STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155203	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST VILLAGE	203 SPARKS AVE JEFFERSONVILLE, IN 47130

(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
F000000	This visit was for the Investigation of Complaints IN00141969, IN00142716 and IN00143809. Complaint IN00141969 - Unsubstantiated due to lack of evidence. Complaint IN00142716 - Substantiated. Federal and State deficiencies related to the allegation are cited at F157, F282, and F507. Complaint IN00143809 - Unsubstantiated due to lack of evidence. Survey Dates: January 30, 31, February 3, and 4, 2014 Facility Number: 000110 Provider Number: 155203 AIM Number: 100271120 Survey Team: Gloria J. Reisert, MSW Census bed type: SNF/NF: 115 Total: 115 Census payor type:	F000000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies.Please accept this plan of correction as our credible allegation of compliance. Please	

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Medicare: 27 Medicaid: 73 Other: 15 Total: 115 Sample: 8 These deficiencies also reflect state findings cited in accordance with 410 IAC. Quality review completed on February 6, 2014 by Cheryl Fielden RN.		find enclosed the plan of correction for survey ending February 4, 2014. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allecgation of compliance. Thus, the facility respectfully requests the grantingof paper compliance.	

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F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify the physician when labs were not drawn and/or were unable to be	F000157	It is the practice of this provider to immediately inform resident, consult with the residents physician and if known, notify the residents legal representative or an interested family member	02/21/2014

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	drawn per orders. This deficient practice affected 2 of 8 residents reviewed for physician notification of labs. (Residents #A and #C) Findings included: 1. Review of the clinical record for Resident #A on 1/31/14 at 9:55 a.m., indicated the resident had diagnoses which included, but were not limited to: status post bilateral lung transplants, diabetes mellitus, and iron deficiency anemia. On 1/7/14 at 2:27 p.m., the Transplant Center where the resident had had his lung transplants, faxed over a request for laboratory procedures. Review of this request indicated: "*Please draw on Weds [Wednesdays] q [every] 2 weeks starting 1/8/14. Prograf level [drug to help with avoiding transplant rejection] - *must be drawn prior to AM dose; CBC with diff [complete blood count with differential], Comprehensive Metabolic Panel [CMP] CK total [Calcium], Phosphorus and Magnesium level." Review of the lab results indicated the Prograf level was not drawn until 1/9/14 and was the only lab drawn.		when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the residents physical, mental or psychosocial status in either life threatening condition or clinical complications);a need to alter treatment significantly (i.e.) a need to discontinue an existing form of treatment due to adverse consequences or a decision to transfer or discharge the resident from the facility as specified S483.12 or a decision to transfer. What correction action will be accomplished for those resident found to have been affected by the deficient practice?Resident A labs were immediately redrawn on 2/5/14 and family, physician and Jewish Transplant Center were notified. Resident C physician was notified of the lab not being obtained. A lab was drawn 12/27/13 and was within normal limits. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All resident have the potential to be affected by the deficient practice. A lab audit was conducted by the DNS/designee to ensure all labs were drawn and the appropriate notifications occurred. If non compliance is identified physician and family will be notified and follow up will be	

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	Documentation was lacking in the nursing notes of the physician/Transplant Center having been notified the other labs were not drawn. During an interview with LPN #2 on 2/3/14 at 4:15 p.m., she indicated that the physician would be called if there was a problem with obtaining ordered labs to see about re-drawing the next day or for any other new orders. 2. Review of the clinical record for Resident #C on 1/31/14 at 12:48 p.m., indicated the resident had diagnoses which included, but were not limited to: spinal cord injury, diabetes mellitus, hyponatremia/hyposmolality (low levels of proteins, nutrients and electrolytes in bloodstream). On 12/16/13, a new order was given to draw a Vancomycin (antibiotic) trough level (to check amount of antibiotic in bloodstream) 30 minutes before the dose was to be given on 12/20/13. Documentation was lacking of this trough having been drawn before administering the dose of Vancomycin. Review of the MAR [Medication Administration Record] indicated the resident did receive his		conducted as per physician order. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses were in-serviced on 2/12/14 and 2/13/14 on the policy for Resident Change in Condition, Guidelines for Lab Tracking and includes Physician and Family notification by the DNS/designee. Post Test included. During morning meeting the lab/x-ray tracking log, new orders and EMR activity report will be reviewed by DNS/designee to ensure the appropriate labs/x-rays were drawn and the follow-up/notification has occurred. New orders for lab/x-ray will be documented on the lab/x-ray tracking log . Non compliance will result in further education including disciplinary action. DNS is responsible to ensure compliance. How the correction action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS/Designee will complete the Lab /Diagnostics CQI tool, and the Change in Condition CQI tool monthly for 6 months and ongoing thereafter. Findings from the CQI process will be reviewed monthly and action plan will be implemented for thresholds below 95%.	

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	dose of Vancomycin via IV on 12/20/13. Documentation was also lacking of the physician/pharmacy having been notified that the Vancomycin trough level had not been drawn prior to the resident receiving his dose of antibiotic as ordered and that the resident did receive the medication for 12/20/13. During an interview with the DoN and the Administrator during the final exit meeting on 2/4/14 at 2:20 p.m., the DoN had the Medical Records nurse contact the pharmacy to see if they had a record of the trough level having been drawn. At 2:30 p.m., the DoN was notified by the Medical records nurse that the pharmacy had no record of the level having been drawn for 12/20/13 as ordered. 3.1-5(a)(3)			
F000282 SS=D	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.	F000282	It is the practice of this facility to provide or arrange services by	02/21/2014

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	Based on record review and interview, the facility failed to ensure labs were drawn according to physicians orders for 2 of 8 residents reviewed for lab orders. (Residents #A and #C) Findings included: 1. Review of the clinical record for Resident #A on 1/31/14 at 9:55 a.m., indicated the resident had diagnoses which included, but were not limited to: status post bilateral lung transplants, diabetes mellitus, and iron deficiency anemia. On 1/7/14 at 2:27 p.m., the Transplant Center where the resident had had his lung transplants faxed over a request for laboratory procedures. Review of this request indicated: "*Please draw on Weds [Wednesdays] q [every] 2 weeks starting 1/8/14. Prograf level [drug to help with avoiding transplant rejection] - *must be drawn prior to AM dose; CBC with diff [complete blood count with differential], Comprehensive Metabolic Panel [CMP] CK total [Calcium], Phosphorus and Magnesium level." Review of the lab results indicated the Prograf level was not drawn until		qualified persons in accordance with each residents written plan of care.What correction action will be accomplished for those resident found to have been affected by the deficient practice? The DNS contacted Jewish Transplant Center and exchanged information to ensure communication of labs occurs timely. Resident A labs were immediately redrawn on 2/5/14 and family, physician and Jewish Transplant Center were notified. Resident C physician was notified of the lab not being obtained. A lab was drawn 12/27/13 and was within normal limits and the physician was notified. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by this practice. A lab/x-ray audit will be conducted by the DNS/designee to ensure all labs were drawn and the appropriate notifications occurred. If non compliance is identified physician and family will be notified and follow up will be conducted as per physician order. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses were in-serviced on 2/12/14 and 2/13/14 by the DNS/Designee on the policy for Resident Change in Condition, Guidelines for Lab	

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	1/9/14 and was the only lab drawn. During an interview with the Transplant Center on 1/31/14 at 1:34 p.m., the nurse indicated she had made numerous calls to the facility between 1/7/14 and 1/13/14 attempting to obtain the labs results from 1/8/14 and was told they had not been drawn as ordered. On 2/3/14 at 9:15 a.m., the Director of Nursing [DoN] presented a copy of the lab's 1/9/14 request sheet which indicated what was to be drawn. Review of this sheet only had the Prograf level on it and in pen on the carbon copy was the wording "[not] enough level blood." The DoN indicated she was unsure if one of the nurses or whoever had written that statement and if that was the reason for the labs not being drawn. 2. Review of the clinical record for Resident #C on 1/31/14 at 12:48 p.m., indicated the resident had diagnoses which included, but were not limited to: spinal cord injury, diabetes mellitus, hyponatremia/hyposmolality (low levels of proteins, nutrients and electrolytes in bloodstream). Review of the resident's Vancomycin		Tracking and includes Physician and Family notification and maintaining medical information(lab results) in the medical records (3 months).Post Test included. During morning meeting the lab/x-ray tracking log, new orders and EMR activity report will be reviewed by DNS/designee to ensure the appropriate labs were drawn and the follow-up/notification has occurred. New orders for lab/x-ray will be documented on the lab/x-ray tracking log. Non compliance will result in further education including disciplinary action.. DNS is responsible to ensure compliance. How the correction action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The DNS/Designee will complete the Lab /Diagnostics CQI tool, and the Change in Condition CQI tool monthly for 6 months and ongoing thereafter. Findings from the CQI process will be reviewed monthly and action plan will be implement for thresholds below 95%.	

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	(an antibiotic) orders, indicated he was currently receiving 1750 mg [milligrams] via IV [intravenously] every 24 hours. His dosage was also based upon a trough level [amount of antibiotic in the blood stream] being drawn weekly prior to that morning's dose. On 12/16/13, a new order was given to draw the Vancomycin trough level 30 minutes before the dose was to be given on 12/20/13. Documentation was lacking of this trough having been drawn before administering the dose of Vancomycin. Review of the MAR [Medication Administration Record] indicated the resident did receive his dose of Vancomycin via IV on 12/20/13. During an interview with the DoN and the Administrator during the final exit meeting on 2/4/14 at 2:20 p.m., the DoN had the Medical Records nurse contact the pharmacy to see if they had a record of the trough level having been drawn. At 2:30 p.m., the DoN was notified by the Medical records nurse that the pharmacy had no record of the level having been drawn for 12/20/13 as ordered.			

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	3.1-35(g)(2)			
F000507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. Based on record review and interview, the facility failed to ensure recent laboratory results were available for review in the residents' clinical record. This deficient practice affected 2 of 8 residents reviewed for laboratory results. (Residents #A and #C) Findings included: 1. Review of the clinical record for Resident #A on 1/31/14 at 9:55 a.m., indicated the resident had diagnoses which included, but were not limited to: status post bilateral lung transplants, diabetes mellitus, and iron deficiency anemia. On 1/7/14 at 2:27 p.m., the Transplant Center where the resident had had his lung transplants, faxed over a request for laboratory procedures. Review of this request indicated: "*Please draw on Weds [Wednesdays] q [every] 2	F000507	It is the practice of this facility to file in the residents clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. What correction action will be accomplished for those resident found to have been affected by the deficient practice?The DNS contacted Jewish Transplant Center and exchanged information to ensure communication of labs occurs timely. Resident A labs were immediately redrawn on 2/5/14 and family, physician and Jewish Transplant Center were notified. Resident C physician was notified of the lab not being obtained. A lab was drawn 12/27/13 and was within normal limits.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by this practice.Wh A lab audit will be conducted by the DNS/designee to ensure all labs were drawn and the appropriate notifications occurred by 2/21/14. If non compliance is identified	02/21/2014

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	weeks starting 1/8/14. Prograf level [drug to help with avoiding transplant rejection] - *must be drawn prior to AM dose; CBC with diff [complete blood count with differential], Comprehensive Metabolic Panel [CMP] CK total [Calcium], Phosphorus and Magnesium level." Review of the lab results indicated the Prograf level was not drawn until 1/9/14 and was the only lab drawn. During an interview with the Transplant Center on 1/31/14 at 1:34 p.m., the nurse indicated she had told RN #1 on 1/7/14 about the lab orders and he indicated that he would put the orders into the computer to be drawn the next day. On 1/8/14, she called the facility and spoke to LPN #1, who indicated that only the Prograf level had been drawn and she would have to put in the request again for the other labs to be drawn, but did not have the results of the Prograf available to tell her. On 1/10/14, the Transplant Nurse called the facility and spoke to RN #1 again who indicated the lab requests were incorrectly coded and would have to be re-drawn and that he would fax over the results as		physician and family will be notified and follow up will be conducted as per physician order.What measures will be put into place or what systemic changes will be made toensure that the deficient practice does not recur?Licensed nurses were in-serviced on 2/12/14 and 2/13/14 by the DNS/Designee on the policy for Resident Change in Condition, Guidelines for Lab Tracking which includes Physician and Family notification and maintaining medical information(lab results) in the medical records (3 months). Post Test included. During morning meeting the lab tracking log, new orders and EMR activity report will be reviewed by DNS/designee to ensure the appropriate labs were drawn and the follow-up/notification has occurred. New orders for lab will be documented on the lab tracking log and review of the lab noted. Non compliance will result in further education including disciplinary action. DNS is responsible to ensure compliance. How the correction action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS/Designee will complete the Lab /Diagnostics CQI tool, Change in Condition CQI tool and the Medical Records CQI tool monthly for 6 months and	

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	soon as he got them. She indicated he never did so. She also indicated she had spoken to the Administrator about the difficulties in obtaining the lab results and was referred back to the nursing department. On 1/11/14, the Transplant nurse called the facility again for the results and spoke to RN #2 who told her the labs had not been drawn and would have to re-key them into the computer again. On 1/12/14, when the facility was called again, she was told the lab results still were not available. On 1/13/14, the Transplant Nurse spoke to RN #2 again and gave new orders for the resident's Prograf to be increased because when she was finally given the results from the 1/8/14 lab drawn, the results were considered subtherapeutic and needed to be higher to prevent possible rejection of the lungs. She also indicated she made sure she got verbal confirmation from RN #2 that the new lab orders were put into the system correctly. During interviews with the Director of Nursing [DoN] and with the Unit Manager on 1/31/14 at 1:27 p.m., neither one could recall there being		ongoing thereafter. Findings from the CQI process will be reviewed monthly and action plan will be implement for thresholds below 95%.	

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	any problems with the Transplant Center not being notified of lab results or having any difficulties obtaining lab results. During interviews with RN #1 at 1:55 p.m. and with the Administrator at 2:08 p.m. on 1/31/14, neither one could remember speaking with the Transplant Center regarding the resident's labs. 2. Review of the clinical record for Resident #C on 1/31/14 at 12:48 p.m., indicated the resident had diagnoses which included, but were not limited to: spinal cord injury, diabetes mellitus, hyponatremia/hyposmolality (low levels of proteins, nutrients and electrolytes in bloodstream). Review of a 12/30/13 "Pharmacokinetic Dosing Recommendation" from the pharmacy indicated: "Vancomycin (antibiotic) trough = 18 on 12/27/13 @ [at] 3:30 p.m. (as reported by RN)." On 1/2/14, a new order was received from the physician: "Obtain stool specimen r/t [related to] possible infection."			

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NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130	

(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
	Review of the lab section of the clinical record failed to locate these results. During an interview with the DoN on 2/3/14 at 2:35 p.m., she indicated that she found the stool specimen and Vancomycin trough results still in the physicians's book and was unsure why they had not been placed in the resident's clinical record by now. During an interview with LPN #2 on 2/23/14 at 4:15 p.m., she indicated that the labs have been reviewed and signed by the physician, they would then be filed into the resident's clinical record shortly after being received. 3.1-49(f)(4)			