STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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	This visit was for a Recertification and State Licensure Survey. Survey dates: January 2, 3, 4, 5, 8, and 9 2018. Facility number: 010478 Provider number: 155649 AIM number: 200197620 Census Bed Type: SNF/NF: 79 Total: 79 Census Payor Type: Medicare: 8 Medicaid: 58 Other: 13 Total: 79 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on January 12, 2018.	F 0000	We are requesting paper compliance of these citations. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by the provisions of federal and state law.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	the requirements set forth in paragraph (c) of this section. Based on observation, interview, and record review, the facility failed to implement care plan interventions for 1 of 1 resident reviewed for fall risk (Resident 33) in a sample of 18 residents reviewed for care plans. Findings include: On 1/2/18 at 1:15 P.M., Resident 33 was observed in the hallway in her wheelchair. The wheelchair was not equipped with an anti-rollback device. On 1/2/18 at 1:25 P.M., the resident's bathroom was observed to have no non-skid strips in place on the floor. On 1/4/18 at 10:25 A.M., the resident's clinical record was reviewed. Diagnoses included, but not limited to schizophrenia. The care plan, with a start date of 11/25/14 and revision date of 8/21/17, with interventions to be implemented through 2/5/18 indicated, "The resident is at risk for falls related to unaware of safety needs, psychoactive drug use." Interventions were indicated as, "....anti roll back device on wheelchair... and non skid strips to be	F 0656	1. The resident #33 involved in the alleged practice was not negatively affected by this practice. Resident 33 anti roll backs were immediately applied to residents wheelchair by Maintenance Director. Skid strips were immediately applied to the bathroom floor on resident 33's bathroom by the Maintenance Director. 2. Residents at risk for falls could have been negatively affected by this practice. An audit by the DON/designee was done to ensure bed side interventions matched the care plans on residents at risk for falls. 3. Staff were reeducated on pulling the Kardex for current fall interventions. Return demonstration was done during an in-service to ensure competency on using Kardex for fall interventions. 4. The DON or designee will do random audits to ensure bed side interventions match current plan of care. (Attachment 1) 5 residents will be audited 3 x a week for 30 days to ensure care plan matches fall intervention. Then 2 residents will be audited for 60 days 3 x a week to ensure care plans match fall intervention. Then 1 resident will be audited for 90 days 3 x a week to ensure care plan matches fall intervention.	01/25/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	placed...in the bathroom..." On 1/4/18 at 1:15 P.M., during an interview, Physical Therapy Assistant 1 indicated the resident's wheelchair was supposed to be equipped with an anti rollback device, but there currently was no device on the wheelchair. On 1/5/18 at 1:40 P.M., during an interview, the Director of Nursing indicated there were supposed to be non skid strips placed on the resident's bathroom floor and and the wheelchair was supposed to be equipped with an anti rollback device, as indicated in the care plan, but there were currently no strips in place and no anti rollback device on the wheelchair. 3.1-35(a)		Audit findings will be presented by the DON or designee to the QAA Committee monthly x 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process. Compliance will be determined based on results of audits.	
F 0675 SS=D Bldg. 00	483.24 Quality of Life § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to ensure a nutritional supplement was provided to 1 of 3 residents reviewed for nutrition (Resident 55). Findings include: On 1/5/18 at 10:46 a.m., Resident 55's clinical record was reviewed. The diagnoses included, but were not limited to: congestive heart failure (CHF), diabetes mellitus (DM), and hypertension (HTN). Resident 55's quarterly Minimum Data Set (MDS) assessment, dated 12/4/17, indicated the resident was cognitively intact. Resident 55's physician orders, dated January 2018, indicated healthshake (nutritional supplement) one time a day for decreased meal intake, with an order start date of 12/22/17. December 22, 2017 through January 7, 2018; Medication Administration Record (MAR) lacked documentation of Resident 55 having received healthshakes every day.	F 0675	1. Resident 55 was not negatively affected by this alleged practice. The DON immediately sent the documentation to go to the MAR in PCC for the nurses to be able to document percent of consumption. 2. Residents requiring supplements were immediately audited by the DON or design to verify all consumption went to the MAR in PCC. No other resident were negatively affected by this practice and no other errors were found. 3. Nurses were reeducated on using the order template and changing from the default of CNA to Nurse. Return demonstration from the nurses using the order template was shown in the in-service. 4. The DON or designee will do audits on new supplement orders for accuracy of the order for the next 6 months on new 3 new admissions for 30 days then 2 new admissions for 60days then 1 new admission for 90days. . (Attachment 2) Audit findings will be presented by the DON or designee to the QAA Committee monthly x 6 months. The QAA	01/25/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	During an interview, on 1/9/18 at 11:34 a.m., Resident 55 indicated the only time she had received healthshakes was on 1/9/18, when her blood sugar was 62. During an observation, on 1/9/18 at 12:23, Resident 55 was eating in the main dining room and no healthshakes were observed on the lunch tray. During an interview, on 1/9/18 at 11:55 a.m., License Practical Nurse (LPN) 1 indicated healthshakes are documented on the MAR but she did not know why the MAR, dated December 22, 2017 through January 7, 2018, was blank. During an interview, on 1/9/18 at 2:39 p.m., the Director of Nursing (DON) indicated when the facility received the physician order for the healthshake; the order was placed in the computer for the Certified Nursing Assistant (CNA) to document. The computer does not allow the CNA to document the administration of healthshakes. Documentation was requested and no documentation was provided to indicate Resident 55 received healthshakes from December 22, 2017 through January 7, 2018. On 1/9/18 at 2:57 p.m., the DON indicated		Committee will review findings and determine the need for further monitoring and /or education per the QAA process. Compliance will be determined based on results of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	the facility did not have a policy for following physician orders. 3.1-37(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to promptly provide Activities of Daily Living (ADL) care for a resident needing the bedpan for 1 of 2 residents reviewed for ADL care. (Resident 42) Findings include:	F 0677	1. Resident #42 was not negatively affected by this alleged practice. DON or designee conducted an inventory of available bedpans and placed some in each supply closet on residents hallways. 2. Residents dependent on ADL care by staff have the potential of being affected by this practice.	01/25/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	During an interview, on 1/2/2018 at 2:50 p.m., Resident 42 indicated she had asked staff approximately 10 minutes ago to use the bedpan but staff told her they didn't currently have any bedpans and she would have to wait. Resident 42 indicated she didn't think she could wait much longer. On 1/02/2018 at 3:00 p.m., Certified Nursing Assistant (CNA) 1 was notified Resident 42 needed the bedpan. CNA 1 was observed to enter the resident's room, immediately exit and enter a locked storage room. CNA 1 exited the locked storage room without a bedpan. He was observed asking a staff member in the nurses charting room if there were any clean bedpans. He was then observed saying, "I guess I will go get one from another unit." On 1/2/2018 at 3:17 p.m., CNA 1 had not yet returned to give Resident 42 the bedpan. On 1/2/2018 at 3:30 p.m., Resident 42 indicated she was still not on the bedpan. Certified Nursing Assistant 2 was notified and observed to enter Resident 42's room, immediately exit and enter a locked storage room. CNA 2 exited the locked storage room without a bedpan.		DON or designee conducted an inventory of bed pans and placed some in each supply closet on residents hallways. 3. Staff were reeducated on ADL care by Director of Staff Develpment. Return demonstration was observed for competency during observation of ADL care. (attachement3) Aide that was alleged of this practice is no longer an employee of this facility. 4. The DON or designee will do random audits on ADL care. Random audits will include all shifts including the weekends. Don or designee will do 5 random audits weekly x 30 days and then 2 random audits weekly x 60 days and 1 random audit weekly x 90 days. (attachement #3) Audit findings will be presented by the DON or designee to the QAA Committee monthly x 6 months. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process. Compliance will be determined based on results of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	On 1/2/2018 at 3:35 p.m., CNA 2 was observed passing ice and indicated during an interview, Resident 42 was now on the bedpan and she would have to wait for another aide to come on the floor to help get her off. On 1/2/2018 at 3:37 p.m., Resident 42 indicated she was not on the bedpan at this time and she has now waited for almost an hour. The resident indicated, "this should not be allowed." On 1/2/2018 at 3:48 p.m., Resident 42's call light was observed lit up. Resident 42 indicated she was now on the bedpan and needed to get off. Resident 42's clinical record was reviewed on 1/3/2018 at 10:40 a.m. Diagnosis included, but were not limited to endocarditis. Review of Resident 42's Quarterly Minimum Data Set (MDS) Assessment, dated 11/15/2017, indicated a BIMS (Brief Interview for Mental Status) score of 13, with a score of 13 to 15 being interviewable and cognitively intact. The MDS further indicated the resident as frequently incontinent of bowel and required extensive assistance of two staff with Activities of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Daily Living (ADL's). On 1/8/2018 at 4:15 p.m., The Director of Nursing (DON) and Administrator did not deny Resident 42 should have been placed on the bedpan sooner. On 1/9/2018 at 3:07 p.m., the DON provided the facility's policy, "Bedpan/Urinal, Administration of" dated 2016, and indicated it was the policy currently being used by the facility. The policy did not address providing ADL care in a prompt manner. 3.1-38(a)(3)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure the seat	F 0921	1. Resident #45 in the alleged practice was not negatively	01/25/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	of a resident's wheelchair was kept clean for 1 of 1 random observation of resident care equipment (Resident 45). Findings include: The seat of Resident 45's wheelchair, which was next to the resident who was in bed, was observed to be stained with a dry brown substance; approximately 6 inches in diameter; on the following dates and times: 1/2/18 at 1:15 P.M. 1/4/18 at 1:45 P.M. 1/5/18 at 1:00 P.M. On 1/4/18 at 2:15 P.M., the resident's clinical record was reviewed. Diagnoses included, but not limited to epilepsy. The Minimum Data Set Assessment, dated 11/21/2017, indicated Resident 45 was cognitively intact. On 1/5/18 at 1:00 P.M., during an interview, the resident indicated she spends most of her time in her wheelchair when not in bed. On 1/5/18 at 1:05 P.M., during an interview, the Director of Nursing indicated the resident's wheelchair was to have been cleaned by staff on night shift, each night,		affected. #45 Wheelchair was cleaned immediately when brought to our attention. 2. Residents requiring wheelchairs have the potential to be negatively affected by this practice. W/cs were cleaned that night on night shift by the aides. 3. Staff were reeducated on wheelchair cleaning. Return demonstration during in-service on proper cleanliness was done to ensure for competency. 4. The DON or designee will do random audits on wheelchairs to ensure cleanliness. Wheelchair audits will be done randomly seven days a week any shift on 5 wheelchairs weekly for 30 days. (attachment 4) 3 wheelchairs weekly for 60 days and 1 wheelchair weekly for 90 days. Audit findings will be presented by the DON to the QAA Committee monthly x 6 months. The QAA Committee will review findings and determine the need for further monitoring and/ or education per the QAA process. Compliance will be determined based on results of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	01/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	and the resident's wheelchair seat did not appear to have been cleaned. On 1/5/18 at 1:15 P.M., during an interview, Certified Nursing Assistant 3 indicated the resident's wheelchair seat was in need of a cleaning and should have been cleaned on night shift. 3.1-19(f)			