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	11/05/2015

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 28, 29, 30, November 2, 3, and 5, 2015. Facility number: 010478 Provider number: 155649 AIM number: 200197620 Census bed type: SNF/NF: 61 Total: 61 Census Payor type: Medicare: 6 Medicaid: 44 Other: 11 Total: 61 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. QR completed by 14466 on November 09, 2015.	F 0000	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	

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

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F 0164 SS=D Bldg. 00	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation, interview, and record review, the facility failed to ensure a residents privacy was provided during wound care for 1 of 1 randomly observed resident receiving wound care. (Resident #100)	F 0164	Resident 100 was given a new privacy curtain immediately. The other residents and rooms were checked to make sure they had proper privacy curtains in their rooms. Curtains will be ordered to ensure proper privacy occurs for each resident. Nursing staff	12/01/2015

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	Findings include: On 11/4/15 at 4:09 p.m., RN #2 was observed to walk into Resident #100's room to provide wound care. Resident #100 was facing the window with their back side exposed to the inner room and hallway. The privacy curtain between Resident #100 and his roommate was not pulled enough to provide privacy for Resident #100. Resident #100's roommate had two visitors enter the room. One visitor was observed at the edge of the privacy curtain where she could be seen removing a chair to sit in. RN #2 indicated she could not pull the privacy curtain further, because it would expose the top of the bed between the two residents and there was not a second privacy curtain available to pull for the bottom of Resident #100's bed. The room door remained open, staff and visitors walked right in. On 11/5/15 at 4:05 p.m., the Director of Nursing provided policy "RESIDENT RIGHTS" dated 10/1/07, and indicated the policy was the one currently used by the facility. The policy indicated, "... [a] Dignity A facility must care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full		will be in-serviced by DON or designee on proper privacy while giving care to a resident. A minium of 5 Quality Rounds will be completed weekly randomly will include all shifts seven days a week for 2 months then quarterly there after. (Attachment A) The results of our Quality rounds will be reviewed during our QA process and a subsequent plan will be developed as necessary. The systematic changes will be completed by December 1, 2015.	

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	recognition of his or her individuality. ..." The policy lacked documentation about resident privacy during wound care. 3.1-3(p)(2)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure blood work was drawn as indicated by the physician's order for 1 of 2 residents reviewed for death (Resident #101) and to ensure care plans were followed for Activity of Daily Living and bed mobility for a resident with hemiplegia for 1 of 25 resident reviewed for following of a careplan. (Resident #2) Findings include: 1). On 10/28/2015 at 11:11 a.m., interview with RN #1 indicated, Resident #2 had an abrasion on his right knee after a fall on 9/28/15. Resident #2's clinical record was reviewed on 11/4/15 at 11:20 a.m.	F 0282	Resident 101 and 43 were affected by this deficient practice. Resident 101 is no longer in facility and resident 43 the staff was educated to review the Kardex prior to giving care. No other residents were affected by this deficient practice. Nursing staff will be in-serviced by the DON or designee on reviewing the Kardex prior to providing care and the lab process. Review of lab orders will ocuur 5 days a week during the clinical meeting. (attachment B). The DON or designee will complete 5 Quality Round per week randomly all shifts seven days a week to ensure that the cna's are able to pull up the Kardex. A minimum of 5 quality rounds will be completed weekly randomly all shifts seven days a week for 2 months and then quarterly x 2. The results of the rounds will be reviewed in our	12/01/2015

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	Diagnoses included, but were not limited to:abnormal posture, epilepsy, unspecified convulsions, flaccid hemiplegia (loss of purposeful movement) affecting right dominant side. The Admission Minimum Data Set(MDS) dated 5/6/2014, indicated Resident #2 needed extensive assistance of 2 staff persons for bed mobility and personal hygiene. Resident #2 had impairment on one side upper and lower extremities. The quarterly MDS dated 7/6/15, indicated Resident #2 needed extensive assistance of 2 staff persons physical assist for bed mobility and personal hygiene. Care plan "ADL" Activity of Daily Living initiated date 3/4/15, revision 10/29/15 through 1/2/16, indicated "... BED MOBILITY: ...resident requires [extensive assistance] by [2] staff to turn and reposition in bed r/t [related to] hemiplegia ... revised on 6/3/15 and 10/29/15 through 1/2/16, PERSONAL HYGIENE: The resident requires [extensive assistance] by [2] staff with personal hygiene, ..." Care plan "High risk for falls" dated 9/29/15, staff educated to review POC/Kardex (plan of care) prior to providing care.		QA process monthly with a subsequent plan to be developed as necessary. The systematic changes will be completed by December 1, 2015.	

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	Care plan dated 10/29/15 through 1/2/16, indicated, "The resident has an ADL [Activity of Daily Living] self-care performance deficit ... Goal: ...resident will maintain current level of function in ADLs ... Intervention /Task ... BED MOBILITY: The resident requires [extensive assistance] by [2] staff to turn and reposition in bed r/t [related to] hemiplegia ... PERSONAL HYGIENE: The resident requires [extensive assistance] by [2] staff with personal hygiene ... " Care plan "The resident is High risk for falls r/t Psychoactive drug use dated 9/29/15 through 1/2/16, indicated ... Goal: ...will be free of falls ... Intervention/Tasks ... Staff educated to review POC/Kardex prior to providing care. ... Resident to be assisted by 2 staff members at all times for t/r [turn and reposition] in bed. ..." On 11/4/15 at 10:36 a.m., interview with the Rehab Director indicated Resident #2 was not ambulatory and is currently on Occupational Therapy (OT) due to leaning in his wheelchair. Resident transfers with assist of 2 staff persons. On 11/4/15 at 10:53 a.m., the Minimum Data Set (MDS) Coordinator indicated			

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	Resident #2 doesn't try to get out of bed. Resident had a CVA (Cerebral Vascular Accident) (stroke) years ago and knows his limitation. On 11/4/15 at 12:00 p.m., interview with CNA #2 indicated Resident #2 needed extensive assist of two staff person for toileting, and transfer. Bed mobility for rolling in bed Resident #2 needed assist of one staff person, "Resident #2 usually holds the side rail with left hand and stay where you place him." Review of the "Post Fall Documentation flow sheet" dated 9/28/15, indicated Resident #43 was receiving incontinent care when the Certified Nursing Assistant #1 (CNA) lifted her hands off the resident and Resident #2 rolled on the floor. . On 11/4/15 at 12:14 p.m., interview with the Assistant Director of Nursing (ADON) indicated CNA #1 was providing toileting care reached back to get supplies to provide care and slightly lifted her hand and Resident #2 rolled off the bed to the floor between window and bed. "Resident #2 was an extensive assist of 2 person for toileting and personal hygiene's. I educated the CNA how to use the kardex." The kardex was used to instruct CNA staff on what care to			

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	provide for Resident #2. The kardex was not provided. On 11/4/15 at 2:00 p.m. interview with CNA #1 indicated "I went in to room by myself to do incontinent care." CNA #1 indicated she was not aware of the amount of staff needed to provide care for Resident #2. "I was educated on how to use the kardex." On 11/4/15 at 3:36 p.m., the Administrator provided the policy " Fall Management " dated Aug 2014, and indicated the policy was the one currently used by the facility. The policy indicated, " ... EQUIPMENT: Fall Prevention Equipment may include, but is not limited to: Alarms, sensor mats, ... floor pads, ...hand rails, grab bar, ... FALL PREVENTION PROCEDURE: ...2. Initiate a fall prevention care plan when appropriate with strategies to minimize risk and potential for injuries. ... " 2.) On 11/02/15 at 11:32 a.m., Resident #101's clinical record was reviewed. Diagnosis included, but were not limited to: neoplasm (an abnormal growth of tissue, especially characteristic of cancer) and hemorrhage (bleeding) of the GI (gastrointestinal) tract. A review Resident #101's blood laboratory report indicated the following:			

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	On 6/5/15 at 2:28 a.m., the resident had a BMP (basic metabolic panel) drawn. The results included, but were not limited to, a critically low glucose level of 39 (normal range 65-99 milligrams/deciliter) and a low potassium level of 3.0 (normal range 3.5-5.3 milliequivalents/liter). On 6/5/15 at 11:39 a.m., Resident #101's physician ordered a follow-up BMP to be drawn on 6/11/15. The order was automatically discontinued on 6/11/15 and lacked documentation of who discontinued the order. Resident #101's clinical record lacked documentation which indicated blood work was drawn on 6/11/15. Resident #101 expired (died) on 6/16/15. On 11/2/15 at 2:31 p.m., the DON (Director of Nursing) indicated she did not know why the lab was discontinued. On 11/5/15 at 2:36 p.m., the Administrator (ADM) provided the policy, "Managing Change of Condition," updated 10/2015, and indicated it was the policy currently being used by the facility. The policy did not address the following of physician's order related to laboratory services.			

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	On 11/5/15 at 2:59 p.m., the ADM indicated the facility did not have any additional policies which discussed the following of physician's orders. 3.1-35(g)(2)			
F 0323 SS=D Bldg. 00	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 interview and record review, the facility failed to ensure that a resident with a history of falls and a diagnosis of hemiplegia was provided the assistance of 2 staff to prevent accidents while turning or providing personal care while in bed as indicated by careplan to prevent falls for 1 of 3 reviewed for accidents. (Resident #2) Findings include: On 10/28/2015 at 11:11 a.m., interview with RN #1 indicated, Resident #2 had an abrasion on his right knee after a fall on 9/28/15. Resident #2's clinical record was	F 0323	Resident #43 was affected by this deficiency by the aide not following the kardex. No other residents were affected by this deficiency. The nursing staff will be in-serviced by DON or designee on how to use the kardex. A disciplinary action was given to the aide at the time of the occurrence on resident #43. A minimum of 5 staff a week will be asked during Quality Rounds randomly all shifts seven days a week to show the department head the location of Kardex and how to read it. (Attachment A) A minimum of 5 quality rounds will be completed weekly and quarterly there after randomly any shift seven days a week. . The results of these rounds will be	12/01/2015

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	reviewed on 11/4/15 at 11:20 a.m. Diagnoses included, but were not limited to:abnormal posture, epilepsy, unspecified convulsions, flaccid hemiplegia (loss of purposeful movement) affecting right dominant side. The Admission Minimum Data Set (MDS) dated 5/6/2014, indicated Resident #2 needed extensive assistance of 2 staff persons for bed mobility and personal hygiene. Resident #2 had impairment on one side upper and lower extremities. The quarterly MDS dated 7/6/15, indicated Resident #2 needed extensive assistance of 2 staff persons physical assist for bed mobility and personal hygiene. Care plan "ADL" Activity of Daily Living initiated date 3/4/15, revision 10/29/15 through 1/2/16, indicated "... BED MOBILITY: ...resident requires [extensive assistance] by [2] staff to turn and reposition in bed r/t [related to] hemiplegia. ... revised on 6/3/15 and 10/29/15 through 1/2/16, PERSONAL HYGIENE: The resident requires [extensive assistance] by [2] staff with personal hygiene, ..." Care plan "High risk for falls" dated 9/29/15, staff educated to review POC/Kardex (plan of care) prior to providing care.		reviewed during our QA process with a subsequent plan to be developed as necessary. The systematic changes will occur by December 1, 2015.	

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	Care plan dated 10/29/15 through 1/2/16, indicated, "The resident has an ADL [Activity of Daily Living] self-care performance deficit ... Goal: ...resident will maintain current level of function in ADLs ... Intervention /Task ... BED MOBILITY: The resident requires [extensive assistance] by [2] staff to turn and reposition in bed r/t [related to] hemiplegia ... PERSONAL HYGIENE: The resident requires [extensive assistance] by [2] staff with personal hygiene ... " Care plan "The resident is High risk for falls r/t Psychoactive drug use dated 9/29/15 through 1/2/16, indicated ... Goal: ...will be free of falls ... Intervention/Tasks ... Staff educated to review POC/Kardex prior to providing care. ... Resident to be assisted by 2 staff members at all times for t/r [turn and reposition] in bed. ..." On 11/4/15 at 10:36 a.m., interview with the Rehab Director indicated Resident #2 was not ambulatory and is currently on Occupational Therapy (OT) due to leaning in his wheelchair. Resident transfers with assist of 2 staff persons. On 11/4/15 at 10:53 a.m., the Minimum Data Set (MDS) Coordinator indicated			

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	Resident #2 doesn't try to get out of bed. Resident had a CVA (Cerebral Vascular Accident) (stroke) years ago and knows his limitation. On 11/4/15 at 12:00 p.m. interview with CNA #2 indicated Resident #2 needed extensive assist of two staff person for toileting, and transfer. Bed mobility for rolling in bed Resident #2 needed assist of one staff person, "Resident #2 usually holds the side rail with left hand and stay where you place him." Review of the "Post Fall Documentation flow sheet" dated 9/28/15, indicated Resident #43 was receiving incontinent care when the Certified Nursing Assistant #1 (CNA) lifted her hands off the resident and Resident #2 rolled on the floor. . On 11/4/15 at 12:14 p.m., interview with the Assistant Director of Nursing (ADON) indicated CNA #1 was providing toileting care reached back to get supplies to provide care and slightly lifted her hand and Resident #2 rolled off the bed to the floor between window and bed. "Resident #2 was an extensive assist of 2 person for toileting and personal hygiene's. I educated the CNA how to use the kardex." The kardex was used to instruct CNA staff on what care to			

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	provide for Resident #2. The kardex was not provided. On 11/4/15 at 2:00 p.m. interview with CNA #1 indicated "I went in to room by myself to do incontinent care." CNA #1 indicated she was not aware of the amount of staff needed to provide care for Resident #2. "I was educated on how to use the kardex." On 11/4/15 at 3:36 p.m., the Administrator provided the policy " Fall Management " dated Aug 2014, and indicated the policy was the one currently used by the facility. The policy indicated, " ... EQUIPMENT: Fall Prevention Equipment may include, but is not limited to: Alarms, sensor mats, ... floor pads, ...hand rails, grab bar, ... FALL PREVENTION PROCEDURE: ...2. Initiate a fall prevention care plan when appropriate with strategies to minimize risk and potential for injuries. ... " 3.1-45(a)(2)			
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or			

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MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure outdated nutritional supplement drinks were discarded from 1 of 2 resident's snack refrigerator and proper drying of equipment when food will make contact during observation of pureed diet preparation for 9 residents served from the kitchen as indicated by the Retail Food Establishment Sanitation Requirements Manual. Findings include: 1). On 10/30/15 at 11:25 a.m., the Dietary Manager (DM) was observed to use a damp cloth which was dipped in sanitizing water and wrung out, to dry the puree pot before giving the pot to the cook to continue pureeing food for lunch. The DM indicated she was informed it was ok to use a damp cloth to dry out tear drop or little water from the pot. On 11/5/15 at 9:00 a.m., the DM indicated it was ok to use a damp cloth dipped in sanitize water to wipe the tear drops out of the puree pot according to a training she attended. 2). On 11/4/15 at 8:40 a.m., the residents	F 0371	At the time of these events no residents were negatively affected by these practices. DM and dietary staff will be in-serviced by DON or designee on proper drying techniques of equipment. Nursing staff and dietary staff will be in-serviced by DON or designee on proper disposal of expired supplements. Daily audits including proper disposal of supplements and daily audits of all meals seven days a week on proper drying techniques will be completed daily x 5 days for 2 months then quarterly there after. (attachment C and D) The results of these audits will be reviewed in our QA process and systematic changes will be reviewed if necessary. The systematic changes will be completed by December 1, 2015.	12/01/2015

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	11/05/2015

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	snack refrigerator located on the North hall was observed with the Dietary Manager (DM) to have two small cartons of boost (nutritional supplement) with expiration dates of 9/15/15 and 10/6/15. The DM was observed to remove and discard. The DM indicated the nursing staff was responsible for checking the expiration dates. On 11/6/15 at 2:37 p.m., review of the "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT Manual 410 IAC 7-24-304, dated November 13, 2004, indicated, "Equipment and utensils; air drying required, ... (a) After cleaning and sanitizing, equipment and utensils:(1) shall be air-dried or used after adequate draining as specified in the 21 CFR 178.1010(a), before contact with food; and (2) may not be cloth-dried except the utensils that have been air-dried may be polished with cloths that are maintained clean and dry. ... " On 11/5/15 at 4:02 p.m., the Administrator provided policy "FOOD SAFETY IN RECEIVING AND STORAGE" dated 2/2009, and indicated the policy was the one currently used by the facility. The policy indicated, "... 2. Expiration dates and use-by dates will be checked to assure the dates are within acceptable parameters. ..."			

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	3.1-21(i)(2) 3.1-21(i)(3)			
F 0460 SS=D Bldg. 00	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. Based on observation, interview, and record review, the facility failed to ensure residents rooms were equipped with curtains to ensure visual privacy for 1 randomly observed during stage 2. (Resident #100) Findings include: On 11/4/15 at 4:09 p.m., RN #2 was observed to walk into Resident #100's room to provide wound care. Resident #100 was facing the window with their back side exposed to the inner room and hallway. The privacy curtain between Resident #100 and his roommate was not pulled enough to provide privacy for Resident #100. Resident #100's roommate had two visitors enter the	F 0460	Resident 100 was given a new privacy curtain immediately. The other residents and rooms were checked to make sure they had proper privacy curtains in their rooms if not they were ordered. Curtains will be ordered to ensure proper privacy occurs for each resident. Nursing staff will be in-serviced by DON or designee on proper privacy while giving care to a resident. A minium of 5 Quality Rounds will be completed weekly for 2 months then quarterly there after. (Attachment A) The results of our Quality rounds will be reviewed dureing our QA process and a subsequent plan will be developed as necessary. The systematic changes will be completed by December 1, 2015.	12/01/2015

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	room. One visitor was observed at the edge of the privacy curtain where she could be seen removing a chair to sit in. RN #2 indicated she could not pull the privacy curtain further, because it would expose the top of the bed between the two residents and there was not a second privacy curtain available to pull for the bottom of Resident #100's bed. On 11/5/15 at 4:05 p.m., the Director of Nursing provided policy "RESIDENT RIGHTS" dated 10/1/07, and indicated the policy was the one currently used by the facility. The policy indicated, "... [a] Dignity A facility must care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. ..." 3.1-19(l)(7)			