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| | 155392 | A. BUILDING 00<br>B. WING | 07/23/2021 |

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| HICKORY CREEK AT KENDALLVILLE | 1433 S MAIN STREET<br>KENDALLVILLE, IN 46755 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: July 20, 21,22 and 23, 2021<br><br>Facility number: 000402<br>Provider number: 155392<br>AIM number: 100288120<br><br>Census Bed Type:<br>SNF/NF: 23<br>Total: 23<br><br>Census Payor Type:<br>Medicaid: 18<br>Other: 5<br>Total: 23<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed July 26, 2021. | F 0000 | This Plan of Correction constitutes the written allegation of the 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 the requirements established by state and federal law. Hickory Creek at Kendallville desires this Plan of Correction to be considered the facility's allegation of Compliance. Compliance effective 8/22/21. We respectfully request paper compliance for this Plan of Correction. | |
| F 0655<br>SS=D<br>Bldg. 00 | 483.21(a)(1)-(3)<br>Baseline Care Plan<br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission. | | | |

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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| | (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary. | | | |
| | Based on interview and record review the facility failed to ensure baseline care plans were completed within 48 hours of admission for 2 of 6 residents reviewed for baseline care plans (Resident 16 and Resident 64).<br><br>Findings include: | F 0655 | **F655** It is the policy of this facility to develop and complete a baseline care plan for each resident within 48 hours of admission.<br><br>**What corrective action will be** | 08/22/2021 |

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| | 1. The clinical record for Resident 16 was reviewed on 7/21/21 at 2:21 PM. Diagnoses included, but were not limited to, type 2 diabetes, major depressive disorder, stage 3 chronic kidney disease, history of falling, and fracture of left lower leg.<br><br>There was no documentation to indicate Resident 16 had a baseline care plan initiated within 48 hours of admission.<br><br>2. The clinical record for Resident 64 was reviewed on 7/21/21 at 11:20 AM. Diagnoses included, but were not limited to, dysphagia, type 2 diabetes, and neuromuscular dysfunction of the bladder.<br><br>There was no documentation to indicate Resident 64 had a baseline care plan completed within 48 hours of admission.<br><br>The Registered Nurse Consultant was interviewed on 7/23/21 at 9:33 AM. During the interview the Registered Nurse Consultant indicated there were no documented baseline care plans for Resident 16 or Resident 64. The Nurse Consultant indicated they both should have had baseline care plans within 48 hours of being admitted to the facility.<br><br>No State rule | | **accomplished for those residents found to be affected by the deficient practice?**<br><br>Baseline care plans have been completed for Residents 16 and 64. The DON will in-service the nurses regarding the facility policy for completing baseline care plans for newly admitted residents by 8/22/21.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?**<br><br>All new admissions have the potential to be affected by this practice; however, there have been no other residents found lacking baseline care plans.<br>If the DON finds an issue with completion of baseline care plans, she will re-train the nurse(s) involved regarding the facility policy and process for completion of baseline care plans. Written counseling will be administered for continued noncompliance.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>The DON or designee will review the completion of baseline care | |

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| | | | plans for new admissions as part of the morning clinical meeting which occurs at least 5 days a week. If a concern is identified by the IDT, the DON will follow up as indicated in question #2.<br><br>**How the corrective action will be monitored to ensure the deficient practice will not recur?**<br>Addendum:<br>The DON or designee will bring the results of the IDT review of new admission baseline care plans to the monthly QA Committee meeting for further review and recommendations. Any recommendations made by the committee will be followed up by the DON, who will report the results of those recommendations at the next monthly meeting. After 60 days, the QA Committee may decide to stop the reporting to them; however, the process as described above will continue. The DON is responsible for the implementation and monitoring of this process.<br>Inservice will be completed on 8/17/2021 at 2pm facilitated by the DON. All nursing staff is required to attend. See attached Baseline Care Plan in service.<br>As per the plan of correction that was submitted, after 60 days and achievement of 100% compliance, and if the QA Committee has decided to stop the reporting of | |

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| | | | the DON's monitoring of baseline care plans, the DON will continue monitoring and the IDT will review her findings as part of the morning clinical meeting (at least 5 days a week). If the compliance is less than 100% during any month, the IDT will perform a root cause analysis of the issue and set up a QAPI plan for process improvement. The DON will bring the results of the root cause analysis and the QAPI plan to the monthly QA meeting for review by the QA committee members. Further revision to the plan may be made at that time.<br>Once the facility achieves 100% compliance again, the QA Committee may decide to stop the DON's reporting at every monthly meeting – if that is done, the DON will continue her monitoring and report results to the QA Committee at least quarterly, unless compliance is less than 100%. At that time, the IDT process and reporting to the QA Committee will occur as outlined above. | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with | | | |

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| | professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br><br>Based on interview and record review the facility failed to ensure physicians orders were followed for blood sugar checks for 1 of 1 resident reviewed for insulin (Resident 16).<br><br>Findings include:<br><br>The clinical record for Resident 16 was reviewed on 7/21/21 at 2:21 PM. Diagnoses included, but were not limited to, type 2 diabetes.<br><br>A physician's order dated 6/25/21 indicated Resident 16's blood sugar was to be checked before meals and at bedtime (4 times daily- AM, noon, PM, hs).<br><br>Glucometer Blood Sugar Check logs for Resident 16, dated 6/25/21 to 7/22/21, were provided by the Registered Nurse Consultant on 7/22/21 at 4:11 PM. The Glucometer Blood Sugar Check logs indicated Resident 16's blood sugar was not checked on the following dates and times: 6/25/21 noon and PM; 6/28/21 PM; 6/29/21 PM; 6/30/21 noon and PM; 7/1/21 PM; 7/5/21 noon and PM; 7/7/21 PM; 7/8/21 PM; 7/9/21 PM; 7/10/21 PM; 7/12/21 noon and hs; 7/16/21 PM; 7/17/21 PM; 7/20/21 noon and PM.<br><br>The Registered Nurse Consultant was interviewed on 7/22/21 at 2:45 PM. During the interview the Registered Nurse Consultant indicated Resident 16's blood sugar should have been taken four times a day (AM, noon, PM, and hs). The Registered Nurse Consultant indicated staff was not following the orders for Resident 16's blood sugar checks and they should have been. | F 0684 | **F684** It is the policy of this facility to follow physician orders, including those for checking blood glucose levels for residents with diabetes.<br><br>**What corrective action will be accomplished for those residents found to be affected by the deficient practice?**<br><br>The DON will in-service all nurses by 8/22/21 regarding the facility policy for following physician orders, including those for the frequency of checking blood glucose levels for diabetics.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?**<br><br>All diabetic residents have the potential to be affected; the DON or designee will review all diabetic residents who have orders for checking blood glucose levels to ensure that documentation is in place to show that those checks are being done as ordered.<br>If any issues are identified, the DON will retrain the nurse(s) involved and will administer written counseling at that time. | 08/22/2021 |

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| | 3.1-37 | | **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>The DON will bring the results of her review of the blood glucose checks to the clinical IDT meeting which occurs at least 5 days a week. Any identified concerns will be addressed as indicated in #2.<br><br>**How the corrective action will be monitored to ensure the deficient practice will not recur?**<br><br>The DON or designee will bring the results of the daily review of the blood glucose checks to the QA Committee's monthly meeting for the next 60 days. If 100% compliance has been achieved, the Committee may decide to stop the monthly reporting by the DON; however, the process as indicated above will continue.<br><br>**Date of Compliance:** 8/22/21<br><br>Addendum:<br>MARS have been updated on diabetic residents, the way we document, insulins given, blood sugar reading, who administered said treatment, the time, date, and location administered. In service directed by DON will be completed on 8/17/2021 at 3pm. All nursing | |

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| | | | staff required to attend.<br>As per the plan of correction that was submitted, achievement of 100% compliance, and if the QA Committee has decided to stop the reporting of the DON's monitoring, the DON will continue monitoring and the IDT will review her findings as part of the morning clinical meeting (at least 5 days a week). The DON will report results of her monitoring to the QA Committee at least quarterly.<br>If noncompliance is identified, the IDT will perform a root cause analysis of the issue and set up a QAPI plan for process improvement. The DON will bring the results of the root cause analysis and the QAPI plan to the monthly QA meeting for review by the QA committee members. Further revision to the plan may be made at that time.<br>Once the facility achieves 100% compliance again, the QA Committee may decide to stop the DON's reporting at every monthly meeting – if that is done, the DON will continue her monitoring and report results to the QA Committee at least quarterly, unless compliance is less than 100%. At that time, the IDT process and change in reporting to the QA Committee will occur as outlined above. | |
| F 0688<br>SS=D | 483.25(c)(1)-(3)<br>Increase/Prevent Decrease in ROM/Mobility | | | |

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| Bldg. 00 | §483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br><br>Based on observation, record review and interview the facility failed to ensure 1 of 3 residents reviewed (Resident 15) had received a received passive range of motion exercises consistently.<br><br>Findings include:<br><br>On 7/22/21 at 9:17 A.M., Resident 15's record was reviewed. Diagnoses included, but were not limited to, rheumatoid arthritis, hemiplegia and hemiparesis (a loss of strength on one side of the body) following cardiovascular disease.<br><br>The quarterly MDS (Minimum Data Set) assessment dated 5/14/21, indicated the resident was not interviewable, had a functional limitation in range of motion (rom) was impaired in the lower extremities on both sides, included the resident's | F 0688 | **F688** It is the policy of this facility to ensure that each resident is able to maintain his/her mobility and ROM, unless clinically unable to do so.<br><br>**What corrective action will be accomplished for those residents found to be affected by the deficient practice?**<br><br>The DON will in-service the nursing staff, including CNAs, on the facility policy for documenting ROM in the POC, a section of the electronic charting system. They will also be reminded to document refusals of care, including ROM, and to notify the nurse if they are unable to complete the ROM due | 08/22/2021 |

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| | hips, knees, ankles and feet and received range of motion exercises 7 times a week.<br><br>"Request/Screen for Rehabilitation Assessment" dated 5/12/21, indicated, but were not limited to, the following: A physical therapy (PT) and occupational therapy (OT) assessment were done with the quarterly MDS. The PT assessment for Resident 15 had "...No change in functional mobility" and the OT assessment the resident had "...No change in functional ability..."<br><br>The resident's care plan last reviewed 6/4/21, indicated the following Resident 15's ADL (activities of Daily living)/Rehabilitation was decreased range of motion in upper and lower extremities. The recommendation was: resident would participate in completing 10 repetitions of restorative passive range of motion (PROM) exercises provided by staff 2 times a day, once on day shift and once on the evening shift.<br><br>The resident's "Point of Care Restorative Nursing Category Report..." dated for the months of June and July 2021, indicated, the following: There was no Restorative Nursing data recorded for Resident 15's passive range of motion (PROM) exercises from 6/1 through 6/4, 6/10 though 6/12, 6/23, 6/24, 6/26, 6/29 through 7/1, 7/3, 7/5, 7/8 though 7/7/11, 7/14, 7/16, 7/19, 7/20 and 7/22/21.<br><br>A current CNA Assignment Sheet dated 7/13/21, indicated no documentation Resident 15 had a PROM Program.<br><br>On 7/21/21 at 1:45 P.M., in an interview, Resident 15's Representative indicated the following: The Representative thought the resident had gotten stiff in her left side of her body. The resident's right side had been affected by a stroke but the | | to resident refusal. This will be done by 8/22/21.<br><br>A request for a therapy screen for this resident's ROM will be done, as well, to ensure that the resident is receiving the appropriate treatment for her ROM/mobility.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?**<br><br>All residents have the potential to be affected; however, no others have been identified. In the future, if a resident is identified as declining in function, he/she will be screened by physical and occupational therapy to see if he/she is in need of rehabilitative or restorative care. Once the screen has been completed, the physician will be notified of the screen results and resulting orders will be obtained.<br>The DON or designee will review the POC documentation for the prior day(s) at the clinical IDT meeting which occurs at least 5 days a week. If any questions or concerns are identified, the DON will follow up with the nursing staff involved. Retraining regarding the facility policy will occur, if needed, and written counseling will also be administered for continued noncompliance. | |

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| | stiffness in the resident's left side was not normal. Resident 15 attended group exercises but she was unsure if the resident received an individual exercise program.<br><br>On 7/22/21 at 9:46 A.M., in an interview PTA 1 indicated screens for rehabilitation were done for new admissions, the MDS and change in condition. The nurse would refer the resident for therapy if indicated. The CNA was responsible for the Functional Maintence program (PROM) with the resident's morning care.<br><br>On 7/22/21 at 10:49 A.M., in an interviewed, CNA 2 indicated the CNA Assignment Sheet had no documentation Resident 15 had PROM exercises. She indicated other residents had their restorative nursing program documented on the form. CNA 2 indicated PROM should had been documented in the electronic medical record (EMR).<br><br>On 7/22/21 at 11:03 A.M., in an interview, the Nurse Consultant indicated the CNA should have documented any resident refusals of PROM, but was unable to find any documentation Resident 15 had refused PROM. The Nurse Consultant indicated the facility had started documentation in the EMR on May 17, 2021.<br><br>On 7/23/21 at 11:11 A.M., in an interview, CNA 5 indicated at times Resident 15 only allowed passive range of motion less than 10 repetitions at a time. CNA 5 attempted more than 1 time a shift. She indicate CNAs should have documented on the Point Of Care in the EMR.<br><br>On 7/23/21 at 2:13 P.M., in an interview, the Nurse Consultant indicated she had no other information on the resident's program for PROM. | | **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>As part of the morning clinical IDT meeting that occurs at least 5 days a week, documentation of residents' ADLs for the prior shifts will be audited for any changes by review of the POC. Any changes or identified concerns will be followed up as indicated in the previous paragraph. His/her care plan will also be updated at that time.<br><br>**How the corrective action will be monitored to ensure the deficient practice will not recur?**<br><br>The DON or designee will bring the results of the IDT clinical meeting reviews to the monthly QA Committee meeting for further review and recommendations by the Committee members for the next 60 days. When the 2 months is over and when 100% compliance has been achieved, the QA Committee may decide to stop the reporting to the Committee each month. However, the process of reviewing the POC documentation will continue as part of the morning clinical meeting on an ongoing basis. The | |

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| HICKORY CREEK AT KENDALLVILLE | 1433 S MAIN STREET<br>KENDALLVILLE, IN 46755 |

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| | Resident 15 was observed in bed on the following dates and times: On 7/22/21 at 9:35 A.M., on 7/22/21 at 2:45 P.M., on 7/23/21 at 9:53 A.M., and on 7/23/21 at 2:26 P.M. No passive range of motion was observed.<br><br>The most current policy titled Restorative Nursing Program (RNP) dated 3/21, received on 7/22/21 at 10:25 A.M., from the Physical Therapy Assistant (PTA). The Restorative Nursing Program policy indicated, but were not limited to, the following: "Purpose: To provide a nursing program for residents who no longer need skilled therapy services, but still have functional goals to be met or maintained through practice and repetition. The resident can also be placed on a program to maintain the ability to function at his or her optimal level within the given environment. These programs facilitate the use of skills that are present but not utilized unless compensations or adaptations are provided and designated to foster maximum independence in functional activities....The program is coordinated, supervised, and carried out by the nursing staff, and overseen by the MDS coordinator. Program initiation: Appropriateness of current programs or the need for a new program will be determined by routine assessment of the resident via the RAI (Resident Assessment Instrument) process....CNAs (Certified Nursing Assistant) will document in the electronic medical record or on a monthly flowsheet, the number of minutes the program was provided...."<br><br>3.1-42(a)(2) | | DON is responsible for the implementation and monitoring of this process.<br><br>**Date of Compliance:** 8/22/21<br>Addendum:<br>Reached out to IT Department so Range Of Motion will be highlighted as due during C N A Shift documentation. In service will be completed on 8/17/2021 at 1pm and all C N As are required to attend. See attached document.<br>As per the plan of correction that was submitted, after 60 days and achievement of 100% compliance, and if the QA Committee has decided to stop the reporting of the DON's monitoring of ADLs, including completion of ROM, the DON will continue monitoring and the IDT will review her findings as part of the morning clinical meeting (at least 5 days a week). If the compliance is less than 100% during any month, the IDT will perform a root cause analysis of the issue and set up a QAPI plan for process improvement. The DON will bring the results of the root cause analysis and the QAPI plan to the monthly QA meeting for review by the QA committee members. Further revision to the plan may be made at that time. Once the facility achieves 100% compliance again, the QA Committee may decide to stop the DON's reporting at every monthly meeting – if that is done, the DON | |

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| | | | will continue her monitoring and report results to the QA Committee at least quarterly, unless compliance is less than 100%. At that time, the IDT process and reporting to the QA Committee will occur as outlined above. | |
| F 0693 SS=D Bldg. 00 | 483.25(g)(4)(5)<br>Tube Feeding Mgmt/Restore Eating Skills<br>§483.25(g)(4)-(5) Enteral Nutrition<br>(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and<br><br>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.<br>Based on observation, record review and interview the facility failed to ensure feeding tube procedures were followed for 1 of 1 residents reviewed. (Resident 1). | F 0693 | **F693** It is the policy of this facility to document the intake of all residents, including those who are receiving tube feedings. | 08/22/2021 |

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| | Findings include:<br><br>The record was reviewed for Resident 1 on 7/22/21 at 9:40 AM. Diagnosis included but not limited to: gastrostomy status, profound intellectual disabilities, and cerebral palsy.<br><br>A list of Resident 1's orders was provided by the Registered Nurse Consultant on 7/23/21 at 9 AM. The list indicated to hold tube feed from 9AM-11AM. The list did not include any orders to document Resident 1's daily intake.<br><br>The Registered Dietitian was interviewed on 7/22/21 at 4:12 PM. The Dietitian indicated because the facility does not document Resident 1's daily intake, she assumed Resident 1's daily intake was stable based on physician orders.<br><br>An observation was made on 7/23/21 at 8:50 AM. Resident 1's feeding tube was disconnected.<br><br>An observation was made on 7/22/21 at 1:54 PM. Resident 1's feeding tube was disconnected.<br><br>Employee 2 was interviewed on 7/22/21 at 2:02 PM. Employee 2 indicated Resident 1's feeding would be disconnected only to provide care.<br><br>A continuous observation was made on 7/23/21 from 11:02 AM to 12:15 PM, Resident 1 was up in her wheelchair and disconnected from her feeding tube. The DON entered the room at 12:15 PM and connected Resident 1's feeding tube.<br><br>Resident 1's care plan was provided by the Registered Nurse Consultant on 7/23/21 at 10:44 AM. The care plan indicated Resident 1 required a g-tube to meet nutritional needs, interventions included: staff to monitor intake and output every | | **What corrective action will be accomplished for those residents found to be affected by the deficient practice?**<br><br>The DON will in-service the nursing staff on the need for intake documentation for all residents, including those who receive tube feedings by 8/22/21. She will also address the need for the tube feeding to be disconnected only for care and as per the physician's orders. It should be noted that Resident 1 had a dietitian's visit on 7/9/21 and was noted to be at 159.3 pounds with a BMI that indicated she is overweight.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?**<br><br>Residents with tube feedings have the potential to be affected by this practice. There is one other resident with a tube feeding who had the potential to be affected but was not at this time.<br>If the DON or other IDT member observes the tube feeding disconnected, it will be reported to the charge nurse at that time. If a concern is identified regarding this process, it will be addressed with the staff involved and written counseling administered for continued noncompliance. | |

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| | shift.<br><br>Resident 1's intake consumption was provided by the Registered Nurse Consultant on 7/23/21 at 9 AM. No intake was documented for meals for the past month. No intake was documented for the resident's feeding tube intake.<br><br>The Director of Nursing (DON) was interviewed on 7/22/21 at 9:59 AM. The DON indicated staff did not document Resident 1's daily intake because there was not an order. The DON also indicated that Resident 1 had the feeding tube turned off for medications and from 9 AM-11 AM. She indicated the staff should document Resident 1's daily intake.<br><br>3.1-44(a)(2) | | **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>Tube feeding amounts are now being documented on the resident's Medication Administration Record, as well as the time the physician has ordered the tube feeding to be disconnected. The DON or designee will check the MAR and report her findings to the IDT at the morning clinical meeting that occurs at least 5 days a week. Identified issues with compliance will be addressed as outlined in question #2.<br><br>**How the corrective action will be monitored to ensure the deficient practice will not recur?**<br><br>The DON will report the results of her monitoring to the QA Committee at its monthly meeting. Once 100% compliance has been achieved, the QA Committee may decide to stop the monthly reporting; however, the process as indicated above will continue.<br><br>**Date of Compliance:** 8/22/21<br>In service on Documentation for Feeding Tube completed on 8/06/2021 at 2pm. MAR has been | |

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| | | | updated to monitor intake of liquid nourishment each shift. See attached document.<br>As per the plan of correction that was submitted, achievement of 100% compliance, and if the QA Committee has decided to stop the reporting of the DON's monitoring, the DON will continue monitoring and the IDT will review her findings as part of the morning clinical meeting (at least 5 days a week). The DON will report results of her monitoring to the QA Committee at least quarterly.<br>If noncompliance is identified, the IDT will perform a root cause analysis of the issue and set up a QAPI plan for process improvement. The DON will bring the results of the root cause analysis and the QAPI plan to the monthly QA meeting for review by the QA committee members. Further revision to the plan may be made at that time.<br>Once the facility achieves 100% compliance again, the QA Committee may decide to stop the DON's reporting at every monthly meeting – if that is done, the DON will continue her monitoring and report results to the QA Committee at least quarterly, unless compliance is less than 100%. At that time, the IDT process and change in reporting to the QA Committee will occur as outlined above. | |

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| F 0759 SS=D Bldg. 00 | 483.45(f)(1)<br>Free of Medication Error Rts 5 Prcnt or More<br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>Based on record review, interview and observation the facility failed to ensure insulin had been administered correctly to 2 of 2 residents (Resident 5 and Resident 16) during medication administration. This resulted in a medication error rate of 7.14%.<br><br>Findings include:<br><br>On 7/22/21 from 11:40 A.M. to 12:15 P.M., a continuous observation was completed of an accucheck and medication administration with RN 4. RN 4 obtained Resident 16's blood glucose level result of 395. RN 4 checked the resident's Medication Administration Record (MAR). The physician's order indicated Humalog KwikPen insulin give 10 units subcutaneously (SQ). RN 4 removed the resident's Humalog pen checked the MAR with the Humalog KwikPen, dialed 10 units, then rechecked the resident's MAR. RN 4 entered Resident 16's room, used alcohol based hand rub, donned gloves, opened the sterile needle, and placed the needle on the insulin pen. RN 4 administered Humalog 10 units in the resident's abdomen. RN 4 was not observed to prime the Humalog KwikPen before she administered the insulin.<br><br>On 7/23/21 at 11:40 A.M., and observation of an accuckeck and medication administration with Director Of Nursing (DON) was completted. The DON obtained Resident 5's blood glucose level of 419. The DON checked the resident's MAR. The | F 0759 | **F759** It is the policy of this facility to ensure that residents receive medication, including insulin appropriately, without errors.<br><br>**What corrective action will be accomplished for those residents found to be affected by the deficient practice?**<br><br>The DON will in-service nurses regarding the need to prime the insulin pen before injecting the insulin into the resident. This will be done by 8/22/21.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?**<br><br>Diabetic residents receiving insulin through insulin pens have the potential to be affected; however, no others have been identified. If a nurse is observed to be giving insulin through an insulin pen without priming it first, she will be re-trained at that time. Written counseling will be given for continued noncompliance. | 08/22/2021 |

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| | physician's order indicated Humalog KwikPen insulin give 13 units SQ. The DON removed the resident's Humalog KwikPen insulin pen, checked the MAR with the Humalog insulin pen, applied the sterile needle, dialed the KwikPen to 13 units, then rechecked the MAR. The DON entered Resident 5's room. used hand hygiene, donned gloves, and administered the Humalog insulin in the resident's right upper arm. The DON was not observed to prime the Humalog KwikPen insulin before she administered the insulin.<br><br>On 7/23/21 at 12:04 P.M., in an interview, the DON indicated she had not primed the Humalog KwikPen before she had administered Resident 5's insulin.<br><br>On 7/23/21 at 12:44 P.M., in an interviewed RN 4 indicated she had not primed the Humalog KwikPen before she had administered Resident 16's insulin.<br><br>On 7/23/21 at 1:40 P.M., received from Registered Nurse (RN) 4 a document titled "Humalog KwikPen Insulin lispro Injection" revised on 4/2020, indicated "...Priming you Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your Pen, turn the Dose Knob to select 2 units...Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top...Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and '0' is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle...Turn the Dose Knob to select the number of units you need to inject...." | | **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>The DON or designee will observe each nurse giving insulin through an insulin pen as a return demonstration after being in-serviced by the DON. These return demonstrations will be documented. Any issues identified at the time of the return demonstration will be corrected with re-training and documented on the return demonstration form.<br><br>After the return demonstration, the DON or designee will observe each nurse at least once in the next 30 days for compliance -she will report her observations & any corrective action that was taken at the next IDT clinical morning meeting.<br><br>**How the corrective action will be monitored to ensure the deficient practice will not recur?**<br><br>The DON or designee will bring the results of her return demonstrations, as well as follow up to any issues identified with priming of the insulin pen to the monthly QA Committee meeting for further review. If 100% compliance has been achieved | |

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| | 3.1-48(c)(1) | | through the return demonstrations and follow up observations, the Committee may decide to stop the monthly reporting; however, the DON or designee will continue random observations for every nurse at least every 60 days to make sure that compliance continues. The DON is responsible for the implementation and monitoring of the process.<br><br>**Date of Compliance:** 8/22/21<br>Addendum:<br>In service completed on 8/2/2021 at 2pm on Insulin Pen Priming. All nurses attended. See attached document.<br>As per the plan of correction that was submitted, achievement of 100% compliance with return demonstrations for priming the insulin pen, and if the QA Committee has decided to stop the reporting of the DON's monitoring, the DON will continue monitoring and the IDT will review her findings as part of the morning clinical meeting (at least 5 days a week). The DON will report results of her monitoring to the QA Committee at least quarterly.<br>If noncompliance is identified, the IDT will perform a root cause analysis of the issue and set up a QAPI plan for process improvement. The DON will bring the results of the root cause analysis and the QAPI plan to the monthly QA meeting for review by | |

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| | | | the QA committee members. Further revision to the plan may be made at that time.<br>Once the facility achieves 100% compliance again, the QA Committee may decide to stop the DON's reporting at every monthly meeting – if that is done, the DON will continue her monitoring and report results to the QA Committee at least quarterly, unless compliance is less than 100%. At that time, the IDT process and change in reporting to the QA Committee will occur as outlined above. | |
| F 0921<br>SS=E<br>Bldg. 00 | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ<br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>Based on observation, record review and interview the facility failed to ensure water temperatures in 7 of 7 resident rooms was maintained at or below 120 degrees Fahrenheit. (Resident 2, Resident 4, Resident 5, Resident 7, Resident 14, Resident 19 and Resident 70)<br><br>Findings include:<br><br>On 7/20/21 at 10:04 A.M., during a continuous observation of the water temperatures in the following resident rooms indicated the following:<br>In Resident 4's room temperature was 120.2 degrees.<br>In Resident 2's room the water temperature was 124. | F 0921 | **F921** It is the policy of Hickory Creek at Kendallville to ensure that the resident's environment is safe, functional, sanitary, and comfortable.<br><br>**What corrective action will be accomplished for those residents found to be affected by the deficient practice?**<br><br>All residents had the potential to be affected by the alleged deficient practice. On the date of the survey, the Maintenance Director rectified the water temperatures being over the 120 degrees | 07/24/2021 |

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| | In Resident 14's the temperature was 121 degrees.<br>In Resident 7's room the water temperature was 128 degrees<br>In Resident 19's room water temperature was 129 degrees.<br>In Resident 23's room the water temperature was 125.7 degrees<br>In Resident 70's room the water temperature was 128.8 degrees<br>The water temperature in the shower room was 108 degrees.<br><br>At 10:15 A.M., with the Maintenance Director in Resident 4's room the water temperature was 130 degrees Fahrenheit and in Resident 2's room the water temperature was 133 degrees Fahrenheit. The Maintenance Director went into the mechanical room the temperature at the mixing valve read 126 degrees Maintenance Director turned down the the temperature at the mixing valve and went into several resident room and turned on the water.<br><br>On 7/20/21 at 10:15 A.M., in an interview, the Maintenance Director indicated earlier the temperature at the mixing valve had been 115 degrees Fahrenheit. He indicated prior to taking water temperatures his thermometer had been calibrated. He indicated the water temperature had usually been between 112 and 118 degrees and it depended on the hall. The hot water temperature should have been below 120 degrees. He indicated he had not documented the water temperature at the mixing valve. He indicated the highest the water temperature he had gotten was 118.9 degrees and last month he had replaced the mixing valve with a back up mixing valve and had de-limed the previous valve. The Maintenance Director indicated he had not documented this information in the maintenance log. | | Fahrenheit by turning the temperature down at the mixing valve. The Maintenance Director then turned water on in several resident rooms. Once the work was completed, the water temperatures were decreased enough to be under the 120 degrees Fahrenheit throughout the facility when tested. To ensure that the water heater remained in proper working condition, we had a plumbing contractor service the water heater. They replaced the thermostat cartridge and stated the hot water heater was working properly. The Maintenance Director and or designee continues to check the water temperature in random areas of the facility each day to ensure the temperatures stay within acceptable range.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?**<br><br>All residents have the potential to be affected. The Maintenance Director and or designee will complete random water temperature checks throughout the facility 5 days a week to assess that the water temperatures are within acceptable range. If water temperatures are found to be out | |

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| | On 7/20/21 at 12:12 P.M.,On 7/20/21 at 11:05 A.M., had received from the Social Service Director a list of 8 current residents in the facility who were non-interviewable and could have potentially gotten to a sink.<br><br>On 7/20/21 at 12:40 P.M., the Administrator provided the logbook documentation of water temperature monitoring dated 6/7 through 7/16/21. The book indicated the water temperatures were done in random resident rooms, the shower rooms and the beauty shop and had never reached 120 degrees Fahrenheit.<br><br>On 7/20/21 at 10:28 A.M., in an interview, Resident 4 indicated if the water had been too hot he would have mixed it with the cold water and he had never been burned by the water.<br><br>On 7/20/21 at 10:30 A.M., in an interview, the Administratoe indicated no residents had been burned with the water. She indicated there were no complaints, grievances or work orders related to the hot water<br><br>On 7/20/21 at 10:30 A.M., in an interview, CNA (Certified Nursing Assistant) 5 indicated if the water had been too hot they would mix with the cold water, had the residents feel if the water temperature was too hot or too cold and changed the water accordingly.<br><br>On 7/20/21 at 10:32 A.M., in an interview, Resident 6 indicated had the water been too hot, they would have told the Maintenance Director and mixed the hot and cold together.<br><br>On 7/20/21 at 10:34 A.M., in an interview, Resident 3 indicated he didn't use the sink very often, but | | of acceptable range the water heater will immediately be turned off and adjusted until the temperature concern can be corrected. If for some reason the temperature cannot be brought into acceptable range, a service call will be made.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>The Maintenance Director and or designee will complete random water checks throughout the facility to assess acceptable water temperatures 5 days a week. The findings will be tracked in TELS and the Administrator and Maintenance Director and/or designee will review these daily in the daily stand up meeting.<br><br>The Administrator and Maintenance Director will do an audit of the water temperatures daily for 4 weeks to verify that all water temperatures remain within acceptable range. If all water temperatures remain in acceptable range, the Maintenance Director and or designee and Administrator will audit the TELS program weekly for 3 months.<br><br>**How the corrective action will be monitored to ensure the** | |

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| HICKORY CREEK AT KENDALLVILLE | 1433 S MAIN STREET<br>KENDALLVILLE, IN 46755 |

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| | the water temperature was comfortable when staff had brought the resident water. If the water was too hot, he would turn the faucet off and turn on the cold water and mix the two together.<br><br>On 7/20/21 at 10:44 A.M., in an interview, Licensed Practical Nurse 6 indicated if the water had been too hot, she would turn off the water and immediately notified Maintenance Director.<br><br>The the most current policy titled Life Safety dated 10/1999 and revised on 2/20, was received from the Health Facility Administrator (HFA) on 7/20/21 at 12:40 P.M. The policy indicated "Water Temperatures: hot water for bathing and hand-washing facilities in resident care areas at the point of use, to be maintained between one hundred degrees Fahrenheit (100) and one hundred-twenty degrees Fahrenheit (120) for the safety on the residents. Water temperatures in resident care areas randomly checked daily during normal operations of the maintenance department...."<br><br>3.1-19(e) | | **deficient practice will not recur?**<br><br>The Maintenance Director will bring the audits of the TELs program to the monthly QAPI Committee meeting for further review and recommendations. The QAPI team will determine the frequency with which further monitoring will be completed once the weekly audit shows 100% completion timely. Even when the audits are no longer required, water temperature checks will continue daily 5 days a week on an ongoing basis.<br><br>The Administrator is responsible for the implementation and monitoring of this plan.<br><br>**Date of compliance:** 07/24/2021<br>Addendum:<br>On 7/27/2021, the facility had contractor Poormans Heating & Air replace the thermostat cartridge which fixed the hot water issue. See attached invoice. Daily checks on residents' room water temperatures by Maintenance Director and/or his designee show temperatures to remain in 100% compliance. Maintenance Director will continue to monitor water temperatures 5x week to ensure water temperatures are in acceptable and will report findings to QAPI monthly. See attached document. | |

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| | | | As per the plan of correction that was submitted, achievement of 100% compliance, the Maintenance Director will continue monitoring and the IDT will review findings as part of the morning clinical meeting (at least 5 days a week). The Maintenance Director will report results of monitoring to the QA Committee at least quarterly.<br>If noncompliance is identified, the IDT will perform a root cause analysis of the issue and set up a QAPI plan for process improvement. The Maintenance Director will bring the results of the root cause analysis and the QAPI plan to the monthly QA meeting for review by the QA committee members. Further revision to the plan may be made at that time. Once the facility achieves 100% compliance again, the QA Committee may decide to stop the Maintenance Director's reporting at every monthly meeting – if that is done, the Maintenance Director will continue monitoring and report results to the QA Committee at least quarterly, unless compliance is less than 100%. At that time, the IDT process and change in reporting to the QA Committee will occur as outlined above. | |
| F 9999<br><br>Bldg. 00 | Based on interview and record review the facility | F 9999 | **F999** It is the policy of Hickory | 08/22/2021 |

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| | failed to ensure general orientation was documented as completed and failed to ensure a new employee had a 2 step Mantoux for 1 of 5 employee records reviewed (CNA 3).<br><br>Findings include:<br><br>1. An Employee Record form was provided by the administrator on 7/21/21 at 11:30 A.M. The Employee Record Form indicated CNA 3's start date was 3/30/21.<br><br>There was no documentation to indicate CNA 3 had completed the facilities general orientation.<br><br>A blank General Orientation check list was provided by the Registered Nurse Consultant on 7/23/21 at 10:00 AM. The General Orientation check list included, but was not limited to: HIPAA, Elder Justice Act, Safety Policy, Safety Policy, MSDS, Fire and Disaster plan, Aspects of Aging and Cognitively impaired residents.<br><br>The Administrator was interviewed on 7/23/21 at 2:10 PM. During the interview the Administrator indicated CNA 3's General Orientation check list had not been documented as completed. The Administrator also indicated it should have been documented as completed.<br><br>2. An annual Mantoux form from CNA 3's prior facility, dated 11/21/20, was provided by the Registered Nurse Consultant on 7/23/21 at 10:00 A.M. The form indicated CNA 3's annual Mantoux from 11/21/20 did not have a date/time read; results; interpretation, or nurses signature reading results. These areas were blank on the form.<br><br>A Mantoux Tracking form from CNA 3's current | | Creek at Kendallville to ensure that all employee's files are complete and have all of the required documentation in a timely manner.<br><br>**What corrective action will be accomplished for those residents found to be affected by the deficient practice?**<br><br>All residents have the potential to be affected by the alleged deficient practice. All employee files have been audited at this time and the facility is in the process of obtaining the required documentation. For employee, CNA 3, their general orientation has been completed and the 2 step Mantoux is in the process of being completed.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?**<br><br>All residents have the potential to be affected. The Business Office Manager has completed employee file audits and is in the process of obtaining the required documentation. Moving forward, the Business Office Manager and/or designee will audit the new employee files and ensure that all documentation is obtained as required. | |

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| | facility was provided by Registered Nurse Consultant on 07/23/21 at 10:00 A.M. The Mantoux Tracking form indicated a first step had been given. The form included the results of the Mantoux, the date, the time and had a nurse's signature. The Mantoux Tracking Form did not show any further testing.<br><br>The Administrator was interviewed on 7/23/21 at 2:10 PM. During the interview the Administrator indicated the annual Mantoux from CNA 3's previous employer had not been completed. The Administrator indicated because the annual Mantoux from the other facility had not been completed they should have done a two-step Mantoux for CNA 3 when she started.<br><br>A policy, dated June 2020, was provided by the Administrator on 7/23/21 at 3:00 PM, titled Tuberculosis. The policy indicated " ... The baseline Tuberculin skin testing should eploy the two-step method. If the first step is negative, a second skin test should be performed within one (1) to three (3)weeks after first test."<br><br>3.1-14(p)(7)<br>3.1-14(t)(1) | | **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>The Business Office Manager will complete an employee file audit on all new employee files using a checklist which includes all required documentation. The Administrator will sign off on all new employee files once the Business Office Manager ensures that the file is complete. This will allow for any corrections to be made timely if need be.<br><br>**How the corrective action will be monitored to ensure the deficient practice will not recur?**<br><br>The Business Office Manager will bring the initial employee audit as well as any new employee file audits to the monthly QAPI Committee meeting for further review and recommendations. The QAPI team will continue to monitor the completion of employee files on an ongoing basis.<br><br>The Business Office Manager is responsible for the implementation and monitoring of this plan.<br><br>**Date of compliance:** 08/22/2021 | |

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| | | | Addendum:<br>The Business Office Manager, as part of her new hire orientation, was educated on the required components which must be in each employee's file. The new BOM is completing the Employee Records State Form 5440 to ensure facility compliance. Education was completed on 8/4/2021. See attached form.<br>As per the plan of correction that was submitted, achievement of 100% compliance, and if the QA Committee has decided to stop the reporting of the BOM's monitoring, the BOM will continue monitoring and the IDT will review her findings as part of the morning clinical meeting (at least 5 days a week). The BOM will report results of her monitoring to the QA Committee at least quarterly.<br>If noncompliance is identified, the IDT will perform a root cause analysis of the issue and set up a QAPI plan for process improvement. The BOM will bring the results of the root cause analysis and the QAPI plan to the monthly QA meeting for review by the QA committee members. Further revision to the plan may be made at that time.<br>Once the facility achieves 100% compliance again, the QA Committee may decide to stop the BOM's reporting at every monthly meeting – if that is done, the BOM will continue monitoring and report | |

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| | | | results to the QA Committee at least quarterly, unless compliance is less than 100%. At that time, the IDT process and change in reporting to the QA Committee will occur as outlined above. | |