

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155419	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2013
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT CRAWFORDSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N WHITLOCK AVE CRAWFORDSVILLE, IN 47933
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 21, 22, 23, 24, 25, 2013</p> <p>Facility number: 000533 Provider number: 155419 AIM number: 100267230</p> <p>Survey team: Teresa Buske RN-TC Mary Weyls RN October 21, 22, 23, 24, 2013 Laura Brashear RN Karen Hartman RN</p> <p>Census bed type: SNF/NF 34 Total: 34</p> <p>Census payor type: Medicare 2 Medicaid 32 Total: 34</p> <p>This deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 11/01/2013 by Brenda Marshall Nunan, RN.</p>	F000000	<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 Crawfordsville desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective November 7, 2013.</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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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 observation, interview, and record review, the facility failed to ensure 1 of 1 resident receiving dialysis and reviewed for nutrition received a food item within ordered dietary restrictions and drinks were not served in specialty glasses as ordered by the physician.</p> <p>Finding includes:</p> <p>On 10/25/13 during the noon meal Resident #25 was observed feeding self in the Assisted Dining Room. The resident was observed to have a sipper cup containing orange drink, a regular tumbler of water, and a smaller tumbler of tomato juice. The resident's dietary card placed with the meal had documentation of sipper cup for breakfast, lunch, and dinner. Additional information on the card under dislikes was noted "oranges, bananas, no milk, no straws, only 1 glass of milk a day." After completion of the meal, it was observed resident had drank the tomato juice and half of the glass of water.</p>	F000282	F 282 It is the policy of this facility that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. What corrective action will be done by the facility? Nursing staff was inserviced 11/06/13 (attachment 1) in regards to appropriate adaptive equipment needed during meal service, as well as double-checking diet cards prior to giving residents their meal trays. Dietary staff was inserviced 11/06/13 (attachment 1) in regards to double-checking diets and ensuring appropriate adaptive equipment is utilized as needed. How will the facility identify other residents having the potential to be affected by this practice? There are no other dialysis residents, or residents requiring a sip cup in the facility at this time. What measures will be put into place to ensure the practice does not recur. The DSM or designee will observe, completing the Dining Observation Audit Sheet (attachment 2) to ensure that appropriate diets are served, and adaptive equipment is in place two (2) meal passes per day,	11/07/2013			

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	<p>The Food Service Supervisor (FSS) was interviewed on 10/25/13 at 1:00 p.m. The FSS indicated the resident should not have received the tomato juice as he is a hemo dialysis patient, and dietary restrictions included, but were not limited to, low potassium. The FSS indicated low potassium diets do not include food items containing tomato. The meal spread sheets for the week of October 21-25, 2013, provided by the FSS on 10/21/13 at 1:00 p.m. were marked "No" under potassium restrictions diets for foods with tomato.</p> <p>During the same interview the FSS indicated the resident was to receive sipper cups for fluids, they were available and should have been provided to the resident for the water and tomato juice.</p> <p>The resident's clinical record was reviewed on 10/25/13 at 2:55 p.m. A physician's order was noted (no date) for Mechanical soft, no added salt, low potassium diet and sipper cup.</p> <p>A plan of care, dated 2/7/13, addressed the problem of the resident refusing to use a sippy cup by taking the lids off of them. Approaches included, but were not limited to remind me that my physician wants</p>		<p>three (3) times per week for twelve (12) weeks. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place? DSM or designee will report on Dining Observation results at QA meeting times three (3) months for further recommendations by QA. The DSM and/or designee will continue to audit on an ongoing basis and will report to the committee as directed.</p>		

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	<p>me to keep the lid on at all times for my safety. Remind me that I can choke. Remind me that drinking without my lid on my cup will increase my risk for pneumonia.</p> <p>Another plan of care, dated 6/13/11 with goal date of 1/3/14, included but was not limited to, Provide a consistent carbohydrate diet, with NAS (no added salt) and low K (potassium.)</p> <p>3.1-35(g)(2)</p>			

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F000315 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 observation, record review, and interview the facility failed to provide appropriate services to prevent infections i.e. maintain the Foley catheter bag below the level of the bladder for 1 of 2 residents who met the criteria for use of a urinary catheter. (Resident 40)</p> <p>Findings include:</p> <p>Upon interview of Resident #40 on 10/22/13 at 2:20 p.m., the resident indicated she was currently being treated for a urinary tract infection, and that she required the Foley catheter due to her illness.</p> <p>On 10/25/13 at 12 p.m., CNA #1 and QMA (Qualified Medication Aide) #2 were observed to transfer Resident #40 from the bed to the wheelchair. Prior to the transfer, the Foley</p>	F000315	F 315 It is a policy of this facility to 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. What corrective action will be done by the facility? Nursing staff was inserviced 11/06/13 (attachment 3) in regards to maintaining Foley catheter bags at appropriate levels while caring for residents who have a catheter, including during transfers. How will the facility identify other residents having the potential to be affected by this practice? Currently there are no other residents in the facility that have catheters that utilize the mechanical lift. What	11/07/2013	

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	<p>catheter bag was placed on the resident's lap while she was lying in bed. The resident was transferred utilizing the mechanical lift. During the transfer with the mechanical lift, the Foley catheter bag was hung on the bar of the mechanical lift above the resident's head. The urine in the Foley catheter tubing flowed back towards the resident's bladder. The Foley catheter bag was secured under the resident's wheelchair after the resident positioned in the wheelchair.</p> <p>Upon review of the clinical record of Resident #40 on 10/25/13 at 1:20 p.m., the most recent Minimum Data Set (MDS) was completed on 8/21/13. The assessment identified the resident as moderately impaired in cognitive decision making skills. A physician's order was noted dated 10/18/13 of Rocephin [antibiotic] 500 milligram intramuscularly now for urinary tract infection and Macrobid [antibiotic] 100 milligram twice daily for ten days for urinary tract infection.</p> <p>Upon review of the facility's current policy and procedure titled "Catheter Care-Closed Urinary Drainage" dated 6/2004 on 10/25/13 at 1:00 p.m., documentation indicated "...General Instructions: Never allow drainage to</p>		<p>measures will be put into place to ensure the practice does not recur. The DON or designee will monitor three (3) transfers weekly times three (3) months for nursing staff who are assisting residents who utilize the mechanical lift with catheter present to ensure that the catheter is in appropriate position. All nursing staff will be observed and checklist (attachment 4) completed on appropriate placement of catheter bag during transfers. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place? The DON will report on the findings of her observations to the QA team monthly times three (3) months. The DON and/or designee will continue to audit on an ongoing basis and will report to the committee as directed.</p>				

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	<p>be at a level above the bladder when drainage bag tubing is not clamped; Urine should not be allowed to collect in the tubing, since a free flow of urine must be maintained to prevent infection..." Upon review of the another current facility policy and procedure titled "Catheter Care-General Information" dated 6/2004 on 10/25/13 at 1:00 p.m., documentation indicated "...b. Always keep tubing and urinary drainage bag lower than the bladder to facilitate gravity drainage and to prevent reflux of urine through the tubing and catheter, and then into the bladder; c. Never lift the urinary drainage bag over the resident..."</p> <p>3.1-41(a)(2)</p>			

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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 record review, the facility failed to ensure</p>	F000441	F 441 It is a policy of this facility to establish and maintain	11/07/2013			

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	<p>hand hygiene was maintained to prevent cross contamination for 1 of 1 random observation of staff handling Foley catheter tubing and bag without changing gloves before touching other surfaces. (Resident #40)</p> <p>Findings include:</p> <p>On 10/25/13 at 12 p.m., CNA #1 and QMA [Qualified Medication Aide] #2 was observed to transfer Resident #40 from the bed to the wheelchair. The resident was observed to utilize a Foley catheter. During the transfer, the CNA and QMA handled the resident's Foley catheter bag and tubing. The CNA and the QMA were noted to have gloves on. Without changing the contaminated gloves, the CNA and the QMA applied the foot pedals to the resident's wheelchair and moved the mechanical lift. The staff then removed their contaminated gloves.</p> <p>Upon review of the facility's current policy and procedure titled "Handwashing" dated January 2003 on 10/25/13 at 1 p.m., documentation indicated "...Gloves should be changed: Anytime you would need to wash your hands (Anytime you change tasks-go from one thing to another); When they are torn or</p>		<p>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. What corrective action will be done by the facility? Nursing staff were inserviced 11/06/13 (attachment 5) on proper hand-washing protocol while handling catheter and tubing. How will the facility identify other residents having the potential to be affected by this practice? There are currently two (2) patients using catheters in the facility. What measures will be put into place to ensure the practice does not recur. The DON or designee will observe all nursing staff during hand washing and catheter handling three (3) times per week, times three (3) months and checklist completed (attachment 6) on appropriate hand washing protocol. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place? The DON will report on the findings of her observations to the QA team monthly times three (3) months. The DON and/or designee will continue to audit on an ongoing basis and will report to the committee as directed.</p>				

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	soiled..." 3.1-18(l)			