| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155424 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 08/10/2016 |
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| HICKORY CREEK AT COLUMBUS | 5480 E 25TH STREET<br>COLUMBUS, IN 47203 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00206231.<br><br>Complaint IN00206231 - Substantiated. Federal/state deficiency related to the allegations are cited at F309.<br><br>Survey dates: August 8, 9 and 10, 2016<br><br>Facility number: 000284<br>Provider number: 155424<br>AIM number: 100290690<br><br>Census bed type:<br>SNF/NF: 35<br>Total: 35<br><br>Census payor type:<br>Medicare: 1<br>Medicaid: 31<br>Other: 3<br>Total: 35<br><br>Sample: 3<br><br>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed by 34233 on August 15, 2016. | F 0000 | The Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, the submission of the Plan of Correction is not an admission that a deficiency exists or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by the state and federal law. Hickory Creek at Columbus desires this Plan of Correction to be considered the facility's allegation of compliance. Compliance is effective 8/26/16. | |

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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| F 0309<br>SS=G<br>Bldg. 00 | 483.25<br>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br>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.<br>Based on interview and record review, the facility failed to provide nursing assessments in a timely manner related to vital signs as indicated by the resident's condition, and physician notification of change in condition on 1 resident with bradycardia (abnormally low heart rate) and hypothermia (abnormally low temperature). This deficient practice resulted in harm in that Resident B developed septic shock, which required intubation (breathing tube/machine) and intensive care. (Resident B)<br><br>Findings include:<br><br>Resident B's closed clinical record was reviewed on 8/9/2016 at 12:05 p.m. Diagnoses included, but were not limited to, atrial fibrillation, congestive heart failure (CHF), chronic obstructive | F 0309 | 309 It is the policy of this facility that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psycho social well-being, in accordance with comprehensive assessment and plan of care, including provision of nursing assessments, in a timely manner, as indicated by the resident's condition followed by physician notification of change of condition when indicated by the results of the assessment. 1.) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?: Resident B no longer resides at this facility. The DON will educate all the licensed nurses by 8/26/16 regarding the facility policies for change of condition, parameters for vital signs, assessment of | 08/26/2016 |

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| | pulmonary disease (COPD), chronic renal insufficiency, recurrent urinary track infections (UTIs), neurogenic bladder, urinary retention, and chronic indwelling Foley catheter.<br><br>Resident B was hospitalized for acute cystitis related to a urinary tract infection with severe sepsis and septic shock on 7/9/2016 and returned to the facility receiving antibiotic therapy on 7/13/2016. Resident B was transferred to the Hospital #1 Emergency Department due to hypothermia, bradycardia, hypotension, and altered mental status on 7/22/2016.<br><br>Resident B's quarterly Minimum Data Set (MDS) assessment, dated 7/8/2016, indicated a Brief Interview for Mental Status (BIMS) score of 6; this indicated moderate cognitive impairment. The resident required extensive, 1-2 person assistance for all ADLs (activities of daily living) and had a Foley catheter.<br><br>A Care Plan for Resident B, revised on 7/14/2016, indicated: "Focus: I have a Foley cath [catheter] placed for elimination of my urine...I am at risk for a UTI...Interventions/Tasks: I need staff to alert MD ASAP [as soon as possible] of any abnormal findings...monitor me for any alterations in cognitive function | | residents who are exhibiting signs and symptoms of a change in condition, including those who are on antibiotic therapy, and prompt notification of the physician or nurse practitioner with current information regarding the resident, including current assessment findings and vital signs results. 2.) 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 ability to be affected by this practice. An audit has been completed for all residents to check on the timeliness of weekly assessments and documentation of residents' vital signs,including pulse and temperature to make sure that changes in residents'conditions or vital signs have been followed up appropriately. If any are found either as a result of this audit or in the future, the DON will make sure that the resident has been assessed and his/her information is current and accurate. She or the charge nurse will call the physician to report any abnormalities as quickly as possible, with prompt follow up as needed. Once that is done, the DON will re-train the nurses involved regarding the facility's policies for resident assessment of condition changes, including vital signs, documentation of weekly assessments of the | |

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| | and notify MD."<br><br>A Care Plan for Resident B, initiated 2/29/2016, indicated: "Focus: I take medication for high blood pressure...Interventions/Tasks: I need monitored for signs and symptoms of high/low blood pressure...blood pressure taken as ordered..."<br><br>A Care Plan for Resident B, initiated 2/29/2016, indicated: "Focus: I am at risk to experience shortness of breath and/or low oxygen sats related to my diagnosis of COPD...Interventions/Tasks: ...I need by [sic] O2 [oxygen] sats [saturations] monitored every shift and as needed..."<br><br>A Care Plan for Resident B, initiated 4/13/2016, indicated: "Focus: I am at risk for blood clots and decreased cardiac output related to my diagnosis of A-Fib...Interventions/Tasks: ...Staff will observe me for...decreased level of consciousness...Vital signs as ordered with abnormal results reported to MD..."<br><br>A Care Plan for Resident B, initiated 2/29/2016, indicated: "Focus: I have chronic UTIs and am at risk for future infections...Interventions/Tasks: My nursing staff will observe my vital signs for s/s infection and notify MD if noted..." | | residents' condition, and physician notification. Progressive disciplinary action will be given for continued noncompliance in this area up to and including termination of employment. 3.) What measures will be put into place or systemic changes will be made to ensure that the deficient practice does not recur?: Each resident will have their baseline temperatures redone in order to make sure that they are accurately documented. Parameters for notification of the physician for abnormal vital signs have been obtained from the Medical Director who is also the attending physician for the residents in this facility. The DON has reviewed the parameters with the nurses and will post them in a visible place in the nurses' station area for reference by the nurses. The DON has reviewed and revised the calendar for completion of the weekly summaries to make sure that all residents are on the list. As the summaries are completed, the nurse will highlight the resident on the list to indicate that a particular summary is done. The DON will monitor the completion of the summaries at least 5 times a week. If she should find that any are not completed as per the schedule, she will review the policy and procedure with the nurse involved, and will render progressive disciplinary action as indicated by the situation. The | |

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| | There was no evidence in the Physician's Orders, Care Plans, or anywhere in the clinical record which indicated an order for frequency of vital signs.<br><br>Documentation review indicated Resident B received an Admission Nursing Assessment on 7/13/2016. There was no evidence in the clinical record that Resident B received a nursing assessment after 7/13/2016.<br><br>Resident B's vital signs, dated 7/19/2016 at 3:01 p.m., indicated, "Temperature: "95.1 [degrees] F [Fahrenheit] (tympanic), Pulse: 50 bpm [beats per minute] - irregular - chronic, Blood Pressure: 122/60, O2 [oxygen] sats [saturation]: 98% (Room air), Respiratory Rate: 18 breaths per minute."<br><br>Review of Resident B's vital signs from 5/30/2016 through 7/19/2016 indicated the resident only experienced a pulse/heart rate of 50 or lower on 7/9/2016, when the resident was admitted to the hospital with sepsis.<br><br>There was no evidence anywhere in the clinical record that Resident B's pulse, blood pressure, O2 sats, or respiratory rate were evaluated between 7/19/2016 at 3:05 p.m. and 7/22/2016 at 8:50 a.m. | | DON or Designee will review changes in physician's orders, progress notes and documentation of vital signs during the daily stand up meeting which is attended by managers and members of the Interdisciplinary team. This will be done at least 5 times a week. The IDT will review and offer recommendations for process improvement as indicated. The DON or designee will follow through and report progress back to the IDT at the next scheduled stand up meeting. 4.) How the corrective actions will be monitored to ensure the deficient practice will not recur? The DON will bring the results of her monitoring residents' conditions, residents' assessments, abnormal vital signs, and physician notification to the monthly QA committee for further review for the next 90 days. After the 90 day period, the QA Committee may decide to stop the requirement for reporting results if 100% compliance has been achieved. However the monitoring and follow up will continue by the DON and designee on an ongoing basis. 5.) By what date will the systemic changes be completed: 8-26-16 | |

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| | Resident B's vital signs, dated 7/22/2016 at 8:50 a.m., indicated: "Temperature: "93.9 [F] (Rectal), Pulse: 61 bpm - irregular - chronic, Blood Pressure: 95/60, O2 [oxygen] sats [saturation]: 98% (Room air), Respiratory Rate: 16 breaths per minute."<br><br>Resident B's Progress Notes, dated 7/20/2016 at 6:25 a.m., indicated: "Temp 95.5 [F]...Foley catheter is draining clear yellow liquid...."<br><br>Resident B's Progress Notes, dated 7/21/2016 at 6:30 a.m., indicated, "...F/C [Foley catheter] patent draining dark yellow concentrated urine with scanty [sic] amount of blood noted. Temp 95.8 [F]..."<br><br>Resident B's Progress Notes, dated 7/22/2016 at 4:15 a.m., indicated: "Temp 94.8 [F]. F/C patent draining tea colored urine decreased output noted...Resident BLE [bilateral lower extremities] noted weeping legs wrapped with Kerlix and ACE wraps."<br><br>Resident B's Progress Notes, dated 7/22/2016 at 8:52 a.m., indicated: "res [resident] lethargic, weak, shaky, cold to touch, temporal temp 86.5 [F] rectal temp 93.9 [F]; BP 95/60, P [pulse] 61, RR | | | |

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| | 16...BLE with weeping edema with generalized non pit [pitting] edema; disoriented from baseline...F/C patent with tea colored cloudy urine with decreased output...NP [Nurse Practitioner] paged for further orders."<br><br>Resident B's Progress Notes, dated 7/22/2016 at 9:09 a.m., indicated: "...send to ER [Emergency Room] for eval [evaluation] and treat [treatment]."<br><br>Resident B's Progress Notes, dated 7/22/2016 at 9:20 a.m., indicated: "Transfer to hospital by [ambulance] d/t [due to] hypotension, hypothermia, lethargic, confusion..."<br><br>Resident B's Hospital #1 EMS (Emergency Medical Services/Ambulance) Report, dated 7/22/2016, indicated EMS arrived to the facility at 9:20 a.m. Vital signs and cardiac monitor indicated a heart rate in the 30's and no palpable blood pressure. EMS Narrative indicated: "...Upon arrival, the crew was advised by nursing staff that the patient is hypotensive and hypothermic. The patient presented alert and oriented...states she is sleepy and her belly hurts. The patient presented with a PICC [peripherally inserted central catheter] line in her R [right] arm and a Foley catheter in place..." The resident | | | |

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| | received two doses of Atropine [medication used to treat abnormally low heart rate in an emergency] en route to the Emergency Department (ED) at Hospital #1.<br><br>Resident B's Hospital #1 Emergency Physician Record, dated 7/22/2016 at 9:46 a.m., indicated: "...chief complaint: ? sepsis - low temp at ECF [extended care facility]...EMS had bradycardia [abnormally slow heart rate], [no palpable] BP [blood pressure]. Pt has been awake and alert and responsive however...hospitalized: recent UTI/sepsis...Extremities: [positive sign] weeping wounds to RLE...[Cardiology Consult] - transcutaneous pacing. Suspect brady [bradycardia] 2/2 [secondary to] infection/sepsis..."<br><br>Resident B's Hospital #1 ED Clinical Summary, dated 7/22/2016 at 9:57 a.m., indicated: "Temp Rectal: 34.8 Deg C. O2 Sat 89%. Respiratory Rate: 21 br/min [breaths per minute]. Peripheral Pulse Rate: 37 bpm [beats per minute]. Blood Pressure: 70/40..."<br><br>The resident was transferred to Hospital #2 for ICU (Intensive Care Unit) admission 7/22/2016 at 3:00 p.m.<br><br>Resident B's Hospital #2 Critical Care | | | |

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| | Admission History and Physical, dated 7/22/2016 at 7:57 p.m., indicated, "...History of Present Illness: [Resident B] presenting from [Hospital #1] as a transfer for further management. [Resident B] was hypothermic [low temperature] , bradycardic [low heart rate] in the 30's..., hypoTN [low blood pressure] at 70/40, hyperK [abnormally high potassium] at 6.5, lactate 1.9...Upon arrival to our facility...PICC line was removed was [sic] showed concern for infection...Impression and Plan: 1. HyperK...2. Bradycardia...3. SIRS [Systemic Inflammatory Response Syndrome; criteria include hypothermia and elevated white count] - hypothermia, hypoTN, WBC [white blood cell count] elevated [indicates infection]...giving levophed and dopamine infusions...5. Acute Respiratory Failure - intubated [breathing tube/machine] for respiratory failure and failure to protect airway in setting of ams [altered mental status]..."<br><br>Resident B's Hospital #2 Discharge Summary, dated 7/29/2016, indicated, "...Discharge Diagnoses: 1. Septic Shock [severe sepsis with hypotension, despite adequate fluid resuscitation]. 2. Enterococcus faecalis bacteremia from peripherally inserted central catheter line. 3. Encephalopathy/delirium. 4. Acute renal failure..." | | | |

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| | The facility Nurse Practitioner (NP) was interviewed on 8/9/2016 at 3:40 p.m. She indicated her records indicated she last saw Resident B on 6/30/2016. The NP indicated she was not notified of the resident's decreased heart rate on 7/19/2016. The resident's vital signs and condition could fluctuate rapidly, indicating, "[It's] based on good assessment and what else is going on with [Resident B]...not just [Resident B's] numbers [vital signs]." The NP indicated she would expect the abnormal heart rate of 50, documented on 7/19/2016, to be re-checked and followed up on. The NP indicated she would expect abnormal findings to prompt a nursing assessment and to be notified of any significant changes. The NP indicated, "Vital signs should be completed every shift until it's cleared up... if it's a UTI, pneumonia..."<br><br>The Director of Nursing (DON) was interviewed on 8/9/2016 at 3:59 p.m. She indicated Resident B's last weekly nursing assessment was 7/13/2016 and the resident should have received a weekly nursing assessment on 7/19/2016. The DON indicated she was made aware via written communication from the nurse on 7/19/2016 that the assessment was not completed and that she normally would follow up. The DON indicated: | | | |

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| | "They [nurses] all know abnormal one's [vital signs] need to be reported to the MD." The DON indicated there was no policy and procedure related to nursing assessments or abnormal vital signs. The DON indicated the expectation was that residents received a weekly nursing assessment and additional assessments were based on nursing judgement.<br><br>The Executive Director (ED) was interviewed on 8/9/2016 at 4:34 p.m. She indicated, "Corporate said if the doc [doctor] didn't give parameters, our policy [regarding vital signs and nursing assessments] was nursing judgement."<br><br>On 8/10/2016 at 1:42 p.m., the ED indicated: "[Resident B] should have had vital signs those two days."<br><br>On 8/10/2016 at 1:50 p.m., the DON indicated: "[Resident B's] recorded baseline temperature was "97.9' [F]."<br><br>A copy of the current Vital Signs Nursing Policy and Procedure was provided by the DON on 8/9/2016 at 4:25 p.m. The policy indicated: "Vital signs will be taken as per physician's order or per nursing judgement...D. Establishing a Baseline Temperature: ...3. Average...7 days worth of temperatures to determine the baseline temperature. 4. Document | | | |

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| | baseline temperature..."<br><br>A copy of the current Change of Condition Nursing Policy and Procedure was provided by the DON on 8/9/2016 at 2:30 p.m. The Policy indicated: "...The resident's primary physician or designated alternate will be notified immediately of any change in the resident's physical or mental condition...will be documented in the resident's clinical record...Guidelines: Documentation in the nurses' notes is required each shift on any resident who experiences a problem, demonstrates a symptom, or any change of status. Documentation must continue each shift for at least 24 hours, and usually 72 hours, after the problem is identified, then daily until the problem is noted as resolved. Examples of significant change include, but are not limited to: ...change in level of consciousness, signs and symptoms of infection, change in temperature, antibiotic therapy...Procedure: ...Nurses' notes will identify the condition change and will describe any pertinent nursing assessment indicators and interventions taken. 3. Vital signs will be taken every shift until the resident is stable. 4. Physician and family will be notified. 5. Follow up charting will continue every shift until the problem has resolved..." | | | |

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| | This Federal tag relates to Complaint IN00206231.<br><br>3.1-37 (a) | | | |