

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 08/23/2013
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 18, 19, 20, 21, 22, and 23, 2013</p> <p>Facility number: 000341 Provider number: 155459 AIM number: 100286550</p> <p>Survey team: Barbara Gray RN TC Sharon Lasher RN Leslie Parrett RN Angel Tomlinson RN (August 19, 20, 21, and 23, 2013)</p> <p>Census bed type: SNF/NF: 33 Total: 33</p> <p>Census payor type: Medicare: 3 Medicaid: 25 Other: 5 Total: 33</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed to August 30, 2013, by Janelyn Kulik, RN.</p>	F000000		
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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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F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview and record review, the facility failed to accommodate 1 residents requests to use a sliding board for transferring from the bed to the wheelchair for 1 of 20 residents reviewed for choices. (Resident #17)</p> <p>Findings include:</p> <p>The record of Resident #17 was reviewed on 8/23/13 at 9:33 a.m. Resident #17's diagnoses included but were not limited to, below the knee amputation of right lower extremity, infection left lower extremity, insulin dependent diabetes and peripheral artery disease.</p> <p>Resident #17's most recent MDS (Minimum Data Set), assessment, dated 7/25/13, indicated the following:</p> <ul style="list-style-type: none"> - BIMS, (Brief Interview for Mental Status), was a 15, with a score of 13-15 indicating cognition intact - transfer, activity did not occur - walk in room, activity did not occur 	F000246	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at New Castle desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective 9/17/13. F246 It is the policy of this facility that each resident has a right to receive services in the facility with reasonable accommodations of individual needs and preferences, including accommodation of a resident's request for use of a sliding board for transfers. The facility wants to state that the following corrections should be made to the CMS-2567, page 4 of 20, paragraph 4: The DON was misquoted; instead she stated the following, "C.N.A. asked for something to transfer resident # 17 from her bed to a gurney for a MD appointment - not from the</p>	09/17/2013			

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	<p>- walk in corridor, activity did not occur</p> <p>- functional limitation in range of motion, upper extremity, no impairment</p> <p>- functional limitation in range of motion, lower extremity, impairment on one side</p> <p>Resident #17's care plan, dated 7/20/13, indicated "Problem, I need help with toileting as I do not get out of bed per my choice. Goal, I will be independent with my care after set up except for toileting thru 10/20/13. Interventions, set up everything I need and allow me time to finish, assist me when I need it, use hoyer lift if I want up from the bed as I am now weight bearing and monitor for articles needed."</p> <p>On 8/23/13 at 10:55 a.m. Resident #17 was observed in bed with the head of her bed up her, right leg was amputated below the knee.</p> <p>During an interview with Physical Therapist #7 indicated Resident #17 indicated she would like to use a sliding board (a flat table-like object used in patient transfer from one place to another) last Tuesday or Wednesday and they have a sliding board they are going to try to transfer</p>		<p>bed to a W/C." Also it should be noted that at no time did the C.N.A.'s inform the DON that the resident was afraid of the lift. It is also misquoted in that paragraph 4 that the DON was aware the resident requested a sliding board and a Z-Slider was provided - at no time did the resident request a sliding board to the DON. Correction also needs changed on page 3 paragraph 1, in that the care plan dated 7/20/13 states resident is weight bearing. The actual care plan states resident is non weight bearing. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? This resident had therapy orders on 7/11/13 for both OT and PT evaluations, but refused both. On 8-23-13 Resident #17 was provided with a slide board which she immediately refused until after her morning care. She was approached again later that same day by the Therapist and MDS coordinator and she refused slide board again since it was not like the wooden one she had used at another facility. Resident # 17 also refused again to LPN #3 on 8-27-13. Another type sliding board was not available in the facility and could not be obtained before the resident's planned discharge took place. The resident was scheduled to be discharged home around the end of August/beginning of</p>				

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	<p>Resident #17.</p> <p>During an interview on 8/23/13 at 11:02 a.m., Resident #17 stated "yes, I asked the CNAs about a sliding board because I have used one for 5 years at the last nursing home I was in and I did well with a sliding board, it was great. I hate the lift I am so afraid of it that I don't want to use it at all but I have to use it on Tuesday because that is the day I get my hair washed. No, they have not seen about getting me a sliding board and I have told the social worker, (CNA #6), (CNA #4) and (CNA #5)." Resident #17 also indicated it was so much better to get up in the chair to eat instead of eating in the bed. She indicated she would sit in her chair about 3 hours after lunch and about 3 hours around supper time if she could use a sliding board.</p> <p>During an interview on 8/23/13 at 11:24 a.m., the Social Service Director indicated she was not aware Resident #17 wanted to use a sliding board to be transferred.</p> <p>During an interview on 8/23/13 at 11:35 a.m., CNA #4 indicated about a month ago Resident #17 told her and CNA #5 that she would like to use a sliding board to transfer because she</p>		<p>September. Once home, she had no use for a sliding board. She planned to use her prosthetic leg since her physician had approved its use because the resident's heel ulcer was healed and weight bearing was possible again. Resident #17 continued to get up daily with the Hoyer lift; she was discharged home on 9-4-13. All nursing staff will be re-educated on the importance of accommodating residents' needs and preferences, including communication of residents' choices and preferences to the charge nurse and DON when they become aware of what the residents want or need. In addition they will be re-trained on the appropriate use of the Z-slider. This will be done by 9/13/13. On 9/13/13 all staff was re-educated on the use of the Social Services Referral form as another means to communicate residents' choices, requests, and preferences. The Social Service Referral Form was reviewed with residents at that Resident Council Meeting on 9-9-13 so that they would be familiar with its use. This process will continue to be reviewed with the Resident Council at least annually and upon admission. 2. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? On 9/9/13 the Social Service Director interviewed all resident to</p>		

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	<p>had used one for a long time and could get up easier and that she hated the lift. CNA #4 also indicated she told the nurse about Resident #17 wanting to use a sliding board instead of the lift.</p> <p>During an interview on 8/23/13 at 11:53 a.m., LPN #3, indicated about a month ago Resident #17 told her she would like to use a sliding board and she told the DON (Director of Nursing) and the DON got some kind of a plastic sheet to transfer Resident #17 and Resident #17 did not want to try the plastic sheet.</p> <p>During an interview on 8/23/13 at 12:53 p.m., the DON indicated about a month ago she had a CNA ask her if she had something besides the lift to get Resident #17 into the wheelchair from the bed because Resident #17 was so afraid of the lift and she needed to be encouraged to get out of bed. The CNAs tried a Z-Slider (patient transfer sheet, a friction-reducing patient transfer and repositioning sheet designed to prevent debilitating back injuries to healthcare workers) I gave them the Z-Slider to use and the CNA said it worked but after that, Resident #17 refused to use the Z-Slider. " Yes, we probably did have a sliding board at</p>		<p>ensure reasonable accommodations are being met. No other residents have been identified as being affected by this practice. 3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DON will bring the 24 hour report, focus charting, incident reports, and physician telephone orders to the interdisciplinary morning management and clinical meeting which occurs at least 5 days a week for review by the team. In addition, the team members will bring the results of the Guardian Angel rounds of their assigned residents, including any resident's requests or indication of choices, preferences, or needs. The Social Service Director will bring any social services referral forms that she has received to the morning meeting for review and change in interventions if required. Through these ongoing mechanisms, the interdisciplinary team will formulate plans of action and interventions to meet the residents' choices, needs, and preferences. Those plans and interventions will be made part of the resident's care plan and the CNAs' assignment sheets. The expressed concerns or needs of the residents will continue to be reviewed by the team at the morning management and clinical meetings until the issue has been resolved</p>		

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	<p>the time the resident asked for it but we provided the Z-Slider." The DON also indicated Resident #17 had not had an evaluation for transfer by Physical therapy or Occupational therapy.</p> <p>During an interview on 8/23/13 at 1:57 p.m., Resident #17 indicated the CNAs did try to use a plastic sheet to transfer her a few weeks ago and she refused to use it because it was not safe. "It did not look safe and I read the instructions for the plastic sheet and it was for transfers from a bed to a gurney not from the bed to a chair."</p> <p>During an interview on 8/23/13 at 2:35 p.m., with a Customer Service Representative at the company that supplies the Z-Slider sheet indicated the Z-Slider sheet was only to be used to reposition a resident in the bed or to transfer the resident from the bed to a gurney or a gurney to the bed as was stated in the manufacturers recommendations. The two options given repositioning and lateral transfer. "The Z-Slider is not to be used to transfer a resident from the bed to a chair and to only be used with the resident lying down. If you were getting the resident up in a chair or a wheelchair there would be too much potential for a fall."</p>		<p>accordingly. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Administrator, DON, and SSD will bring the results of the Guardian Angel rounds, the management and clinical reviews of residents' needs, preferences and choices, and any social service referral forms to the monthly QA Committee for further review. Any recommendations made by the QA Committee will be followed up by a person designated by the committee for that responsibility at the next scheduled monthly meeting. All of these processes and monitoring activities will continue on an ongoing basis. Date of Compliance 9/17/13</p>		

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	<p>Manufacturers recommendation, undated, provided by the DON on 8/23/13 at 1:45 p.m., indicated the Z-Slider was used for repositioning and lateral transfers (only). "Repositioning: 1.) The Z-Slider is designed to be placed between the draw sheet and the bed sheet....log roll the patient in the opposite direction and putt the Z-Slider through the remainder of the way. 2.) Straighten out the Z-Slider so that is under the patient's body. 3.) While on each side of the bed, each caregiver should grasp the draw sheet and simultaneously slide the patient up in the bed. 4.) The Z-Slider should be removed after repositioning the patient. Log roll the patient and remove the Z-Slider from under the patient."</p> <p>Lateral Transfer: (DON marked this transfer to indicated this transfer as the one the facility used for transferring Resident #17) 1.) The Z-Slider should be placed between the draw sheet and the bed sheet...log roll the patient in the opposite direction, pull the Z-Slider through the remainder of the way. 2.) Straighten out the Z-Slider so that it is under the patient's body....</p>						

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	<p>3.) While on each side of the beds, and using the draw sheet, one caregiver gently pulls the draw sheet while the other caregiver gently pushes, sliding the patient from gurney to bed or bed to gurney. Care should be taken to ensure proper positioning of the head and lower legs during the transfer.</p> <p>4.) The Z-Slider should be removed after transferring the patient. Log roll the patient and remove the Z-Sider from under the patient.</p> <p>3.1-3(n)(3)</p>			

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F000282 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 record review and interview the facility failed to follow Physician's orders for blood sugar monitoring for 1 of 3 residents out of 5 residents reviewed who met the criteria for unnecessary medication use (Resident # 5).</p> <p>Findings include:</p> <p>On 8/22/13 at 10:00 a.m. review of Resident # 5's record indicated his diagnoses included but were not limited to, anxiety, hypertension, diabetes mellitus, coronary artery disease, bilateral prostate hypertrophy and constipation.</p> <p>Review of a Physician's order dated 5/29/13, indicated accuchecks every a.m., record on flow sheet for diabetes mellitus, notify Medical Doctor (MD) if blood sugar less than 60 or greater than 400.</p> <p>The Physician's recapitulation orders dated 8/2013, indicated Lantus inject 28 units subcutaneous at bedtime for diabetes mellitus. Humalog 6 units</p>	F000282	<p>F 282 It is the policy of this facility that services are provided or arranged by qualified persons in accordance with each resident's written plan of care including following the physicians' orders for blood sugar monitoring.</p> <p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #5's accuchecks were reviewed from 05/29/13 through 09/09/13. The MD was notified on 9/4/2013 of the 7/1/13 and 7/15/13 elevated blood sugars and no new orders were received. No other blood sugars were found to require MD notification. The Physician orders for Resident #5 regarding monitoring Blood Sugars were reviewed with nursing staff 08/26/13. Re-education on Blood Sugar checks was completed for the nurses on 09/13/13 by Director of Nursing.</p> <p>2.How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? An audit was performed on 09/09/13 by MDS Coordinator on all residents with a Physician order for blood</p>	09/17/2013			

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	<p>subcutaneous every evening for diabetes mellitus.</p> <p>Review of a document titled "Glucometer Blood Sugar Checks" indicated Resident had an increased blood sugar level on 7/1/13 at 8:00 p.m. of 406 and on 7/15/13 at 8:00 p.m. of 415. No documentation of Physician notification and no new orders were obtained.</p> <p>Resident # 5's diabetes care plan dated 6/6/13 was reviewed and indicated "Problem: I am diabetic which puts me at risk for abnormal blood sugars. Goal and target date: My blood sugars will be within normal limits thru 9/5/13. Approaches: Give me Actos as ordered. Give me Metformin as ordered. Monitor my blood sugars as ordered and notify MD if below 60 or above 400. Encourage me to eat at least 75% of my meals."</p> <p>On 8/22/13 at 10:30 a.m. interview with the Director of Nursing indicated she could find no documentation that Physician was notified.</p> <p>Review of a document provided by the Administrator on 8/23/13 at 12:32 p.m. indicated "Medications-General Policies... For Administering Insulin -</p>		<p>glucose testing, and none were found in need of MD notification or to be other- wise affected by this practice. However, if the Director of Nursing or designee finds that a resident's blood sugar reading has been outside the physician ordered parameters without physician notification, she will make sure that the physician is checked as soon as possible and will also make sure that any orders given by the physician are transcribed appropriately. Once that is done, the DON will review the facility's policy for blood sugar checks and the need for physician notification of those instances when the blood sugar reading exceeds the para- meters with the nurse(s) involved. The DON will also render progressive discipline as deemed appropriate by the circumstances. 3.What measures will be put into place or what s ystemic changes will be made to ensure that the deficient practice does not recur? The Director of Nursing/Designee will monitor the Glucometer Blood Sugar Flow Sheet at least 5 times per week for 4 weeks, then will continue to monitor on a weekly basis. Any identified concerns will be addressed as outlined in question #2. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Director of Nursing/Designee will bring the results of the Glucometer Blood</p>		

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	<p>All physician orders for insulin that is regularly given must contain physician call parameters, including a low and high threshold. For example , "Notify the physician if glucose meter reading is below 60 or above 350". The results of the glucose meter readings should be charted in the resident's medical record- either on the MAR (medication administration record) or on a blood glucose flow sheet..."</p> <p>3.1-35(g)(2)</p>		<p>Sugar checks to interdisciplinary team meeting 5 days a week, the weekly Standards of Care meeting for 8 weeks, and the monthly QA meeting for review and recommendations. The QA committee will review and monitor progress for the next 60 days. After 60 days the QA Committee may decide to stop the requirement for reporting results if 100% compliance has been reported; however, the weekly monitoring by the DON/designee will continue on an ongoing basis.</p> <p>Date of Compliance: 9/17/13</p>		

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F000314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review the facility failed to do skin assessments on one resident resulting in the resident acquiring a stage four pressure ulcer (full thickness tissue loss) and an unstageable pressure ulcer (necrotic tissue) that the facility was unaware of for 1 of 2 residents reviewed for pressure ulcers for 2 who met the criteria for pressure ulcers (Resident #20).</p> <p>Finding include:</p> <p>1.) Interview with LPN #3 on 8-20-13 at 10:41 a.m. indicated Resident #20 had an unstageable pressure ulcer on his right foot that he acquired at the facility.</p> <p>Review of the record of Resident #20 on 8-21-13 at 10:15 a.m. indicated</p>	F000314	<p>The facility is requesting a face to face IDR for F314. However, a plan of correction has been devised, as per requirements and is listed below: F 314 It is the policy of this facility that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrated that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sore from developing. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 8/21/13 upon identification of Resident # 20's skin condition, the Physician was notified and treatment ordered, family was notified, pressure ulcer assessment was completed and the plan of care reviewed. The</p>	09/17/2013

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	<p>the resident's diagnoses included, but were not limited to, hypertension, anxiety, dementia, depression, psychosis, peripheral artery disease, and ascending gangrene of the right foot.</p> <p>The record of Resident #20 indicated he began receiving hospice care on 7-23-13.</p> <p>The Braden scale for predicting pressure sore risk for Resident #20 dated, 6-6-13 indicated the resident had a score of 15. A score of 17 and below requires a weekly skin assessment and documentation in the medical record.</p> <p>The Minimum Data Set (MDS) annual assessment for Resident #20 dated, June 14, 2013 indicated the following: bed mobility- extensive assistance of one person, transfer- extensive assistance of two people, walk in room - did not occur and toilet use extensive assistance of two people. The MDS indicated the resident was at risk for pressure ulcers and had an infection of the foot.</p> <p>The physician order for Resident #20 dated, 8-15-13 indicated the resident was ordered an optifoam to the buttock area every 7 days and as</p>		<p>Administrator and DON have met with the hospice provider to clarify their role in wound care. As of this time, hospice is NOT to perform any wound care on residents. However, hospice nurses and nurse aides have been asked to notify the charge nurse immediately if they have concerns about an existing wound or if they should find a newly developed wound. The facility charge nurse will notify the attending physician of the wound status and will receive orders from the physician for the wound care. The charge nurse from the facility will also be responsible for performing the treatment and for documenting information about the wounds, including the weekly wound assessments on all residents, including those who are receiving hospice services. During the week of August 26th the Director of Nursing educated the nursing staff on completion of weekly kin assessments, as well as the role of the hospice staff in caring for residents' wounds. 2.How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken?</p> <p>On 8-21-13 head to toe skin assessments were completed by the Director of Nursing and MDS Coordinator on every resident. No new areas were discovered during the assessments. However, if a new wound is found or a concern is identified</p>		

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	<p>needed.</p> <p>Interview with the Director Of Nursing (DON) on 8-21-13 at 10:41 a.m. indicated the order for the optifoam was from hospice as a preventive measure for pressure ulcers not because the resident had a pressure ulcer.</p> <p>During an observation on 8-21-13 at 11:17 a.m. with CNA #1 and CNA #2 Resident #20 had a black and brown pressure ulcer on his left heel. CNA #1 and CNA #2 indicated they were not aware the resident had a pressure ulcer on his left heel. CNA #1 and CNA #2 rolled resident #20 on his side and the resident had a black pressure ulcer on the left lower buttock and thigh area with red and yellow surrounding the wound. The area was draining serosanguineous fluid (consisting of both blood and serous fluid). The resident began having a bowel movement at this time. When CNA #2 attempted to clean the resident up, the resident began moaning and yelling out in pain. CNA #2 indicated hospice had been putting a foam piece on the area on his bottom but she did not know why the resident did not have one on now. CNA #1 got the resident's nurse. LPN #3 came in the</p>		<p>concerning an existing wound, the DON will follow up to make sure that the physician has been notified and that the wound has been assessed and cared for appropriately. Once the resident situation has been cared for, the DON will follow up with the involved staff and will re-train them on the facility policy regarding wound care and notification. The DON will also render progressive disciplinary action as indicated by staff performance. The DON will also bring the situation to the next scheduled interdisciplinary morning meeting for review by the interdisciplinary team to make sure that interventions are current and appropriate to meet the resident's changing needs. Any new interventions will be added to the resident's care plan and the CNA assignment sheet. The DON will note the changes on the 24 hour report so that oncoming shifts can be made aware.</p> <p>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nurses will complete weekly skin assessments as scheduled and will put the completed weekly skin assessments in the Director of Nursing box located behind the nurse's station door. The Director of Nursing/Designee will take the summaries to morning interdisciplinary team meeting that occurs at least 5 days a week</p>				

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	<p>room and indicated she was not aware of Resident #20 having a pressure ulcer on his left heel.</p> <p>Interview with the DON on 8-21-13 at 11:30 a.m. indicated the day shift nurse was suppose to be doing skin assessments on Resident #20 every week. The DON indicated the last weekly skin assessment she could find was done on 7-13-13.</p> <p>Interview with LPN #3 on 8-21-13 at 11:40 a.m. indicated she was aware of the area on Resident #20's buttocks. LPN #3 indicated the hospice nurse put a optifoam dressing on the area on 8-15-13. LPN #3 indicated when she saw the area on 8-15-13 it was purple and it was not black or open. LPN #3 indicated she had not been assessing the area because she thought hospice staff was doing the assessments. LPN #3 indicated she was unaware the optifoam dressing was not in place. LPN #3 looked for skin assessments for Resident #20 and was not able to find any besides the one done on 7-13-13. LPN #3 indicated the facility was relying on the hospice staff too much.</p> <p>Interview with the Resident #20's</p>		<p>for review. The Administrator will verify the summaries are completed as scheduled and will initial the back of the summary. The Director of Nursing/Designee will file the summaries in the resident's medical record once reviewed. If the DON finds that a summary has not been completed, she will review the facility policy with the nurse involved and will use progressive disciplinary action for continued noncompliance. If any other concerns are noted regarding wounds, the DON and interdisciplinary team will follow through as indicated in question #2. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Director of Nursing/Designee will bring the results of the weekly skin assessments to the monthly QA meeting for 60 days. The QA committee will review and monitor progress for the next 60 days. After 60 days the QA Committee may decide to stop the requirement for reporting results in 100% compliance has been reported. However, the review of the status of existing wounds or development of new wounds will continue to be brought to the monthly QA Committee on an ongoing basis for review and recommendations for process improvement. Date of Compliance: 9/17/13</p>				

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	<p>hospice nurse on 8-21-13 at 3:04 p.m. indicated the last skin assessment he had done on the resident was on 8-15-13 when he applied the optifoam dressing to the resident's left lower buttocks. The hospice nurse indicated on 8-15-13 the area was bright pink. The hospice nurse indicated the pressure ulcer was a stage one.</p> <p>The weekly pressure ulcer/deep tissue injury assessment for Resident #20 dated, 8-21-13 indicated the resident had a stage four and unstageable pressure ulcer on his left lower buttocks. The area measured 5 centimeters (cm) by 3 cm. The area was black with outer edge yellow slough. The area was acquired in the facility.</p> <p>The weekly pressure ulcer/deep tissue injury assessment for Resident #20 dated, 8-21-13 indicated the resident had an unstageable pressure ulcer on his left heel. The area measured 2 cm by 2.3 cm. The area was soft black with a dry center. The area was acquired in the facility.</p> <p>The "Skin Integrity/Wound program" provided by the Administrator on 8-21-13 at 12:20 p.m. indicated "to prevent deep tissue injury for</p>			

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	<p>occurring, it is important for frequent, if not daily, skin assessments, particularly checking for any changes in the skin's appearance, especially in residents who have diabetes or some type of arterial disease."</p> <p>3.1-40(a)(2)</p>			

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F000323 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. Based on observation, interview, and record review, the facility failed to transfer a resident safely and failed to implement appropriate interventions to prevent falls for 1 of 3 residents reviewed for falls of 3 who met the criteria for falls (Resident #27)</p> <p>Findings include:</p> <p>Resident #27's record was reviewed on 8/21/13 at 10:12 A.M. Diagnoses included but were not limited to, hypertension, congestive heart failure, peripheral artery disease, neuropathy, osteoarthritis. Alzheimer's disease, and dementia with behavior disturbances.</p> <p>Resident #27's quarterly MDS (Minimum Data Set) assessment dated 5/31/13, indicated she was usually understood and usually understood others. She scored 3 on her BIMS (Brief Interview for Mental Status), indicating she was severely impaired for her cognitive decision making. She required extensive</p>	F000323	<p>F 323 It is the policy of this facility to ensure that the resident environment remains as free of accidents hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents, including implementation of appropriate interventions to prevent falls.</p> <p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Re-education was done by Director of Nursingwith CNA #4 and CNA #8 on 08/23/13 to review the policy on Gait Belts and their application. This re-education was documented and placed in their employee file. The proper transferring technique for Resident #27 was also discussed at that time. The C.N.A.'s will be re-educated annually by the DON on the proper use of gait belts. Resident #27 was immediately placed on pressure alarm after the Interdisciplinary Care Team met on 08/17/13 instead of clip alarm that had been previously recommended and used. Resident #27 has had no</p>	09/17/2013

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	<p>assistance of 1 person for bed mobility, transfer, dressing, eating, toileting, and personal hygiene. She required extensive assistance of 2 persons to walk. She had a history of falls.</p> <p>A care plan for Resident #27 initiated 2/24/11, indicated the following: Problem-Resident #27 had frequently fallen and was at risk for more falls due to her impaired vision, weakness, and decline in cognition. Goal-Resident #27 would not have any injuries or falls through 8/29/13. Approaches included but were not limited to: February 28, 2013-She would utilize a pressure alarm on her bed. March 4, 2013-She would utilize a pressure alarm in her wheelchair and recliner. Labs would be requested to rule out a medical condition. July 22, 2013-She would be placed in her recliner to rest between meals. August 16, 2013-She would be referred to therapy for a positioning device due to leaning left.</p> <p>A nurses note for Resident #27 dated 2/28/13 at 4:00 A.M., indicated the following: Resident #27 was returning to her bedroom from the nurses station. She was holding onto her walker in a forward bent over position.</p>		<p>additional falls at this time. Staff was in-serviced on 08/16/13 on following care plans and will be in-serviced again on 09/13/13. On 8-6-13 the Nurse Consultant provided education to the Director of Nursing and Administrator on Incident and Accident documentation. 2.How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? An audit was performed on 09/10/13 by MDS Coordinator on all current Fall Interventions to ensure that appropriate interventions were in place for any resident identified as being at risk for falls. In the future, if any resident does not appear to have the appropriate interventions in place to prevent future falls, the interdisciplinary team will meet as part of the morning management meeting at least 5 days a week to discuss the identified safety concerns with any resident. The team will recommend interventions for prevention of other accidents, will update the resident's care plan, and the DON will make sure that the CNA assignment sheets are brought up-to-date with the new interventions. Any changes in interventions will also be added to the 24 hour report sheet for communication with other shifts. If any concerns in staff performance are identified, the DON will meet with the involved</p>		

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	<p>The writer instructed Resident #27 to continue holding onto her walker and she would retrieve the resident's wheelchair. The writer was returning with the wheelchair and Resident #27 was in a forward squatting position, holding onto the lower level of her walker. She let go of the walker and landed on the floor on her bottom, then rolled back, not hitting her head.</p> <p>A nurses notes for Resident #27 dated 3/4/13 at 6:00 A.M., indicated the following: Resident #27 was beginning to ambulate to the dining room with her rolling walker. She was observed standing with her knees bent 90 degrees. She was eased to the floor by staff with no injury. She had sat in her recliner most of the night and was stiff. Her confusion remained high, as she did not know how to get back to her bedroom without assistance. She had no injury.</p> <p>A nurses note for Resident #27 dated 3/21/13 at 8:10 P.M., indicated the following: Resident #27 was observed sitting in bathroom #4 beside the toilet with her pants down. She had a .5 cm (centimeter) skinned area to her left knee. The skinned area was cleaned. She had denied hitting her head. She was highly</p>		<p>staff to re-train them on the facility process for accident prevention and will also render progressive disciplinary action for instances of continued noncompliance.</p> <p>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Department Managers will monitor the rooms of residents assigned to them at least 5 times a week to make sure that interventions are in place and the appropriate equipment is in use. They will also observe staff for proper transfer techniques as part of their rounds throughout the facility. If they observe questionable technique or have a concern about the transfer, the Manager will stop the transfer immediately and make sure that the resident is safe. Once that is done, the Manager will notify the charge nurse (if not already involved) and the DON so that the necessary follow up can be done as quickly as possible. When an incident occurs, the Director of Nursing/ Designee will bring the Incident report to the next scheduled morning interdisciplinary meeting. The Interdisciplinary Team will review the circumstances of the incident and will implement new interventions as needed. Any changes will be documented and followed through as indicated in question #2. 4. How will corrective action be monitored to</p>				

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	<p>confused and unaware she needed to use a wheelchair or walker. She had walked to another resident's room earlier and was going to go to bed. She would have a personal alarm on when she was in bed.</p> <p>An Incident Intervention Audit for Resident #27 dated 3/21/13, indicated the following-"Immediate Intervention Implemented"-An alarm was placed.</p> <p>A nurses note for Resident #27 dated 7/19/13 at 10:40 A.M., indicated the following: Resident #27 was seated in her wheelchair and fell out. She received a skin tear to her left elbow 3 cm in length. She had no other injuries. She had a chair alarm in place.</p> <p>A nurses note for Resident #27 dated 8/15/13 at 7:00 P.M., indicated the following. A CNA walked by Resident #27's bedroom at 3:30 P.M., and saw her lying on the floor. She had stated she "wanted to get up." A slight bump was observed on her left forehead. She had a alarm in place that had slid off of her clothing, not setting the alarm off. Neurological checks were initiated.</p> <p>A Fall Investigation Report for Resident #27 dated 8/15/13, indicated</p>		<p>ensure the deficient practice does not recur and what QA will be put into place? In addition to the morning interdisciplinary meeting, the Director of Nursing/Designee will review all incidents and accidents weekly at the Standards of Care Meeting, and the monthly QA meeting for review and recommendations. The QA committee will review and monitor progress of implementation of new nterventions on an ongoing basis. Date of Compliance: 9/17/13</p>				

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	<p>the following. Resident #27's mental status was disoriented. She had a clip alarm in use. The clip alarm had slid off of her clothing.</p> <p>Assessment/interventions put into place after her fall included, a fall risk assessment, her care plan updated, re-education of staff regarding her clip alarm. How the incident would be prevented from re-occurring again included, referring her to therapy for a positioning device as she leaned to the left. An inservice would be scheduled to review care plans.</p> <p>On 8/21/13 at 4:03 P.M., the DoN (Director of Nursing indicated Resident #27 fell in the hallway on 2/28/13 at 4:00 A.M. She indicated the new intervention placed on the care plan was a pressure alarm on her bed. She indicated when Resident #27 fell in the bathroom on 3/21/13, the documentation did not indicated what type of footwear Resident #27 was wearing or if any alarm sounded. She indicated no interventions were added to the care plan.</p> <p>On 8/22/13 at 9:06 A.M., Resident #27 was observed being transferred to the toilet and back to her wheelchair, with the assistance of CNA #4 and CNA #8, with the use of</p>				

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	a gait belt. Resident #27 stood from her wheelchair and her knees began to bend as she took a few steps toward the toilet. The gait belt slid up around her chest. She pivoted and sat down on the toilet after her slacks and brief were lowered. She stood from the toilet with the assistance of CNA #4 and CNA #8, with the use of a gait belt. Her knees began to bend as she took a few steps toward the wheelchair and pivoted to prepare and sit down. Her knees continued to bend further and the gait belt slid up around her chest. She was getting close to the floor, when CNA #4 and CNA #8 lifted her feet completely off the floor, with one hand each holding the gait belt, and one arm each under the resident's arms, and placed her in her wheelchair. At that time CNA #8 indicated Resident #27 should use a stand-up-lift. She indicated Resident #27 had gotten progressively weaker at times. She indicated she did not lower the resident to the floor because her and CNA #4 had a good hold on the resident to go ahead and place her in the wheelchair. She indicated they had lifted Resident #27's feet off the floor. CNA #4 indicated she would prefer if Resident #27 used a stand-up-lift for "the residents own comfort." She indicated approximately a month			

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	<p>prior, she had to lift Resident #27's feet off the floor to transfer her. She indicated she had reported to the nurse how the resident transferred, but could not recall which nurse she reported to. She indicated she would normally lower the resident to the floor if their legs were giving out but she just reacted and lifted the resident to her wheelchair.</p> <p>On 8/23/13 at 12:16 P.M., the DoN indicated when a resident falls the IDT (Interdisciplinary Team) meets and discusses why they thought a resident had fallen and decide what action needed to be taken. Any new interventions were documented on the resident's care plan. She indicated when Resident #27 fell on 3/21/13 at 8:10 P.M., an alarm was not in place as indicated on the Resident #27's care plan and according to the documentation an alarm was placed. She indicated when Resident #27 fell on 8/15/13 at 7:00 P.M., she was wearing a clip alarm on her clothing and according to her care plan, should have had a pressure alarm. She indicated Resident #27 was seated in her wheelchair and according to her care plan, should have been seated in her recliner. She indicated she had completed an inservice with staff</p>			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
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	<p>related to following care plans. She indicated if staff had difficulty transferring a resident, they should report to their nurse. She indicated staff are not trained to lift a resident's feet off the floor. She indicated lifting a resident's feet off the floor during a transfer could injure the resident or the staff.</p> <p>The most recent Gait Belt Use policy and procedure provided by the Administrator on 8/23/13 at 2:11 P.M., indicated the following: "Purpose in ambulation and transfers: >To provide a "handle" for staff to provide support for resident. >To ensure minimum interference by staff. >To allow maximum functional performance of resident. >To assist in lifting a resident to a standing position. >To allow resident and assisting staff person optimal control over their center of gravity. >to ensure the safety of both staff and resident...."</p> <p>3.1-45(a)(2)</p>			

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F000329 SS=D	<p>483.25(I) 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 record review and interview the facility failed to notify the Physician of increased blood sugars for 1 of 3 residents out of 5 residents reviewed who met the criteria for unnecessary medication use (Resident # 5).</p> <p>Findings include:</p> <p>On 8/22/13 at 10:00 a.m. review of Resident # 5's record indicated his diagnoses included but were not</p>	F000329	F 329 It is the policy of this facility to ensure each resident's drug regimen is free from unnecessary drugs. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #5's accuchecks were reviewed from 05/29/13 through 09/09/13. The MD was notified on 9/4/2013 of the 7/1/13 and 7/15/13 elevated blood sugars and no new orders were received. No other blood sugars were found to require MD notification. The	09/17/2013			

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	<p>limited to, anxiety, hypertension, diabetes mellitus, coronary artery disease, bilateral prostate hypertrophy and constipation.</p> <p>Review of a Physician's order dated 5/29/13, indicated accuchecks every a.m., record on flow sheet for diabetes mellitus, notify Medical Doctor (MD) if blood sugar less than 60 or greater than 400.</p> <p>The Physician's recapitulation orders dated 8/2013, indicated Lantus inject 28 units subcutaneous at bedtime for diabetes mellitus. Humalog 6 units subcutaneous every evening for diabetes mellitus.</p> <p>Review of a document titled "Glucometer Blood Sugar Checks" indicated Resident had an increased blood sugar level on 7/1/13 at 8:00 p.m. of 406 and on 7/15/13 at 8:00 p.m. of 415. No documentation of Physician notification and no new orders were obtained.</p> <p>Resident # 5's diabetes care plan dated 6/6/13 was reviewed and indicated "Problem: I am diabetic which puts me at risk for abnormal blood sugars. Goal and target date: My blood sugars will be within normal limits thru 9/5/13. Approaches: Give</p>		<p>Physician orders for Resident #5 regarding monitoring Blood Sugars were reviewed with nursing staff 08/26/13. Re-education on Blood Sugar checks was completed for the nurses on 09/13/13 by Director of Nursing. 2.How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? An audit was performed on 09/09/13 by MDS Coordinator on all residents with a Physician order for blood glucose testing, and none were found in need of MD notification or to be other- wise affected by this practice. However, if the Director of Nursing or designee finds that a resident's blood sugar reading has been outside the physician ordered parameters without physician notification, she will notify physician as soon as possible and will also make sure that any orders given by the physician are transcribed appropriately. Once that is done, the DON will review the facility's policy for blood sugar checks and the need for physician notification of those instances when the blood sugar reading exceeds the parameters with the nurse(s) involved. The DON will also render progressive discipline as deemed appropriate by the circumstances. 3.What measures will be put into place or what systemic changes will be made to ensure that the deficient</p>		

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	<p>me Actos as ordered. Give me Metformin as ordered. Monitor my blood sugars as ordered and notify MD if below 60 or above 400. Encourage me to eat at least 75% of my meals."</p> <p>On 8/22/13 at 10:30 a.m. interview with the Director of Nursing indicated she could find no documentation that Physician was notified.</p> <p>Review of a document provided by the Administrator on 8/23/13 at 12:32 p.m. indicated "Medications-General Policies... For Administering Insulin - All physician orders for insulin that is regularly given must contain physician call parameters, including a low and high threshold. For example , "Notify the physician if glucose meter reading is below 60 or above 350". The results of the glucose meter readings should be charted in the resident's medical record- either on the MAR (medication administration record) or on a blood glucose flow sheet..."</p> <p>3.1-48(a)(3)</p>		<p>practice does not recur? The Director of Nursing/Designee will monitor the Glucometer Blood Sugar Flow Sheet at least 5 times per week for 4 weeks, then will continue to monitor on a weekly basis. Any identified concerns will be addressed as outlined in question #2. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Director of Nursing/Designee will bring the results of the Glucometer Blood Sugar checks to interdisciplinary team meeting 5 days a week, the weekly Standards of Care meeting for 8 weeks, and the monthly QA meeting for review and recommendations. The QA committee will review and monitor progress for the next 60 days. After 60 days the QA Committee may decide to stop the requirement for reporting results if 100% compliance has been reported; however, the weekly monitoring by the DON/designee will continue on an ongoing basis. Date of Compliance: 9/17/13</p>		