the facility. In addition, the facility failed to ensure an air vent over the freezer was clean.</p> <p>Findings include:</p> <p>During the general observations of the facility tour on 2/13/12 at 1:15 P.M., the ice machine in the kitchen was noted to have feathery black substance on the roof of the ice bin.</p> <p>During observation of the kitchen, conducted on 02/13/12 at 8:00 A.M., the air vent located above the upright reach in freezer was noted to be heavily laden with dust.</p> <p>An interview with the Maintenance Director on 2/14/12 at 2:00 P.M. indicated the ice machine had not been on the routine maintenance schedule previously.</p>	F0371	<p>F 371 It is the policy of this facility to store, prepare, distribute and serve food under sanitary conditions. <u>What corrective action will be done by the facility?</u> Ice machine has been cleaned according to manufacturer's recommendations. 2/16/12 (See attached.) Vent covers have been removed, cleaned and repainted. 2/21/12 <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents have been identified as having potential to be affected by this. As part of the preventive maintenance program, the Maintenance Director will perform monthly checks of vents and the ice machine, with necessary cleaning and any other maintenance required to correct this practice. <u>What measures will be put into place to ensure this practice does not recur?</u> Maintenance Director will conduct monthly audits of the vents and ice machine to ensure cleanliness. Once those are</p>	03/17/2012

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	3.1-21(i)(1)		completed he will review his findings with the Administrator at the next scheduled morning management meeting which occurs at least 5 days a week. If there are any outstanding issues that he has identified as a result of his check, he will discuss those with the Administrator so that plans for repair or replacement are put into place quickly. The Administrator will make random monthly rounds with the maintenance director to check the condition of the vents and ice machine. If any concerns are noted at that time, the Administrator will instruct the Maintenance Director on the policy and procedure for maintaining the cleanliness of these areas. She will also render progressive disciplinary action if needed for continued noncompliance. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Maintenance Director will present the results of his preventive maintenance checks, including the condition of the vents and ice machine to the QA Committee at the monthly meeting. The QA committee will make recommendations as deemed necessary. This will continue on an ongoing basis. <u>Compliance Date:</u> 3/17/12Addendum: 3/13/12Dietary staff will clean the internal and external surfaces of		

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			the ice machine weekly with food safe sanitizer. Maintenance will perform the manufacturer's recommended cleaning once every four months or as necessary if needed more frequently.	

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F0441 SS=C	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to ensure 1 air vent,</p>	F0441	F 441 It is the policy of this facility to handle, store, process	03/17/2012	

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	<p>positioned over the clean linens, was clean. This potentially affected 35 of 35 residents in the facility.</p> <p>Findings include:</p> <p>During the general observations of the facility tour on 2/13/12 at 1:35 P.M. an air vent, located above the clean linens storage was noted to be heavily laden with dust.</p> <p>An interview with the Maintenance Director on 2/14/12 at 2:00 P.M. indicated the vents had not previously been on a routine maintenance schedule.</p> <p>3.1-19(g)</p>		<p>and transport linens so as to prevent the spread of infection. <u>What corrective action will be done by the facility?</u> Air vent was cleaned on 2/13/12. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> Housekeeping had cleaned all other vents in common areas and offices the previous week. Clean linen room was missed. All vents will be cleaned on a monthly basis as per schedule. The Housekeeping staff has been reminded to clean the vent in the clean linen room. <u>What measures will be put into place to ensure this practice does not recur?</u> Maintenance Director will audit vents on a monthly basis to ensure cleanliness as part of the facility's preventive maintenance program. The Administrator will make random monthly rounds with the maintenance director to check the condition of the vents. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Maintenance Director will present the results of his preventive maintenance checks, including the condition of the vents to the QA Committee at the monthly meeting. The QA committee will make</p>	

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			recommendations as deemed necessary. This will continue on an ongoing basis. Compliance Date: 3/17/12	

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER				STREET ADDRESS, CITY, STATE, ZIP CODE 340 E 18TH ST ROCHESTER, IN 46975			
(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			
F9999	<p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD) , administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be record in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review, the facility failed to ensure 4 of 5 newly hired employees had physical completed prior to starting work. (Employee #10, 11, 12 and 13) In addition, 1 of 5 had a physical completed and started working prior to the Mantoux test being read. (Employee #14)</p>	F9999	<p>F 9999 <u>What corrective action will be done by the facility?</u> All current employees have a physical completed and place in their employee file. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> There have been no residents affected by this practice; however, if an employee is found to be working without evidence of a physical in his/her file, he/she will be sent home and will not be allowed to continue working until a written physical exam is brought to the administrator. In addition, the Administrator will address the management staff involved and will retrain them on the requirements for a physical examination before beginning employment in the facility. The Administrator will also administer progressive disciplinary action for continued noncompliance. <u>What measures will be put into place to ensure that this practice does not occur?</u> The business Office Manager will audit each new employee's file to make sure that all components are in place, including a physical examination, before the employee reports for orientation. She will then forward the file to the Administrator who will check for the presence of a</p>	03/17/2012			

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	<p>Findings include:</p> <p>During review of the personnel files for Employees # 10 - 14, completed on 12/15/12 between 1:00 P.M. - 2:00 P.M., the following was noted:</p> <p>Employee #10, with a start date of 12/12/11, did not have a physical examination signed by the physician until 01/10/12</p> <p>Employee #11, with a start date of 11/03/11, did not have a physical examination signed by the physician until 11/18/11.</p> <p>Employee #12, with a start date of 09/26/11, did not have a physical examination signed by the physician until 10/04/11</p> <p>Employee #13, with a start date of 01/09/12, did not have a physical examination signed by the physician until 01/10/12. However, the job specific orientation had been completed on 01/09/12.</p> <p>Employee #14, with a start date of 08/15/11, had a physical examination signed by the physician on 08/10/11, even though the front of the physical, signed by the employee was not signed until 08/15/11. In addition, the first step Mantoux test, was not read until 08/13/11, 3 days after the physical form</p>		<p>physical examination. The Administrator will place her initials and date on the general orientation checklist in the top right corner to indicate that a check for a physical has been done and that it is in the file. If the Administrator is on vacation or otherwise absent, the manager of the employee's department will initial and date the orientation checklist as indicated above. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Business Office Manager will bring the names of new employees, their departments and the date of hire, and the date of the physical examination to the monthly QA committee meeting. The QA will review for completeness and compliance. Any committee recommendations for process improvement will be followed up by the Administrator or designated manager. This will continue on an ongoing basis. <u>Compliance Date:</u> 3/17/12</p>				

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	<p>was signed by the physician.</p> <p>3.1-18(k)</p>			