

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155406	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/06/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 390 W BOULEVARD PERU, IN 46970
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F 0000 Bldg. 00	<p>This visit was for the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on March 16, 2016. This visit included the PSR to the Investigation of Complaint IN00193960 completed on March 16, 2016.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00195025.</p> <p>Complaint IN00193960 - Not Corrected</p> <p>Survey dates: May 4, 5 and 6, 2016</p> <p>Facility number: 000475 Provider number: 155406 AIM number: 100290540</p> <p>Census bed type: SNF/NF: 27 Total: 27</p> <p>Census payor type: Medicare: 01 Medicaid: 24 Other: 02 Total: 27</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC</p>	F 0000		
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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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F 0323 SS=E Bldg. 00	<p>16.2-3.1.</p> <p>Quality Review completed by 14454 on May 13, 2016.</p> <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, record review and interviews the facility failed to ensure there was supervision during 3 of 3 meals. This potentially affected 8 who received modified consistency diets of 22 residents who consumed food in the dining rooms. (Residents #31, #3, #1, #14, #25, #6, #19 and #43)</p> <p>Finding includes:</p> <p>The following was observed in the Main Dining room during the noon meal service on 05/04/16:</p>	F 0323	<p>It is the policy of this facility to ensure that each resident receives adequate supervision and assistance devices to prevent accidents, including those residents who have swallowing difficulties and receive thickened liquids.</p> <p>Those residents that have physician orders for thicken liquids will have their liquids placed on their trays by the dietary department and they will be served with the meal. The trays with thicken liquids will not be served to the residents until a nursing staff person is present. A nurse or</p>	05/07/2016			

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	<p>* At 12:04 P.M., the business office manager and Social Service Designee were serving beverages to residents in the main dining room. After they finished serving beverages in the Main Dining Room, they entered the Assisted Dining Room to serve beverages.</p> <p>* At 12:26 P.M., all residents had been served in the Main Dining Room and there was no staff in the Main Dining Room. Staff were in the adjacent Assisted Dining Room. The Administrator entered the Main Dining Room and indicated the CNA (Certified Nursing Assistant) seated in the Assisted Dining Room feeding Resident #1 was visually supervising the Main Dining Room. However, one dining table, with three residents seated at it, could not be visualized at all from the Assisted Dining Room doorway. The Registered Nurse Consultant than entered the dining room and stayed in the Main Dining Room for the remainder of the meal.</p> <p>The following was observed in the Main Dining Room during the noon meal service on 05/05/16:</p> <p>* At 11:36 A.M., the Activity Director was in the Main dining room asking residents what music they would like to hear. The Business office manager, had a</p>		<p>anursing assistant will be present in both dining rooms from the time fluids arebeing passed until the last resident has finished eating.</p> <p>All residents with thickened liquids have the potential to beaffected by this practice. However, none have had any problems with swallowingor choking while drinking their thickened liquids. All residents havebeen moved to the large dining room for more efficient supervision. Staff was notified of the policy change as soon as thesurveyors relayed their concern and have followed that policy and practicesince then. The Administrator hasassigned management staff to assist in supervising the dining room for each meal and to make sure that staff ismonitoring all residents as they eat. Ifthe Administrator or any IDT member identifies a concern of supervision, he orshe will make sure that the resident remains safe while the issue is removed orfixed. Once the resident's welfare ismet, the administrator or manager overseeing the area of noncompliance willaddress the staff involved by retraining them in regards to the facilitypolicy. In addition, progressive written counseling will be rendered forcontinued</p>				

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	<p>beverage cart and was delivering beverages to residents in the Main Dining Room. CNA #15 was bringing residents down to the dining room and leaving the area.</p> <p>* At 11:48 A.M., the Business office manager was now passing beverages in the assisted dining room. The Activity Director was also in the Assisted dining room. There were 13 residents in the Main Dining Room, drinking their beverages without direct supervision.</p> <p>* At 12:02 P.M., the Business office manager delivered the first meal tray to the Main Dining Room. Staff were noted to go back and forth to get meal trays but there were 1 to 2 minutes times when no staff was able to visualize the Main Dining room. The door to the Administrator's office, which was in view of the Main Dining room was shut and the blinds on her office window were closed.</p> <p>* From 12:14 P.M. to 12:19 P.M., no staff were in the Main Dining Room while residents were eating and drinking. At 12:19 P.M., the Director of Nursing arrived in the Main Dining Room to supervise the meal.</p> <p>The following was observed during the</p>		<p>noncompliance.</p> <p>The DON/designee will audit these issuesutilizing the Dining Room Meal Observation Audit. The Administrator or designee will bring the results of the written audits to the IDT morning management meeting, weeklystandard of Care and monthly QA committee meetings for review. After 1 month, and when 100% compliance has been achieved,the QA committee may decide to stop the written Dining Room Meal audit;however, the monitoring of the dining room at meal time will continue on anongoing basis.</p> <p>Date of compliance: 5/7/16</p>				

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	<p>noon meal service on 05/06/16:</p> <p>*At 11:44 A.M., the Business office Manager and the Social Service Director were serving beverages from a cart in the Main Dining Room.</p> <p>* At 11:48 A.M., the staff passing beverages had left the main dining room, the Administrator had gone outside the front doors and there were no staff supervising the residents in the Main Dining Room.</p> <p>*At 11:49 A.M., the Business Office Manager walked from the kitchen serving door around the corner and into the assisted dining room.</p> <p>* At 11:50 A.M., the Nurse Consultant and the Administrator both entered the Main Dining Room.</p> <p>* From 12:16 P.M. to 12:17 P.M., no staff were in the Main Dining Room supervising residents.</p> <p>* From 12:17 P.M. to 12:19 P.M., a licensed nurse was going back and forth from the dietary serving door to the Assisted Dining Room.</p> <p>* At 12:19 P.M., the Director of Nursing entered the Main Dining Room from the</p>			

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	<p>facility front door.</p> <p>On 5/5/16 from 11:55 A.M. thru 12:19 P.M., the Assisted Dining Room was observed to have no staff in it. Ten residents were seated in the assisted dining room, all 10 residents had drinks in front of them. Resident #6 was observed to be coughing and clearing his throat no staff was present, he had 2 plastic cups with lids, straws and thickened liquids sitting in front of him. Resident #3 was observed sitting behind the doorway to the assisted dining room by himself he was attempting to drink his 2 cups of thickened juice by himself. The television was on in the assisted dining room the volume was turned up. Resident #2 was observed reaching for her glass of water, she tipped the glass of water over and spilled it over the top of the table and into her lap.</p> <p>On 5/6/16 at 11:45 A.M., nine residents were observed seated in the assisted dining room. A radio was playing in the dining room and the volume was turned up. At 11:50 A.M., the Social Service Director (SSD) and the Business Office Manager brought a cart in filled with drinks and proceeded to pass out drinks to each the 9 residents. Resident #3 was observed sitting back behind the doorway</p>			

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	<p>by himself. He was served 2 glasses of thickened juice which he was able to pick up the glasses and give himself a drink. After Resident #3 took 2 sips of his thickened juice he started to cough and clear his throat no staff was present in the dining room at this time. At 11:55 A.M., the SSD placed 2 plastic cups with lids, straws and thickened liquids in front of Resident #6 and instructed Resident #6 to wait until a CNA could help him with his drinks. The SSD then left the dining room. From 11:55 A.M. thru 12:12 P.M., no staff were present in the assisted dining room. At 12:13 P.M., the Dietary Manager and CNA #1 entered the assisted dining room each had a tray for a resident. The Dietary Manager observed that no staff was present in the dining room and instructed CNA #1 to stay in the dining room with the residents instead of continuing to deliver trays so that the residents would not be left unattended.</p> <p>During an interview, on 5/6/16 at 12:22 P.M., CNA #1 indicated in the past the staff would deliver the meal trays to the independent dining room and then deliver the trays to the assisted dining room. She further indicated this procedure was changed recently and now 1 staff member was to be present in the assisted dining room during the meal service, while the</p>			

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	<p>other staff pass the meal trays.</p> <p>On 5/6/16 at 2:30 P.M., a record review for Resident #3 was conducted. The diagnoses included, but were not limited to: diabetes, schizoaffective disorder and dysphasia related to cerebrovascular disease. Resident #3's diet order was for puree with honey think liquids.</p> <p>A care plan for Resident #3, dated 12/15/15 and revised on 3/1/16, indicated I will be able to swallow related to my current diet. The interventions included, but were not limited to: Observe resident during and after meals for any swallowing difficulty or coughing episodes and serve my meals per MD (Medical Doctor) order NAS (no added salt) pureed texture with honey consistency.</p> <p>On 5/6/16 at 2:45 P.M., a record review was conducted for Resident #6. The diagnoses included, but were not limited to: diabetes, hemiplegia, pressure ulcer and dysphagia. Resident #6's diet order was for mechanical soft with nectar thick liquids.</p> <p>A care plan for Resident #6, dated 8/24/15 and revised on 4/18/16, indicated I will not have any choking episodes thru next review. The interventions included,</p>			

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	<p>but were not limited to: All staff to be informed of resident's special dietary and safety needs. Alternate small bites and sips. Use a teaspoon for eating. Do not use straws. I am to fed at all meals. I need nectar thickened liquids at all times. Monitor for shortness of breath, choking, labored respirations and lung congestion.</p> <p>A care plan for Resident #6, dated 1/14/16 and revised on 4/1/16, indicated I am on a Mechanical altered diet. The interventions included but were not limited to: I am not allowed to drink with a straw due to being on Nectar thick liquids do not give me one. I require Nectar thick liquids, please make sure that is what I receive.</p> <p>On 6/5/16 at 3:30 P.M., the nurse Consultant provided a list of 22 residents and their diets. Eight (8) residents had modified consistency diets as follows: * Resident #31 - Pureed diet (food that requires little or no chewing and can be easily swallowed) * Resident #3 - Puree with honey thick liquids * Resident #1 - Puree with honey thick liquids * Resident #14 - Mechanical Soft (food designed to minimize that amount of chewing necessary to ingest food) * Resident #25 - Puree all foods but</p>			

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	<p>Mechanical Soft Meat</p> <ul style="list-style-type: none"> * Resident #6 - Mechanical Soft with Nectar Thick Liquids * Resident #19 - Mechanical Soft * Resident #43 - Puree with Honey Thick Liquids <p>On 5/6/16 at 3:25 P.M., the Administrator provided a policy titled "Serving of Meals (Dining Room and Resident Room)", revised on 1/1/16 with an addendum dated 5/6/16, and indicated the policy was the one currently used by the facility. The policy indicated "...Those residents that have physician orders for thicken liquids will have their liquids placed on their trays by the dietary department. The trays with thicken liquids will not be served to the residents until a nursing staff person is present. A nurse or nursing assistant will be present in both dining rooms from the time fluids are being passed until the last resident has finished eating...."</p> <p>This deficiency was cited on March 16, 2016. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-45(a)(2)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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