

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155392	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT KENDALLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1433 S MAIN ST KENDALLVILLE, IN 46755
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 31, 2015 and September 1, 2, 3, 2015</p> <p>Facility number: 000402 Provider number: 155392 AIM number: 100288120</p> <p>Census bed type: SNF/NF: 21 Total: 21</p> <p>Census Payor type: Medicare: 1 Medicaid 18 Other: 2 Total: 21</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on September 4, 2015 by 17934.</p>	F 0000	F000000 Attached for your review and approval is the completed Plan of Correction for the recent Recertification and State Licensure Survey conducted August 31st,2015 thru September 3, 2015 at Hickory Creek at Kendallville in Kendallville, Indiana. Submission of this Plan of Correction is not an admission that a deficiency exists. This Plan of Correction constitutes the written allegation of compliance for Hickory Creek at Kendallville. We respectfully request desk review/paper compliance for the Plan of Correction. The date of compliance is 9/18/2015	
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)			

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:  155392	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT KENDALLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1433 S MAIN ST KENDALLVILLE, IN 46755
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A 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 interview and record review, the facility failed to notify the Power of Attorney (POA) of new physician's orders for medications for 1 of 1 residents (#19), reviewed for proper notifications.</p>	F 0157	<p>F 157 It is the policy of this facility to notify the legal representative of changes in a resident's condition, including new or changed physician orders.</p> <p><u>1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The</u></p>	09/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155392	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT KENDALLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1433 S MAIN ST KENDALLVILLE, IN 46755
---	---

(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>Findings include:</p> <p>An interview with the POA of Resident #19 on 8/31/15 at 2:03 P.M. indicated the facility did not always give notification when the resident's treatments were changed.</p> <p>Review of Resident #19's Physician's orders on September 2 at 9:00 AM, indicated on 7/1/15 a new order was received for a Fentanyl 12.5 micrograms (mcg) patch to be administered every 72 hours for pain. On 7/8/15, a physician's order was received to increase the Fentanyl patch to 25 mcg every 72 hours.</p> <p>Review of Resident #19's nurse's notes did not indicate the POA was notified on 7/1/15 for starting a new opiod pain medication (Fentanyl), or on 7/8/15 when the pain medication was increased.</p> <p>An interview with the Director of Nursing (DN) on 9/2/15 at 10:14 A.M., indicated she could not locate any documentation of notifications made to Resident #19's POA on 7/1/15 for the start of Fentanyl, or on 7/8/15 when the Fentanyl was increased. The DN indicated nurse's should document when notifications of family and/or a POA are made when starting a new medication.</p>		<p>medical record for Resident # 19 was audited by the Director of Nursing on September 2, 2015 to ensure the family had been notified of a new physician order. During that audit, it was found that the family/POA was notified on 7-10-15 via a care conference but was not notified at the time of the order. Licensed nurses involved were counseled and all licensed nurses were inserviced on 9-10-15 by the Director of Nursing on the Policy and Procedure for Notifications.</p> <p><u>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</u> All resident shave the potential to be affected by this practice. An audit completed on 9-2-15 by the Director of Nursing on all residents and no other issues were identified. In the future, if the DON finds that the resident or his/her legal representative have not been notified of a change in his/her condition or treatment, she will make sure that the notification is done as soon as possible. Once that is done, the DON will re-train the nurse(s) involved on the facility policy and procedure for notification and she will render counseling/progressive discipline as indicated for continued noncompliance.</p> <p><u>3.What measures will be put into place or what systematic changes will be made to ensure that the</u></p>	



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155392	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT KENDALLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1433 S MAIN ST KENDALLVILLE, IN 46755
---	---

(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>persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to follow physician's orders for 1 of 5 residents (#5) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>Review of Resident #5's clinical record on 9/2/15 at 11:00 AM, indicated the most recent physician's orders dated 8/31/15, included an order originally started 12/13/2010 for accuchecks for blood sugar levels four times daily and to call the physician if the levels were under 60 or over 450.</p> <p>Review of Resident #5's Glucometer Blood Sugar Checks sheets for July and August 2015, indicated on 7/16/15, at 11:30 A.M., the blood sugar level was 465. On 7/27/15 at 2:00 P.M., Resident #5's blood sugar level was 492.</p> <p>Review of the Glucometer Blood Sugar Checks sheets and the nurse's notes for Resident #5, did not indicate physician notification on 7/6/15 at 11:30 A.M. or on 7/27/15 at 2:00 P.M..</p> <p>An interview with the Director of Nursing (DN) on 9/2/15 at 2:05 P.M., indicated the physician should have been</p>	F 0282	<p>F282 It is the policy of this facility that services provided or arranged by the facility are done in accordance with the residents' plan of care. <u>1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> Licensed nurses involved were counseled and all licensed nurses were inserviced on 9-10-15 by the Director of Nursing on the Policy and Procedure for Notification.</p> <p><u>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</u> All residents who are diabetic have the potential to be affected by this practice. An audit completed on 9-2-15 by the Director of Nursing on all residents with blood sugar checks indicated that no other issues were identified. In the future, if the DON finds that the physicians are not being notified of blood sugar results that are outside of the parameters that the physician has set, she will make sure that the physician is notified of those blood sugar readings as soon as possible. Once that is done, and the resident's needs have been addressed, the DON will re-train the nurse(s) involved on the facility policy and procedure for following physician orders, and she will render</p>	09/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155392	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT KENDALLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1433 S MAIN ST KENDALLVILLE, IN 46755
---	---

(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>notified on 7/6/15 and on 7/27/15, of the blood sugar levels above 450 as noted on the physician's orders.</p> <p>3.1-35(g)(2)</p>		<p>counseling/progressive discipline as indicated for continued noncompliance. <u>3.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</u>Beginning immediately the Director of Nursing or designee will audit blood sugar results for physician notification as per orders at least 5 days a week for 30 days; then 3 days a week for 30 days, then weekly for another 30 days. Weekly audits will continue for an additional 90 days. Any identified issues will be addressed as indicated in question #2. <u>4.How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?</u> The DON will bring the results of these audits to the monthly Quality Assurance Committee meeting for review and further recommendations for process improvement if needed. At the end of the 180 days of written audits, when 100% compliance has been achieved, the QA Committee may decide to stop the written audits. However, monitoring of physician notification in response to blood sugar results will continue on an ongoing basis by the DON as part of her overall monitoring of new physician orders and blood sugar results for diabetic residents. Date of Compliance: 9/18/2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155392	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT KENDALLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1433 S MAIN ST KENDALLVILLE, IN 46755
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0318 SS=D Bldg. 00	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview and record review, the facility failed to provide a restorative, range of motion program for 1 of 3 residents (#4) reviewed for range of motion services.</p> <p>Findings include:</p> <p>On 8/31/15, at 9:17 A.M., an interview with the Director of Nursing (DN) indicated Resident #4 had contractures in both of her knees and did not have a splint device in place or receive range of motion services.</p> <p>On 9/2/15, at 10:30 A.M., an interview with Physical Therapist Assistant (PTA) #1, indicated Resident #4 was in physical therapy(PT) and occupational therapy(OT) programs over a year ago for contractures to her knees and was discontinued from therapy and was put on a restorative program.</p> <p>Review of a Therapy Discharge Notice from 5/23/14 indicated Maximum level</p>	F 0318	<p>F318 It is the policy of this facility that restorative range of motion services are to be provided as per the physician's orders in conjunction with recommendations received from therapy services. <u>1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> A meeting was held on 9-10-15 with the Director of Nursing, MDS Coordinator, Therapy staff and Administrator to review the process of communication and follow up of therapy recommendations for continuing services, such as ROM, when residents are discharged from therapy. <u>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</u> All residents receiving therapy services have the potential to be affected by this practice. A review on 9-2-15 by the Director of Nursing of other residents who had recently discharged from therapy indicated no other issues were identified. In the future, if the DON or MDSC</p>	09/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155392	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT KENDALLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1433 S MAIN ST KENDALLVILLE, IN 46755
---	---

(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>met with OT and PT.</p> <p>Review of a Restorative Nursing Program from 5/30/15 indicated the problem areas as generalized weakness in bilateral lower extremities and contractures in bilateral knees. The goal was to maintain current muscle strength with active range of motion exercises to prevent decline in muscle strength.</p> <p>An interview with the DN on 9/3/15 at 9:26 A.M. indicated Resident #4 was to have been on a restorative range of motion program for knee contractures per therapy recommendations, but was missed.</p> <p>An interview with CNA #2, on 9/3/15, at 10:30 A.M., indicated Resident #4 was not on a restorative range of motion program for range of motion of her knees.</p> <p>3.1-42(a)(2)</p>		<p>finds that the residents are not receiving services as recommended by therapy, including ROM, she will make sure that the physician is notified as soon as possible. Once that is done, and the resident's needs have been addressed, the DON will re-train staff caring for the resident to assure that they are trained and the services are being provided. <u>3.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</u>As a result of the meeting between therapy and the IDT, it was determined that each Functional Maintenance Program developed as the resident is discharged from therapy would be reviewed and signed by the MDS Coordinator and DON, who will then work with therapy and facility staff to make sure that the program is put into place as recommended and agreed upon. The corrective action will be monitored by the MDS Coordinator or designee at least 5 days a week for 30 days; then 3 days a week for 30 days, then weekly for another 30 days. Weekly audits will continue for an additional 90 days. Any identified issues will be addressed as indicated in question #2. <u>4.How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put</u></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155392	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/03/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT KENDALLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1433 S MAIN ST KENDALLVILLE, IN 46755
---	---

(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>into place?</u> The MDSC will bring the results of these audits to the monthly Quality Assurance Committee meeting for review and further recommendations for process improvement if needed. At the end of the 180 days of written audits, when 100% compliance has been achieved, the QA Committee may decide to stop the written audits. However, the process, as indicated, will continue on an ongoing basis with the MDSC and DON monitoring the restorative programs as part of the weekly therapy/nursing meeting and as physician orders are received for the continuation of restorative services when the resident is discharged from therapy. Date of Compliance: 9/18/2015</p>	