STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155436	A. BUILDING 00 B. WING	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT WINAMAC	515 E 13TH ST WINAMAC, IN 46996

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 3, 4, 5, and 6, 2024 Facility number: 000414 Provider number: 155436 AIM number: 100288550 Census Bed Type: SNF/NF: 27 Total: 27 Census Payor Type: Medicare: 1 Medicaid: 17 Other: 9 Total: 27 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/10/24.	F 0000	The creation and submission of this plan of correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Hickory Creek Winamac respectfully requests a paper compliance review of the Plan of Correction.	
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON Based on record review and interview, the facility failed to ensure there were 8 hours of consecutive RN (Registered Nurse) coverage for 9 out of 20 days reviewed. This had the potential to affect all 27 residents in the facility. Finding includes: On 9/6/24 at 11:21 a.m., the Nursing Staff Schedules dated 8/18/24 through 9/6/24 were	F 0727	It is the practice of the facility to use the services of a registered nurse for at least 8 consecutive hours, 7 days a week and to designate a registered nurse to serve as the director of nursing on a full-time basis. **What corrective actions(s) will be accomplished for those residents found to have been**	10/04/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Colleen Nan Folkers	Executive Director	09/20/2024

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	reviewed. There was no RN scheduled for 8/18/24, 8/20/24, 8/21/24, 8/22/24, 8/23/24, 8/27/24, 8/31/24, 9/1/24, and 9/6/24. During an interview on 9/6/24 at 11:49 a.m., the Administrator indicated there was not 8 hours of RN coverage on the above dates. 3.1-17(b)(3)		**affected by the deficient practice:** There were no residents that were negatively affected by the alleged deficient practice. RN coverage will be provided for at least 8 consecutive hours, 7 days a week. **How other residents having the potential to be affected same deficient practice will be identified and what corrective actions(s) will be taken:** All residents have the potential to be affected by the alleged deficient practice. RN coverage will be provided for at least 8 consecutive hours, 7 days a week. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice will not recur:** The Scheduler will ensure an RN is scheduled 8 consecutive hours, 7 days a week. The Executive Director/designee will review the schedule daily in the AM meeting to ensure RN coverage is scheduled per F727 regulations. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:**	

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			The corrective action will be monitored through the Quality Assurance and Performance Improvement Plan. The Executive Director will monitor the schedule daily in the AM meeting for 2 months, then weekly for 2 months, then monthly thereafter for 6 months to ensure compliance. If 100% compliance is not met, an action plan will be implemented. Findings will be submitted to the QAPI Committee for review and follow-up.	
F 0805 SS=D Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs Based on observation, interview, and record review, the facility failed to ensure food was prepared in form to meet individual needs related to not making pureed food the correct consistency. This had the potential to affect the 2 residents who received a pureed diet. Finding includes: On 9/5/24 at 11:27 a.m., Cook 2 was observed preparing pureed food. She indicated she was going to puree 3 servings of Coney Dogs (hot dog with a meat sauce). She placed 3 hot dogs with an unmeasured amount of meat sauce into the blender and blended. She poured the mixture out into a container and indicated it was finished. The cook was asked how she was sure if there were no hot dog chunks in the puree. She then proceeded to take a fork and stir up the puree. There were visible chunks of hot dog still observed. The	F 0805	It is the practice of the facility to provide food in form to meet individual needs. **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** There were no residents affected by the alleged deficient practice. Cook 2 immediately re-pureed the identified food item to correct consistency. **How other residents having the potential to be affected same deficient practice will be identified and what corrective actions(s) will be taken:** All residents have the potential to be affected. Cook 2 was educated on Food in Form to meet individual resident	10/04/2024

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	cook then poured the mixture back into the blender and added an unmeasured amount of water to the blender and blended. She poured the mixture back into another container. She stirred the container with a fork and indicated it was "smooth." The container was still observed with chunks of hot dogs. The cook was interviewed if she saw the chunks of hot dog. She indicated no and then she stirred the container again and acknowledged there were still chunks of hot dog in the container. She poured the mixture back into the blender again and added an unmeasured amount of water to the blender and blended. She poured the mixture into a container, stirred it around with a fork, and the food was smooth with no chunks. During an interview after the observation, Cook 2 indicated they did not have any puree recipes to follow. The staff followed a food and liquid consistency chart. The chart did not say how much or what liquid to use in pureed food. During an interview on 9/5/24 at 12:57 p.m., the Dietary Manager (DM) indicated the cook should have made sure there were no chunks of hot dog in the puree before indicating she was completed with the puree. The facility did not have any puree recipes. The Dietician told them it did not matter what liquid they used to reach the proper consistency. A recipe, titled "Coney Dog" and received as current from the DM, indicated, "...Notes: 1. Pureed Level 4: Smooth texture, NO lumps..." 3.1-21(a)(3)		needs. All Culinary staff were in-serviced regarding Food in Form to meet resident needs and how to prepare pureed by Culinary Manager. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice will not recur:** The Culinary Manager/designee will check the consistency of pureed food to ensure food meets resident's individual needs. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The Executive Director will monitor the Culinary Manager's audits weekly for 6 months. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.	

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F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure a sanitary kitchen related to expired foods, undated and/or unlabeled food, and foods open to air in the refrigerator and freezer. The facility also failed to ensure a cook cleaned a food thermometer probe correctly before checking temperatures of food. This had the potential to affect 27 residents who received meals prepared in the kitchen. Findings include: 1. On 9/3/24 at 10:46 a.m., during the initial kitchen tour with Cook 1, the following was observed: a. First refrigerator - There were 3 bags of lettuce. The best by used date was 8/27/24. - There was a sealable bag of chicken Alfredo dated 8/29/24. The use by date was 9/1/24. - There was a sealable bag that was open to air. The bag contained scrambled eggs and was dated 9/1/24. b. First freezer - There was a sealable bag with an unknown meat in the bag. There was no label on the bag that included the contents or when it was frozen. During an interview at the time of the tour, Cook 1 indicated she had not worked for the past couple of days and the items should have been labeled or thrown out when they expired. A sheet titled, "Labeling and Dating" and provided as current from the Dietary Manager, indicated, "...The date the product must be	F 0812	It is the practice of the facility to store, prepare, distribute and serve food in accordance with professional standards for food service safety. **What corrective actions(s) will be accomplished for those residents found to have been** All items that were identified during the initial kitchen tour were disposed of immediately by Cook 1 which included lettuce, chicken alfredo, scrambled eggs, and meat in the freezer. Cook 1 was educated by the Culinary Manager regarding Labeling and Dating and expired food items. There were no negative outcomes for any residents related to the improper use of the food thermometer by Cook 2 or improper labeling and dating and expired food items. Cook 2 was educated by the Culinary Manager for Proper Use of a Food Thermometer. **How other residents having the potential to be affected same deficient practice will be identified and what corrective actions(s) will be taken:** All residents have the potential to be affected by the alleged deficient practices. All Culinary staff were in-serviced regarding Labeling and Dating and expired food items, and Proper	10/04/2024

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	consumed or discarded may not exceed the manufacturer's use-by-date..."2. On 9/5/24 at 11:58 a.m., Cook 2 was observed checking temperatures of the meal being served for lunch. She began by washing her hands with soap and water. She wiped the food temperature probe with a sanitation wipe and proceeded to check the temperature of a hot dog. She removed the probe, wiped it with a new sanitation wipe, and checked the temperature of the Coney dog sauce. She repeated this process to check the temperature of mashed potatoes, the Coney dog puree, green beans, and pureed green beans. Cook 2 then checked the temperature of a hamburger, removed the probe, and then placed the probe directly into a soft bite-sized hot dog. She repeated this process for checking the temperatures of french fries, Coney dog sauce, and pureed Coney dog sauce without sanitizing the temperature probe between uses. During an interview on 9/5/24 at 12:05 p.m., Cook 2 indicated she needed to sanitize the temperature probe between each use, and she wanted to wash it. She proceeded to wipe the temperature probe with a cloth located inside of a sanitizer bucket. During an interview on 9/6/24 at 11:36 a.m., the Dietary Manager indicated the temperature probe should have been wiped in between each use and she would provide some in-servicing to her staff. A Policy titled, "Proper Use of a Food Thermometer," indicated, "Probe Thermometer...Thermometer is cleaned and sanitized before use. Thermometer is inserted, up to the dimple, into the thickest part of the food. Thermometer is left in the food item until the needle has stopped moving...Thermometer wiped with sanitizing wipe and allowed to dry before		Use of a Food Thermometer. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice will not recur:** The Culinary Manager/designee will observe food for proper labeling and dating utilizing the Daily AM walk thru form each day to ensure outdated food is discarded and all items are properly dated. The Culinary Manager/designee will observe and audit the use of a food thermometer during each meal to ensure proper use of the thermometer. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The Executive Director will monitor the Culinary Manager's audits weekly for 6 months. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.	

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	inserting into the next food item." 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure infection control practices and standards were maintained, related to staff touching pills during medication administration for 1 of 12 residents observed during medication administration. (QMA 1, QMA 2, and Resident 9) Findings include: 1. On 9/4/24 at 11:33 a.m., QMA 1 was observed preparing Resident 9's medications. She popped one tamulosin (medication to improve urination) capsule from the medication card into her hand. She then opened up the capsule with her hands and poured the medication into a cup and administered the medication. During an interview at the time, QMA 1 indicated she normally just opened up the capsules with her hands and did not wear gloves. 2. On 9/5/24 at 12:37 p.m., QMA 2 was observed preparing Resident 9's medications. She popped one tamulosin capsule from the medication card into her hand. She then opened up the capsule with her hands and poured the medication into a cup and administered the medication. During an interview at the time, QMA 2 indicated she normally wore gloves when she opened the medication capsules.	F 0880	It is the practice of the facility to establish and maintain an infection prevention and control program designed to provide a safe, comfortable environment and to help prevent the transmission of communicable diseases and infections. **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #9 was not negatively affected by the deficient practice. QMA #1 & #2 have been educated on infection control practices related to touching medications and opening capsules. **How other residents having the potential to be affected same deficient practice will be identified and what corrective actions(s) will be taken:** All residents have the potential to be affected. DNS/designee will educate all QMAs, LPNs & RNs on proper medication handling. DNS/Designee will complete a medication skills check off with each QMA, LPN & RN. Any concerns will be addressed immediately.	10/04/2024

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	During an interview on 9/5/24 at 3:04 p.m., the Assistant Director of Nursing indicated the staff are expected to apply gloves and not to touch pills with their hands. A Skills Competency checklist titled, "Medication Administration (Medication Pass Procedure)" and received as current from the Director of Nursing, indicated, "...5. Medications are opened without contaminating..." 3.1-18(b)		**What measures will be put in place and what systemic changes will be made to ensure that the deficient practice will not recur:** DNS/Designee will observe nursing staff perform medication pass to ensure staff are utilizing appropriate infection control practices. Any concerns will be addressed immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS /Designee will be responsible for completing the QAPI Audit tool titled, “Hand Hygiene & Glove use during Medication Pass” weekly for 4 weeks and monthly for 6 months. If a threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.	