

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/04/2012
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
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F0000	<p>This visit was for the Investigation of Complaint IN00119976</p> <p>Complaint IN00119976 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-282 and F-309.</p> <p>Unrelated deficiencies cited</p> <p>Survey date: December 4, 2012</p> <p>Facility number: 000341 Provider number: 155459 AIM number: 100286550</p> <p>Survey team: Sharon Lasher RN, TC Angel Tomlinson RN</p> <p>Census bed type: SNF/NF: 29 Total: 29</p> <p>Census payor type: Medicare: 2 Medicaid: 23 Other: 4 Total: 29</p> <p>Sample: 3</p> <p>These deficiencies also reflect state</p>	F0000		

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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	findings cited in accordance with 410 IAC 16.2. Quality review 12/11/12 by Suzanne Williams, RN				

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F0157 SS=D	<p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician immediately when 1 resident's leg was discolored, cold and edematous, for 1 resident of 3</p>	F0157	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited.	01/03/2013			

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	<p>residents reviewed for physician notification in a sample of 3. (Resident #A)</p> <p>Findings include:</p> <p>The record of Resident #A was reviewed on 12/4/12 at 10:30 a.m. Resident #A's diagnoses included, but were not limited to, atrial fibrillation (irregular heart beat) and congestive heart failure.</p> <p>Resident #A's nursing notes, dated 11/13/12 at 2:00 a.m., indicated "Resident's left foot very cold and purple in some spots. Outside blankets upon arrival to room. Faint pedal pulse, both feet cold, left colder than right. Some mottling (skin discolored in irregular patches) of left leg."</p> <p>Resident #A's nursing notes, dated 11/14/12 at 2:20 p.m., indicated "...Left lower leg is swollen but cool to touch. (Family member) is aware and would like doctor to see her soon...."</p> <p>Resident #A's nursing notes, dated 11/14/12 at 10:00 p.m., indicated "... Left foot 5 plus pitting edema, pale with what appears to be mottling and has slight pedal pulse. (Family member) very concerned. Faxed</p>		<p>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 requirements established by state and federal law.</p> <p>Hickory Creek at New Castle desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 1/03/13.</p> <p>-</p>		

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	<p>physician."</p> <p>Resident #A's nursing notes, dated 11/15/12 at 10:00 p.m., indicated "...Obtain Doppler for left lower extremity to rule out clot. Schedule for 11/16/12 at 12:30 p.m."</p> <p>Resident #A's physician's order, dated 11/15/12, indicated "Doppler ultra/sound left leg to rule out clot."</p> <p>Resident #A's nursing notes, dated 11/16/12 at 12:10 p.m., indicated "Resident transported by (local ambulance service) to (local hospital) for left leg Doppler."</p> <p>Resident #A's nursing notes, dated 11/16/12 at 1:10 p.m., indicated "Received call from (local hospital radiology) Resident diagnosed with extensive DVT (deep vein thrombosis) from groin to calf. Requested that they send resident to emergency room."</p> <p>An interview with the DON (Director of Nursing) on 12/4/12 at 12:15 p.m., indicated looking back on Resident #A's left leg being cold, discolored with edema and the nurse not calling the physician right away might be because the nurse practitioner put in her progress notes she wanted to</p>		<p><u>F157</u></p> <p>-</p> <p>It is the policy of this facility to notify the Physician of any</p> <p>change in resident condition, including any signs/symptoms of changes to a resident's extremity.</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>-</p> <p><u>Resident #A went home from the hospital with family.</u></p> <p>-</p>				

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	make Resident #A palliative care only. 3.1-5(a)(2)		<p><u>Nursing staff and IDT were re-educated on physician notification expectations on 12-16-12 and will be re-educated again by the DON and Administrator on 12-20-12. Nurses new to the facility will be educated during orientation to emphasize the importance of the physician being notified.</u></p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p> <p><u>There have been no other residents identified as being affected by this issue.</u></p> <p>-</p> <p>-</p> <p><u>In the future, if any unmet needs or changes in condition are identified by the DON or any member of the IDT, the DON will ensure that the physician is notified immediately. Once the physician has been notified, and</u></p>		

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			<p><u>the resident's needs have been taken care of, the DON will retrain the nurses involved. In addition she will render progressive disciplinary action for continued noncompliance.</u></p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>-</p> <p><u>The DON or IDT will review the nurses' notes and 24 hour report at the morning meeting which is held five times per week, for issues or concerns noted by the charge nurses.</u></p> <p><u>If any are identified, the DON will follow through as indicated in question #2.</u></p> <p>-</p> <p><u>Any recommendations or interventions formulated during the IDT review will be followed through by the DON or designee. The resident's care plan and CNA assignment sheet will be updated accordingly.</u></p> <p>-</p> <p>-</p>		

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			<p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p>The Administrator will bring the minutes of the IDT morning meetings to the monthly QA&A Committee meeting for review and recommendation. Any recommendations made by the committee will be followed through by the Administrator who will report the results of those recommendations at the next scheduled QA&A Committee meeting.</p> <p>The review of the nurses' notes and 24 hour report by the DON or designee will continue on an ongoing basis.</p> <p>-</p> <p><u>Date of Compliance: 1/03/13</u></p>		

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to follow the physician's orders for Lovenox (anticoagulant medication to prevent deep vein thrombosis) to be administered every day and for 1 resident's insulin to be given with meals, for 2 of 3 residents reviewed for physician orders in a sample of 3. (Residents #A and #B)</p> <p>Findings include:</p> <p>1. The record of Resident #A was reviewed on 12/4/12 at 10:30 a.m. Resident #A's diagnoses included, but were not limited to, atrial fibrillation (irregular heart beat) and congestive heart failure.</p> <p>Resident #A's physician's order, dated 11/2/12, indicated "Lovenox 30 mg/0.3 ml (milliliter) injection SQ (Subcutaneous) every day."</p> <p>During an interview on 12/4/12 at 1:45 p.m., the DON (Director of Nursing) indicated after Resident #A was admitted to the hospital, the</p>	F0282	<p>F282</p> <p>-</p> <p>It is the policy of this facility to provide services to all residents in accordance with each one's plan of care.</p> <p>-</p> <p><u>1.What corrective action will be done by the facility?</u></p> <p>-</p> <p><u>Resident #A went home from the hospital with family.</u></p> <p>-</p> <p><u>Resident #B is receiving her insulin injections on a timely basis.</u></p> <p>-</p> <p><u>All nurses were in-serviced on 12/16/12 regarding the facility</u></p>	01/03/2013	

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	<p>hospital called the facility and indicated they had reviewed Resident #A's MAR (Medication Administration Record) sent with her on admission, and there was a concern that Resident #A had not received her Lovenox as ordered at the facility. The MAR faxed from the hospital indicated the Lovenox was not given from 11/11/12 to 11/16/12. After investigating the concern from the hospital it was determined Resident #A had not received her Lovenox as ordered. The facility received 10 doses of the Lovenox from the pharmacy on 11/3/12 and the pharmacy verified the 10 doses were the only Lovenox sent to the facility. Four doses were administered by other nurses, and there were 5 doses of Lovenox remaining in Resident #A's medication drawer after she was sent to the hospital. Resident #A had missed a total of 9 doses of the Lovenox. The DON also indicated the hospital had completed lab work, and the lab work did not reflect levels of Lovenox in Resident #A's blood work consistent with the physician's order for Lovenox.</p> <p>Resident #A's MAR, which had been sent to the hospital, was requested on 12/4/12, but was not provided.</p>		<p><u>policy for following physician's orders and for dispensing medication per the physician's orders and according to the appropriate parameters.</u></p> <p>-</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p> <p><u>There have been no other residents identified as being affected by this practice.</u></p> <p>-</p> <p>In the future, if the DON finds an issue in regards to administration of medications, including not giving medications as ordered, or giving medications on an untimely basis, she will intercede immediately to make sure that the resident is receiving what he/she has been ordered, including the correct medication and the</p>	

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	<p>2. The record of Resident #B was reviewed on 12/4/12 at 11:10 a.m.</p> <p>Resident #B's physician orders, dated 9/13/12 indicated "Novolog (fast acting insulin) 5 units S.Q. (Subcutaneous) three times daily with meals."</p> <p>On 12/4/12 at 9:30 a.m., Resident #B was observed receiving her Novolog insulin injection.</p> <p>During an interview on 12/4/12 at 9:35 a.m., Resident #B indicated she ate her breakfast at 7:00 a.m., this morning.</p> <p>During an interview on 12/4/12 at 9:35 a.m., RN #1, indicated Resident #B ate her breakfast this morning at 7:00 a.m. RN#1 also indicated she was aware the insulin was to be given with meals.</p> <p>Review of the Nursing Spectrum, Drug Handbook, 2010, indicated "Novolog insulin give S.Q. 5 to 10 minutes before meals."</p> <p>This federal tag relates to complaint IN00119976.</p> <p>3.1-35(g)(2)</p>		<p>frequency and timing of the medication as ordered by the physician. The DON will initiate a medication error sheet and notify the physician of the identified issue if indicated by the situation.</p> <p>Once that is done, she will investigate the situation fully and re-train the nurse(s) involved in the issue. She will also give progressive disciplinary action up to and including termination for any noncompliance related to medication administration</p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>The Director of Nursing or designee will complete an audit of the medication administration records three times a week for 30 days and then weekly for 30</p>		

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			<p>days to ensure medications are given as ordered and scheduled. Any medications that have been circled indicating the medication was not given must have a detailed explanation on the reverse side of the medication administration record. The DON will report the results of her audits at the next scheduled morning meeting which occurs at least 5 days a week.</p> <p>A nurse, who circles a medication as not being given but fails to document the explanation, will receive retraining in the proper procedure and disciplinary action. If the DON or designee finds any other issues, the DON will follow through with the nurse(s) involved as indicated in question #2.</p> <p>-</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p>		

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			- Results of the medication administration record audit will be reviewed at the monthly QA&A committee meeting for 60 days. Once 100% compliance is obtained the QA&A Committee may decide to stop the written audits; however, the checking of the DON or designee of the MARs will continue on an ongoing basis. - <u>Date of Compliance: 1/03/13</u>		

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F0309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to administer 9 doses of Lovenox (anticoagulant medication to prevent deep vein thrombosis) for 1 resident, resulting in the resident being hospitalized with a DVT (deep vein thrombosis), for 1 of 3 residents reviewed for medications in a sample of 3. (Resident #A)</p> <p>Findings include:</p> <p>The record of Resident #A was reviewed on 12/4/12 at 10:30 a.m. Resident #A's diagnoses included, but were not limited to, atrial fibrillation (irregular heart beat) and congestive heart failure.</p> <p>Resident #A's MDS (Minimum Data Set), assessment, dated 11/12/12, indicated BIMS (Brief Interview for Mental Status) was a 6, with a score of 0-7 indicating severe impairment of cognition. The MDS also indicated, medications received, anticoagulant, 7 times during the last 7 days.</p>	F0309	<p><u>F309</u></p> <p>-</p> <p><u>It is the policy of this facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being.</u></p> <p>-</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>-</p> <p><u>Resident #A went home from the hospital with family.</u></p> <p>-</p> <p><u>Nursing staff and IDT were re-educated on physician notification expectations on 12-16-12 and will be re-educated again by the DON and</u></p>	01/03/2013	

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	<p>Resident #A's physician's order, dated 11/2/12, indicated "Lovenox 30 mg/0.3 ml (milliliter) injection S.Q. (Subcutaneous) every day."</p> <p>Resident #A's nursing notes, dated 11/13/12 at 2:00 a.m., indicated "Resident's left foot very cold and purple in some spots. Outside blankets upon arrival to room. Faint pedal pulse, both feet cold, left colder than right. Some mottling (skin discolored in irregular patches) of left leg."</p> <p>Resident #A's nursing notes, dated 11/14/12 at 2:20 p.m., indicated "...Left lower leg is swollen but cool to touch. (Family member) is aware and would like doctor to see her soon...."</p> <p>Resident #A's nursing notes, dated 11/14/12 at 10:00 p.m., indicated "... Left foot 5 plus pitting edema, pale with what appears to be mottling and has slight pedal pulse. (Family member) very concerned. Faxed physician."</p> <p>Resident #A's nursing notes, dated 11/15/12 at 10:00 p.m., indicated "...Obtain Doppler for left lower extremity to rule out clot. Schedule for 11/16/12 at 12:30 p.m."</p>		<p><u>Administrator on 12-20-12.</u> <u>Nurses new to the facility will be educated during orientation to emphasize the importance of the physician being notified.</u></p> <p>-</p> <p><u>All nurses were in-serviced on 12/16/12 regarding the facility policy for following physician's orders and for dispensing medication per the physician's orders and according to the appropriate parameters.</u></p> <p>-</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p> <p><u>There have been no other residents identified as being affected by these issues.</u></p> <p>-</p> <p><u>In the future, if any unmet needs or changes in condition are identified by the DON or any member of the IDT, the DON will ensure that the physician is notified immediately. Once the</u></p>		

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	<p>Resident #A's physician's order, dated 11/15/12, indicated "Doppler ultra/sound left leg to rule out clot."</p> <p>Resident #A's nursing notes, dated 11/16/12 at 12:10 p.m., indicated "Resident transported by (local ambulance service) to (local hospital) for left leg Doppler."</p> <p>Resident #A's nursing notes, dated 11/16/12 at 1:10 p.m., indicated "Received call from (local hospital radiology) Resident diagnosed with extensive DVT from groin to calf. Requested that they send resident to emergency room."</p> <p>An interview with the DON (Director of Nursing) on 12/4/12 at 12:15 p.m., indicated looking back on Resident #A's left leg being cold, discolored with edema and the nurse not calling the physician right away might be because the nurse practitioner put in her progress notes she wanted to make Resident #A palliative care only.</p> <p>During an interview on 12/4/12 at 1:45 p.m., the DON (Director of Nursing) indicated after Resident #A was admitted to the hospital, the hospital called the facility and</p>		<p><u>physician has been notified, and the resident's needs have been taken care of, the DON will retrain the nurses involved. In addition she will render progressive disciplinary action for continued noncompliance.</u></p> <p>-</p> <p>Likewise, if the DON finds an issue in regards to administration of medications, including not giving medications as ordered, or giving medications on an untimely basis, she will intercede immediately to make sure that the resident is receiving what he/she has been ordered, including the correct medication and the frequency and timing of the medication as ordered by the physician. The DON will initiate a medication error sheet and notify the physician of the identified issue if indicated by the situation.</p> <p>Once that is done, she will investigate the situation fully and re-train the</p>		

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	<p>indicated they had reviewed Resident #A's MAR (Medication Administration Record) sent with her on admission, and there was a concern that Resident #A had not received her Lovenox as ordered at the facility. The MAR faxed from the hospital indicated the Lovenox was not given from 11/11/12 to 11/16/12. After investigating the concern from the hospital, it was determined Resident #A had not received her Lovenox as ordered. The facility received 10 doses of the Lovenox from the pharmacy on 11/3/12, and the pharmacy verified the 10 doses were the only Lovenox sent to the facility. Four doses were administered, and there were 5 doses of Lovenox remaining in Resident #A's medication drawer after she was sent to the hospital. Resident #A missed a total of 9 doses. The DON also indicated the hospital had completed lab work, and the lab work did not reflect levels of Lovenox in Resident #A's blood work consistent with the physician's order for Lovenox.</p> <p>Resident #A's MAR, which was sent to the hospital, was requested on 12/4/12 at 2:00 p.m., but was not provided.</p> <p>This federal tag relates to complaint</p>		<p>nurse(s) involved in the issue. She will also give progressive disciplinary action up to and including termination for any noncompliance related to medication administration</p> <p>-</p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>-</p> <p><u>The DON or IDT will review the nurses' notes and 24 hour report at the morning meeting which is held five times per week, for issues or concerns noted by the charge nurses.</u></p> <p><u>If any are identified, the DON will follow through as indicated in question #2.</u></p> <p>-</p> <p><u>Any recommendations or interventions formulated during the IDT review will be followed through by the DON or designee. The resident's care plan and CNA assignment sheet will be updated accordingly.</u></p> <p>The Director of Nursing or</p>				

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	IN00119976. 3.1-37(a)		<p>designee will complete an audit of the medication administration records three times a week for 30 days and then weekly for 30 days to ensure medications are given as ordered and scheduled. Any medications that have been circled indicating the medication was not given must have a detailed explanation on the reverse side of the medication administration record. The DON will report the results of her audits at the next scheduled morning meeting which occurs at least 5 days a week.</p> <p>A nurse, who circles a medication as not being given but fails to document the explanation, will receive retraining in the proper procedure and disciplinary action. If the DON or designee finds any other issues, the DON will follow through with the nurse(s) involved as indicated in question #2.</p>		

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			- - 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> - The Administrator will bring the minutes of the IDT morning meetings to the monthly QA&A Committee meeting for review and recommendation. Any recommendations made by the committee will be followed through by the Administrator who will report the results of those recommendations at the next scheduled QA&A Committee meeting. The review of the nurses' notes and 24 hour report by the DON or designee will continue on an ongoing basis. - Results of the medication		

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			<p>administration record audit will be reviewed at the monthly QA&A committee meeting for 60 days. Once 100% compliance is obtained the QA&A Committee may decide to stop the written audits; however, the checking of the DON or designee of the MARs will continue on an ongoing basis.</p> <p>-</p> <p><u>Date of Compliance: 1/03/13</u></p>		