

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155392	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/09/2011
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT KENDALLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1433 S MAIN ST KENDALLVILLE, IN46755
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F0000	<p>This visit was for the Investigation of Complaint IN00098609.</p> <p>Complaint IN00098609 - Substantiated. Federal/state deficiencies related to the allegation are cited at F205</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: November 7, 9, 2011</p> <p>Facility number: 000402 Provider number: 155392 AIM number: 100288120</p> <p>Survey team: Carol Miller RN, TC</p> <p>Census bed type: SNF/NF: 23 Total: 23</p> <p>Census payor type: Medicare: 3 Medicaid: 18 Other: 2 Total: 23</p> <p>Sample: 3 Supplemental sample: 2</p> <p>These deficiencies reflect state findings</p>	F0000	<p><b>November 22, 2011</b></p> <p>Ms. Brenda Meredith, Area Supervisor Division of Long Term Care INDIANA STATE DEPARTMENT OF HEALTH 2 North Meridian Street, Section 4-B Indianapolis, Indiana 46204-3006</p> <p>RE: <b>Hickory Creek at Kendallville</b></p> <p style="text-align: center;"><b>Provider</b></p> <p style="text-align: center;"><b>No: 15-5392</b></p> <p style="text-align: center;"><b>Complaint IN00098609</b></p> <p>Dear Ms. Meredith:</p> <p>Attached for your review and anticipated approval, you will find the completed form CMS - 2567L Statement of Deficiencies and Plan of Correction for the recent Complaint Survey conducted November 9, 2011, at Hickory Creek at Kendallville, Kendallville IN.</p> <p>Please be advised that it is our intent to have this plan of correction also serve as our Allegation of Compliance. Compliance is effective on December 9, 2011.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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F0205 SS=D	<p>cited in accordance with 410 IAC 16.2.</p> <p>Quality review 11/14/11 by Suzanne Williams, RN</p> <p>Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>Based on interviews and record reviews the facility failed to ensure a Nursing Facility Bed Hold Policy was provided to 2 residents upon being transferred to the hospital .</p> <p>This deficiency affected 2 of 3 closed</p>	F0205	<p>Should you have questions regarding the attached Plan of Correction / Allegation of Compliance, then please do not hesitate to contact me.</p> <p>Sincerely,</p> <p>Laura Etter Administrator</p> <p>F205 Notice of Bed Hold Policy Before/Upon Transfer</p> <p><u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></p>	12/09/2011	

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	<p>clinical records reviewed for Bed Hold Policy in a sample of 3 (Residents B, C).</p> <p>Findings include:</p> <p>1. The record of Resident B was reviewed on 11/7/11 at 10:00 a.m., indicated Resident B was transferred to the hospital on 10/7/11.</p> <p>The Nursing Facility Bed Policy for Resident B was blank.</p> <p>On 11/9/11 at 10:45 a.m. the Director Of Nursing (DON) was interviewed in regard to the blank Bed Hold Policy for Resident B, and the DON indicated LPN #1 filled out the Bed Hold Policy and gave it to the resident but did not keep a copy for the resident's chart.</p> <p>2. The record of Resident C was reviewed on 11/7/11 at 2:00 p.m. and indicated Resident C was transferred to the hospital on 8/22/11.</p> <p>The Nursing Facility Bed Policy for Resident C was blank.</p> <p>On 11/7/11 at 3:30 p.m. the Administrator was interviewed in regard to the blank Bed Hold Policy for Resident C and the Administrator indicated the Bed Hold Policy should have been filled out and</p>		<p>It is the policy of this facility to provide written information to the resident and a family member or legal representative that specifies the duration of the bed hold policy under the state plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed hold periods.</p> <p>Upon transfer or discharge of a resident proper bed hold forms will be explained to resident and a family member or legal representative by charge nurse transferring or discharging resident. Forms will be completed and signed and a copy will be sent with the resident as well as placed in resident's medical chart. A mandatory in-service will be presented by the Administrator and Director of Nursing on November 30, 2011 for licensed nurses explaining policy and procedures of bed hold processes will held.</p> <p>- <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <p>No other residents were affected by this deficient practice.</p> <p><u>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</u></p>		

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	<p>sent with the resident to the hospital.</p> <p>3. On 11/7/11 at 1:15 p.m. the facility Bed Hold Policy, dated as revised on 5/1/11, was received and reviewed and indicated, "when a resident of a facility is hospitalized for any condition...the following Bed Hold Policy shall apply as stated under Federal or State Guidelines. The Resident or Resident's Responsible Party/Agent may request that the Facility hold open the resident's bed during this time. This is known a 'bed hold'. The Resident and the Resident's Responsible Party/Agent will be given notice of the bed hold option at the time of hospitalization...."</p> <p>This federal tag relates to complaint IN00098609.</p> <p>3.1-12(a)(1)</p>		<p>Bed hold packets will be put together by the MDS Coordinator or designee with proper forms that need filled out. Upon discharge or transfer MDS Coordinator or designee will audit discharge/transfer forms located in resident's chart to ensure filled out correctly and that all notifications have been made. The results of those audits will be forwarded to the DON and Administrator. Any nurse who fails to fill out forms appropriately and timely will receive additional training and disciplinary action following facility policy.</p> <p><u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur? What quality assurance program will be put into place?</u></p> <p>A transfer/discharge audit will be completed by MDS Coordinator or designee following discharge or transfer of a resident from facility. Any identified issues or concerns will be forwarded to the monthly QA&amp;A committee for review for 60 days. After the 60 days when 100% compliance has been achieved, review of audit results will be done at a frequency recommended by the QA&amp;A committee; however, the audits themselves will continue as indicated above on an ongoing basis.</p> <p><u>Date of Compliance:</u> December 9, 2011</p>		

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F0502 SS=D	<p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on interview and record review, the facility failed to ensure laboratory tests were done as ordered. This deficiency affected 1 of 3 resident whose closed clinical records were reviewed for laboratory tests in a sample of 3 (Resident C).</p> <p>Findings include:</p> <p>The closed clinical record of Resident C was reviewed on 11/7/11 at 2:00 p.m. and indicated Resident C's diagnoses included, but were not limited to, pulmonary embolism, hypertension, and chronic kidney disease stage III.</p> <p>The admission orders dated 8/18/11 indicated to obtain a Basic Metabolic Panel (BMP) and International Ratio (INR) on 8/19/11.</p> <p>The BMP and INR laboratory tests ordered on 8/18/11 were not on the chart.</p> <p>On 11/7/11 at 3:15 p.m. the Director Of Nursing (DON) was interviewed in regard to the BMP and INR not on the resident's chart and the DON indicated she called the Laboratory in regard to the 2</p>	F0502	<p>F502 Provide/Obtain Laboratory Services Quality/Timely</p> <p>- <u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>It is this facility's intent to provide or obtain laboratory services to meet the needs of its residents and be responsible for the quality and timeliness of the services. Resident C had orders for a Basic Metabolic Panel (BMP) and International Ratio (INR) on 8-18-11. These orders were not followed through on and due to resident being discharged cannot be obtained.</p> <p>A mandatory in-service presented by the Administrator and Director of Nursing will be held for licensed nurses on November 30, 2011 explaining policy and procedures for obtaining labs and ensuring proper placement of results of labs are placed on resident's clinical chart. <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <p>No other residents were affected by this deficient practice. <u>What measures will be put into place or what systematic changes</u></p>	12/09/2011	

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	laboratory tests. The DON indicated the Laboratory was unable to find the BMP and the INR test results ordered for 8/19/11.  3.1-49(a)		<u>will be made to ensure that the deficient practice does not recur?</u> A mandatory in-service will be presented by Administrator and Director of Nursing on November 30, 2011 for licensed nurses explaining policy and procedures for obtaining labs and ensuring proper placement of results of labs are placed on resident's clinical chart. Education will include how to complete and utilize the lab tracking log to ensure the process is completed timely and accurately. The Director of Nursing completed an audit for all current residents to ensure proper documentation and that lab results were obtained and placed in resident's clinical chart. Director of Nursing or designee will audit labs five times per week for one month and then three times per week for one month to ensure labs are completed and placed on resident's chart timely. Once that is completed, the Director of Nursing or designee will continue to audit labs and lab orders as part of the review of the 24 hour report and focus charting during each tour of duty. Any identified issues will be addressed with the staff involved with retraining in the facility's policy and procedure. Disciplinary action will also be given for continued noncompliance. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur ? What</u>		

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F0507 SS=D	<p>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.</p> <p>Based on interview and record review the facility failed to ensure 3 laboratory tests were on the resident's chart.</p> <p>This deficiency affected 1 of 3 resident whose closed clinical records were reviewed for laboratory tests in a sample of 3 (Resident C).</p> <p>Findings include:</p> <p>The closed clinical record of Resident C was reviewed on 11/7/11 at 2:00 p.m. and indicated Resident C's diagnoses included, but were not limited to, pulmonary embolism, hypertension, and chronic kidney disease stage 3.</p> <p>The Physician Orders dated 8/19/11 indicated to obtain Laboratory tests for a Urinalysis with a Culture and Sensitivity and an Albumin Creatinine.</p>	F0507	<p><u>quality assurance program will be put into place?</u></p> <p>Results of lab audits will be reviewed by Quality Assurance Committee for 60 days or until 100 % compliance is attained. The DON or designee will continue to audit on an ongoing basis as indicated in the prior section &amp; will report to the committee as directed by the committee members.</p> <p>F507 Lab Reports in Record</p> <p><u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>It is the policy of this facility to file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. Resident C had order to obtain laboratory tests for a Urinalysis with a Culture and Sensitivity and an Albumin Creatinine. Labs were obtained timely but not placed on chart. The Director of Nursing called the laboratory that completed the blood draw and placed the results on the resident's clinical chart.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be</u></p>	12/09/2011	

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	<p>The Urinalysis with a Culture and Sensitivity and a Albumin Creatinine laboratory tests ordered on 8/18/11 were not on the chart.</p> <p>On 11/7/11 at 3:15 p.m. the Director Of Nursing (DON) was interviewed in regard to the Urinalysis with a Culture and Sensitivity and Albumin Creatinine not being on the resident's chart and the DON indicated she called the Laboratory in regard to the 3 laboratory tests. The DON indicated the Laboratory found the Urinalysis with a Culture and Sensitivity and a Albumin Creatinine test results ordered for 8/19/11.</p> <p>On 11/9/11 at 9:45 a.m. the policy for Laboratory Reports dated revised 7/08 indicated "...7. The original laboratory test report will be placed on the resident's clinical record.</p> <p>On 11/9/11 at 9:15 a.m. the DON indicated she had only worked at the facility since 7/20/11. The DON was interviewed in regard to the Urinalysis with a Culture and Sensitivity and Albumin Creatinine not being on the resident's chart. The DON indicated they receive the laboratory results from the laboratory and put them in a "pile to be filed." The DON indicated she felt the</p>		<p><u>taken?</u></p> <p>No other residents were affected by this deficient practice.</p> <p><u>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>A mandatory in-service will be presented by Administrator and Director of Nursing on November 30, 2011 for licensed nurses explaining policy and procedures on orders for obtaining labs and ensuring the results of labs are placed on resident's clinical chart. Education will include how to properly fill out and utilize the lab tracking log to ensure the process is completed timely and accurately.</p> <p>The Director of Nursing completed an audit of all current resident labs to ensure all proper documentation, receipt of labs and placement of results are in resident's clinical chart. Director of Nursing or designee will audit labs five times per week for one month and then three times per week for one month to ensure labs are completed and placed on resident's chart timely. Any identified issues or concerns will be addressed with staff involved and each will be retrained regarding the facility policy for obtaining lab reports. Disciplinary action will also be given for continued noncompliance.</p> <p>-</p> <p><u>How the corrective action(s) will be</u></p>	

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	laboratory results were in the facility at one time.  3.1-49(f)(4)		<u>monitored to ensure the deficient practice will not recur ? What quality assurance program will be put into place?</u> Results of lab audits will be reviewed by Quality Assurance Committee for 60 days or until 100 % compliance is attained. Further audits will be completed as recommended by the QA&A committee.  - <u>Date of Compliance:</u> December 9, 2011		